Inquiry Committee case studies

The following are illustrative examples, by category, of complaints concluded in 2019/20 with criticism and remedial dispositions.

CONDUCT, ETHICS AND PROFESSIONALISM

Prescribing a sedative hypnotic for an extended period mandates documentation of a detailed history

A registrant working in a walk-in setting prescribed a large dispense of a sedative hypnotic essentially on the request of the patient. The encounter note made no mention of appropriateness of sedative use for the patient, indications of addiction, or other risk screening or assessment. The committee determined the prescribing to be inappropriate in the context and directed that the registrant attend a concluding interview and that staff seek the consent of the registrant (later granted) to a remedial educational disposition pursuant to section 36(1) of the *Health Professions Act (HPA)*, and attendance at the College Prescribers Course.

Foundational standards apply in settings applying complementary and alternative approaches

A patient attended a clinic with an explicit focus on "personalized" concepts of health and submitted a complaint alleging inadequate assessment, after-hours medical advice by telephone provided by an unqualified person, inappropriate language, and pressure sales tactics. Following its review, the committee was critical on all counts and directed an interview and a practice investigation on the committee's own motion.

Use of profanity is considered unprofessional

The committee received complaints objecting to the use of profanity by registrants. In response, one registrant argued that it was a deliberate part of their approach to rapport building in the context of the particular community they serve. Another took the position that the four-letter word they used is not really "swearing." Following discussion, the committee concluded that most BC patients would find the language used unacceptable in the professional setting of a medical encounter. The committee directed that registrar staff seek to conclude with written commitments not to repeat the conduct and with in-person interviews. The use of profanity was viewed as a specific instance of the general principle that expressed anger will almost always be regarded as unprofessional. Anger is a normal human emotion. The College expects registrants to possess and apply the foundational competency of managing it in a manner that insulates patients.

Registrants must resist the temptation to respond to online ratings

The committee considered an instance of expressed anger whereby a registrant responded to a negative report posted online by a patient. In their post, the registrant identified the patient by name and made unfounded allegations about them. The committee considered this unprofessional, a serious breach of patient confidentiality and a contravention of the *Social Media* professional guideline (updated in June 2019). The committee concluded that the privacy of patients, colleagues and co-workers must always be maintained. Identifiable patient information or patient images must not be posted. Defamatory comments may be considered libelous.

Registrants are expected to be familiar with the *Social Media* guideline. The committee noted that anger is natural, but expressed anger is unprofessional. Registrants wishing to discuss concerns are encouraged to contact the Canadian Medical Protective Association or the College.

The committee directed that staff seek the registrant's consent (later granted) to a comprehensive package of remedial measures, all provisions of section 36(1) of the *HPA*, including a formal undertaking not to repeat the conduct, attendance at the College's professionalism course, an interview and a reprimand.

Failed attempts at levity in clinical settings are unprofessional conduct

A patient who expressed significant anxiety to a family physician about a symptom alleged that, when asked what the cure might be, the registrant answered "death." In their response, the registrant denied having said it, maintaining that they would never say such a thing to a patient. Following consideration of the two accounts and the context, the committee concluded that the complainant's description of how the registrant made him feel was credible, regardless of what was said. The committee directed that the registrant attend a remedial interview and that their consent be sought (later granted) for a section 36(1) disposition in the form of expert communications coaching on feedback at the bedside.

CLINICAL PERFORMANCE

Failure to perform physical examinations is a recurring source of complaints

A patient attended a hospital emergency department late at night after suffering what was initially considered to be a completed miscarriage, based on examination of aborted tissues by a resident. The on-call obstetrician-gynecologist was consulted by phone and it was agreed that there was no need

for the patient to attend in person. The supervising emergency physician opted not to perform an internal examination.

The patient went on to suffer a prolonged course of pain and bleeding, requiring operative evacuation of the uterus weeks later. The committee was critical of the supervising registrant for their decision not to perform a pelvic examination in circumstances considered to mandate one. The committee directed that the registrant attend a concluding interview to review issues arising from his management of this patient.

The committee was not critical of the resident's performance, noting that the supervisor was ultimately responsible for management decisions. There was likewise no criticism of the specialist as the committee concluded that it would have been reasonable for her to assume that the emergency team had examined the patient.

Expectations when an elderly patient with multiple comorbidities deteriorates in hospital

A family member alleged substandard care when an elderly man developed confusion, agitation, and respiratory distress during the night following hospital admission. The patient suffered a cardiac arrest, was initially resuscitated, but ultimately removed from life support and died. Involved registrants included an emergency physician, hospitalist, two specialists and a first-year resident. The case highlights the challenge of optimally prioritizing calls during busy nights covering patients in a large hospital, directing trainees and communicating with family. The clinical judgment calls involved are inherently difficult and complicated by uncertainty and time pressures. The standard applied must be reasonable performance. Perfect performance is unattainable.

Following deliberation, while sympathizing with all concerned and noting that the fatal outcome was likely inevitable, the committee concluded with criticism and remedial direction on a number of issues including communication with family (physicians must do their best to ensure that a patient death does not come as a surprise to their family), direction to resident staff, personally attending and documenting findings as soon as possible, and documenting what was communicated. The committee directed remedial advice by letter and interview.

Communication between referring physician and consultant is a shared responsibility

A family physician referred an elderly patient to a general surgeon for assessment of bowel symptoms. Records provided to the surgeon included a CT report noting a suspicious lesion, but it was not referenced as an issue of concern in the referral letter. The locum general surgeon addressed the bowel complaint but not the CT abnormality, which clearly fell within the scope of a general surgeon.

The committee was critical of the referring physician for not mentioning the CT abnormality (which, admittedly, was likely unrelated to the symptoms) and of the specialist for not considering it on their own initiative. As it turned out, the patient had an aggressive cancer. While acknowledging that the cancer was incurable at the time of the imaging, the committee noted that the *Referral-Consultation Process* professional guideline was adopted to reduce the risk of significant pathology and the patients afflicted by it "falling through the cracks." The committee directed that both registrants attend for remedial interviews.

Sponge count failure is a systems issue, but the physician is ultimately responsible

The committee was critical of an obstetrician for leaving a sponge behind after repairing a laceration postpartum. The registrant acknowledged responsibility and the hospital and health authority has amended sponge count protocols, based on its review of this event. The committee expressed surprise that this long-recognized and easily addressed risk had still been an issue at this hospital, noted that the system had apparently responded appropriately (if belatedly) and directed that the investigation be concluded with correspondence.

BOUNDARY VIOLATIONS AND DISCIPLINARY MATTERS

Most sexual boundary complaints reviewed by the Inquiry Committee in 2019/20 were determined to have been misperceived examinations, addressed with physician education and remediation. The recently updated practice standard, *Physical Examinations and Procedures*, and accompanying video have assisted the committee in effectively addressing the issue. The College also continues to offer a highly rated workshop addressing the spectrum of professional boundary conduct concerns.