SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "A"

Re: Dr. Sockalingam Senthillmohan

Investigation Committee "A" concluded its investigation into matters arising from a complaint concerning care provided to a patient in 2014. The following is a summary of the Committee's decision.

Background

Dr. Senthillmohan is a physician who at the time of the complaint held a defined license to practice medicine in Nova Scotia. At the end of 2015 Dr. Senthillmohan chose not to reapply for medical licensure in Nova Scotia, and he does not currently hold a licence in this province.

Patient X is a man in his mid-50s who attended at the ER department of a hospital in January 2014. He had experienced a fall, following which he had x-rays and saw a chiropractor several times. Eight days after his fall he began to experience weakness in his right foot and could no longer drive. He attended at the ER department as his chiropractor advised him to get an x-ray and he had been unable to get an appointment with his family physician. He was seen by Dr. Senthillmohan at the ER. At the time of his visit to the ER, Patient X was experiencing increasing pain in his right shoulder, neck and back, and was finding it difficult to walk.

Dr. Senthillmohan relied on a history taken by the ER nursing staff. Dr. Senthillmohan did not take a history or perform a physical examination. No x-rays were ordered. Dr. Senthillmohan determined that the patient's issues would be better addressed by his family doctor rather than the ER department and he contacted the family physician to arrange for an appointment later that evening.

Prior to attending the later appointment with the family physician, Patient X went to a restaurant, and on his way into the restaurant his legs gave out and he fell backwards, hitting his head and losing consciousness. He was transferred by ambulance with neck brace and backboard to the ER where he was again seen by Dr. Senthillmohan. Dr. Sentihillmohan ordered x-rays and then verbally transferred care to a second physician at the end of Dr. Senthillmohan's shift. After a limited assessment by the second physician, Patient X was discharged home. Two days later, Patient X fell while at home, striking his head, and was taken to hospital by ambulance. He was subsequently diagnosed with traumatic incomplete quadriplegia.

Process of Investigation Committee

The Investigation Committee reviewed the complaint of Patient X, the response of Dr. Senthillmohan and other material gathered in the course of the investigation, and conducted interviews.

Patient X also filed a complaint respecting the care provided by the second physician who saw him in the ER. That matter was concluded by the Investigation Committee and a summary appears on the College website.

In the course of this investigation the Committee requested an expert report respecting the care provided by Dr. Senthillmohan. In addition, the Committee ordered an audit of his practice.

DISCUSSION

The Investigation Committee determined that during the first presentation of Patient X at the ER, given the symptoms presented by the patient, Dr. Senthillmohan should have conducted a full physical examination and taken a detailed history. The diverse symptoms could have been caused by a serious condition. Given the patient's condition, Dr. Senthillmohan's discharge of the patient and follow up plan for him to see his own doctor later in the day was imprudent and inappropriate.

During the second presentation, when the patient returned to the ER by ambulance fully immobilized on a backboard, after suffering a witnessed loss of consciousness, Dr. Senthillmohan ordered x-rays but removed Patient X's neck brace before reviewing the results. The x-rays did not clear the cervical spine. Dr. Senthillmohan did not conduct a neurological examination.

After reviewing the expert report, the Committee concluded that Dr. Senthillmohan's care fell below the standard expected of a physician working in an ER department. The diagnoses made by Dr. Senthillmohan were not substantiated by history or physical exam. The documentation indicated that a proper history and physical exams were not done at either of the two ER visits.

The expert also identified concerns with Dr. Senthillmohan's documentation. There was no transfer note made to the second physician. Most concerning to the expert was the failure of Dr. Senthillmohan to document his own patient encounters. Dr. Senthillmohan's practice was to sign the notes taken by nursing staff.

The audit report of Dr. Senthillmohan's practice identified concerns with Dr. Senthillmohan's failure to take detailed histories, relying instead on nurses to capture the necessary information.

DECISION

With the consent of Dr. Senthillmohan, in accordance with Clauses 99(7)(a)(i) and (ii) of the Regulations:

1. Dr. Senthillmohan is reprimanded for failing to provide care in keeping with the standards of the profession, including:
    a. failing to document his encounters with the patient;
    b. failing to document his review of the patient's x-rays before clearing the cervical spine;
    c. failing to recognize an inadequate x-ray; and
    d. failing to document transfer of patient care.

2. Should he seek re-licensure in Nova Scotia, Dr. Senthillmohan shall be subject to the following conditions:
    a. he will first be required to complete a record-keeping course approved by the Registrar, to address his charting deficiencies;
    b. he must then obtain a clinical assessment license and practice in an ER setting under the supervision of a physician approved by the Physician Performance

Department of the College for a period of four weeks. The cost of the supervision shall be borne by Dr. Senthillmohan. The results of the clinical assessment will be provided to the Registration Department of the College, and if considered satisfactory by the Registration Committee, Dr. Senthillmohan will then be eligible to apply for a defined license if he meets the criteria for that license at that time. If the assessment is not deemed satisfactory by the Registration Committee, Dr. Senthillmohan will remain ineligible for a defined licence ; and

c. if granted a defined licence, he will be subject to a re-audit six months after the supervision period ends. The cost of the re-audit will be borne by Dr. Senthillmohan.

In addition, Dr. Senthillmohan was ordered to pay an amount of cost to reimburse the College for a portion of its investigative expenses.

The Committee believes that the disposition outlined above reflects its serious concerns with respect to Dr. Senthillmohan's deficiencies in documentation and patient care.