SUMMARY

DR. SHAHZAD QURESHI (CPSO #89731)

1. Disposition

On June 12, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required medical hospitalist Dr. Qureshi to appear before a panel of the Committee to be cautioned with respect to the assessment and diagnosis of hyponatremia (low sodium level in the blood) and his supervision of a medical resident. The Committee also directed that Dr. Qureshi review College policy #2-11, *Professional Responsibilities in Post-Graduate Medical Education* and update his knowledge of the assessment and diagnosis of hyponatremia, and then provide the Committee with a written report, approximately 2-4 pages in length, with respect to his review in these two areas.

2. Introduction

A family member of a patient complained to the College that Dr. Qureshi failed to provide adequate supervision of a PGY4 (post-graduate year four) resident, which resulted in the premature discharge of the patient from hospital and his death at home in October 2016. The family member also expressed concern that Dr. Qureshi did not inform her or the patient that a resident would be providing care to the patient or clarify the degree of involvement he himself would have in the patient's care.

Dr. Qureshi indicated that, when considering the appropriate level of supervision for residents, he considers the resident's level of training and experience, his level of trust in the resident's clinical judgement, and the resident's demonstrated clinical acumen. He stated that, in his experience, the resident who provided care to the patient in this case was a very experienced

senior internal medicine resident with excellent clinical acumen. Dr. Qureshi noted that he personally discussed and reviewed the patient's case with the resident and helped make a plan of care for the patient.

3. Committee Process

An Internal Medicine Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

It appeared to the Committee that the patient was volume depleted and hypotensive, and that he was in acute renal failure and had severe hyponatremia that was symptomatic. This is a fairly common internal medicine consultation but Dr. Qureshi, as the most responsible physician for the patient, failed to recognize that the resident did not handle it appropriately.

Dr. Qureshi indicated to the College that the patient had asymptomatic hyponatremia when in fact the patient had come to the emergency department (ED) because of symptoms, including shortness of breath and dizziness, as well as fatigue and weakness. Furthermore, the patient's blood pressure was falling while he was in the ED and the last systolic blood pressure before his discharge was less than 100.

There were no documented findings upon physical examination regarding the patient's jugular venous pressure or any comments in the record about his falling blood pressure. The patient's creatinine level was very high and without documentation of a previously elevated level, the

assumption should have been that he had acute renal failure. Dr. Qureshi and the resident dismissed the high creatinine and low sodium level as being due to the patient's thiazide/ACE inhibitor and excessive water intake.

Dr. Qureshi indicated in his response to the complaint that he reviewed the ECG and chest x-ray, but the Committee could find no documentation to indicate that he examined the patient. As the attending physician, Dr. Qureshi should have assessed the patient in order to confirm the findings and arrive at a clearer diagnosis that identified the cause of the hyponatremia.

In the Committee's view, Dr. Qureshi should have been alarmed by the significant fall in the patient's sodium level over a span of only five days, particularly as the cause was unknown. It was unreasonable to send the patient home with a low sodium level knowing that he would not have his blood retested until his appointment with his family physician in two days' time. The patient was discharged from the ED with instructions to drink only when thirsty. This was inappropriate advice - water restriction in patients with hyponatremia that is not dilutional can be disastrous.

In addition, the patient was on dabigatran, which is 85 percent renally excreted. Dr. Qureshi should have reduced the patient's dose of dabigatran in view of the possibility of acute kidney injury.

Dr. Qureshi indicated that he had confidence in the resident's abilities and was content with the resident's review of the patient. The Committee was of the view that Dr. Qureshi should have recognized that the resident's assessment of the patient was inadequate. As Dr. Qureshi indicated he reviewed the history the resident took, he should have recognized that the patient was in fact symptomatic. If he reviewed the resident's physical findings, he should have noted that the findings (such as a normal jugular venous pressure) and the blood work results did not fit with the final diagnosis. Dr. Qureshi pointed out that the patient did not have neurological

signs and was not experiencing seizures. The Committee considered this comment and noted that the diagnosis is coming too late if a hyponatremic patient is having seizures.

It was inappropriate for Dr. Qureshi to allow the resident to make a diagnosis of hyponatremia and discharge the patient without assessing the patient personally. He should have recognized that the patient required admission and observation, as well as treatment of the underlying cause of his hyponatremia and close follow-up of his sodium level.

It was troubling to the Committee that Dr. Qureshi's response to the complaint did not show insight or concern about the inaccurate diagnosis. It was not apparent to the Committee that Dr. Qureshi had considered what he should have done differently either in his clinical care of a hyponatremic patient or in his supervision of the resident. There was no indication that Dr. Qureshi had reviewed this case and determined areas where his knowledge requires updating.

In light of the above, the Committee required Dr. Qureshi to attend at the College to be cautioned with respect to the above-mentioned aspects of his care and to complete the self-study as described above.