COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "C"

Dr. Justin Clark

License Number: 016409

Investigations Committee "C" of the College of Physicians and Surgeons of Nova Scotia (the College) concluded its investigation into a complaint against Dr. Justin Clark. The Investigation Committee reached agreement with Dr. Clark with respect to the disposition of the complaint. A summary of the complaint and its disposition appears below.

PROCESS

This matter was initiated by a letter from the complainant received on March 20, 2017. A response from Dr. Justin Clark was received on May 11, 2017.

Investigation Committee "C", formed in accordance with the *Medical Act* of Nova Scotia, 2011, was responsible for the investigation of this complaint.

In addition to correspondence from the complainant and Dr. Clark, the Committee considered the medical records as provided by the Nova Scotia Health Authority, its interview of Dr. Justin Clark, and its interview of the complainant and her family.

PARTIES

Dr. Justin Clark is a family physician, licensed to practice medicine in Nova Scotia with a primary scope of practice in Emergency Medicine.

The complainant made this complaint regarding the care received by her late mother, who is referred to as "the patient" in this summary.

SUMMARY

Key points as reported by the Complainant

In early 2017, the patient was taken by ambulance to the Colchester East Hants Health Centre in Truro, Nova Scotia. She was very weak and put into a treatment room. Blood work, urinalysis and chest x-ray were completed at this time.

The complainant states Dr. Clark attended to the patient after what seemed like many hours. He

informed family members that the patient would be released. Dr. Clark further informed the family that the patient was elderly, her health was declining and there was nothing more that could be done in hospital. He stated that blood work came back “good”.

The patient was still very weak and not feeling well. She was seen the following day by her family physician. The patient’s family physician informed her and her family that her blood work was not good and they needed to return to the hospital. He provided the family with a letter and a copy of the blood work to take to the emergency department.

Upon arrival at the hospital, the patient was seen by another doctor. That doctor examined the patient and apologized to her for being sent home the night before. That doctor was unsure how this happened and advised the patient that her blood work was now worse than before and her condition was worrisome.

The patient was admitted to hospital during that visit and passed away the next week.

The complainant states she is upset with how her mother was treated in the emergency department by Dr. Clark. She does not feel her mother was treated properly because of her age. The complainant believes Dr. Clark did not take her mother’s condition seriously and, whether she would have lived longer or not, she could have at least had another comfortable night.

Key points reported by the Respondent

Dr. Clark saw the patient in the emergency department. The patient had been brought in by ambulance around 12:00 p.m. and was initially seen by another doctor at about 1:00 p.m.

The presenting complaint was generalized weakness. The triage nurse noted that the patient had complained of weakness for one month that had increased that day.

The patient had been seen several times over the previous month for urinary tract infections. There was a noted history of persistent positive urine cultures despite two courses of Macrobid. The patient was started on a new course of antibiotics three days prior. Poor appetite was also noted.

Dr. Clark came on duty at 3:00 p.m. He reviewed the previous doctor’s notes and received hand over from him. There were no concerning features such as flank pain, fever, surgical abdomen or abnormal vital signs. The previous doctor felt the patient’s symptoms were likely due to a side effect of her antibiotics or ongoing urinary tract infection. The previous doctor had ordered a urinalysis, which was pending at the time of handover to Dr. Clark.

The patient’s care was transferred to Dr. Clark with the plan to discontinue antibiotics if the urinalysis was negative for features of UTI or to consider a different antibiotic if the urine showed signs of ongoing infection.

Dr. Clark attended the patient to obtain a brief history and physical. Dr. Clark noted the patient was not currently having lower urinary tract symptoms such as dysuria, urgency or frequency. In

addition, there was a history of a mild, slow decline in function and appetite for many months prior to the recent acute symptoms.

Dr. Clark ordered chest x-ray and blood work including CBC, electrolytes, liver function tests and creatinine. This blood work was intended as a general screen for possible signs of weakness.

Dr. Clark reviewed the results later in the afternoon. He does not recall if he reviewed paper records or the electronic medical record as both are available to him in the emergency department. Dr. Clark states that the urinalysis was unremarkable and the blood work that he saw was normal.

Accordingly, based on the results he saw, Dr. Clark advised the patient and her family that there was no sign of continuing urinary tract infection and she should stop taking antibiotics which appeared to be giving her side effects. Dr. Clark advised if her condition did not improve or worsened, she should see her family physician or return to the ER.

Dr. Clark further advised the family that based on the patient's longstanding history of slow decline, this overall trend should be expected to continue. The patient was discharged home at 6:00 p.m.

Dr. Clark has since learned that the patient's tests were abnormal. He does not know how this did not come to his attention. He is unsure whether another patient's results were placed on the chart in error or if he reviewed the wrong report online.

Dr. Clark states when the patient was admitted to hospital the following day, the admission diagnosis was acute hepatitis. This was later determined to be secondary to antibiotics. The patient initially made progress and her liver function improved. Unfortunately, her condition deteriorated and she passed away.

Dr. Clark became aware of the patient's family's dissatisfaction and had hoped to arrange a meeting to offer explanation and apology. As a complaint was initiated, he did not pursue this meeting further.

Dr. Clark states he understands the family's distress that he did not see the patient's actual blood work results, which resulted in a delay in her admission to hospital. Dr. Clark offers his apology to the family. Dr. Clark further states this case will be reviewed by the Emergency Department at Colchester East Hants Health Centre to determine if procedural changes are required to prevent problems of this kind in the future.

Further comments as reported by the Complainant

The complainant states that at no time did Dr. Clark perform a physical examination on the patient. The family can confirm this because they never left their mother alone while in the emergency department. Due to Dr. Clark indicating blood work was normal, the patient and her family left the hospital feeling hopeful that she would recover.

Further comments reported by the Respondent

Dr. Clark states he attempted to communicate to the patient's family that although her acute condition would likely improve with the withdrawal of the antibiotic, based on the history of gradual decline, her overall trend in her health may continue. This statement was made based on the patient's history and clinical presentation and was not based on her age. Dr. Clark acknowledges busy emergency room discussions are brief, but hopes he did not express this in a way that led to a misunderstanding.

Dr. Clark states he did not dismiss the patient because of her age. He ordered additional investigations that led to the identification of her illness. Dr. Clark further states he would not have discharged the patient if he had seen the correct results. He would have referred her for internal medicine consultation.

Preliminary Investigation:

Pursuant to Section 88 (1) of the Medical Practitioners Regulations, an Investigator was appointed to conduct a preliminary investigation of this complaint.

CONCERNS/ALLEGATIONS OF COMPLAINANT

The complainant alleges that Dr. Clark inaccurately informed them that the patient's blood work was good when in fact it was not. She further alleges Dr. Clark did not take her mother's condition seriously and she was not treated properly because of her age.

The complainant is unsure whether her mother would have lived longer, but feels that Dr. Clark could have given her mother a comfortable night in hospital rather than sending her home.

CONCERNS OF COMMITTEE

As with all complaints, the Investigation Committee is not limited to investigating only the concerns set out in the complaint. The Committee has the responsibility to look into all aspects of a physician's conduct, capacity or fitness to practice medicine that arise in the course of the investigation.

In this matter, after reviewing all available information, the Committee identified the following additional concerns arising from the investigation of this complaint:

- lack of documentation in the clinical note by Dr. Clark;
- failure to appropriately confirm the identification of patient (as per the family);
- incorrect interpretation of the patient's blood work results;
- lack of history and physical examination completed on the patient by Dr. Clark;
- lack of differential diagnosis;
- inappropriate palliative discussion without a clear diagnosis;

- inappropriate recommendation regarding goals of care; and
- lack of appropriate discharge planning.

DISCUSSION

The Committee offers its condolences to the complainant, along with her family members, on the loss of their mother/grandmother. The Committee would like to thank the complainant for bringing her concerns forward to the College.

In coming to their decision, the Committee considered the mitigating factors presented before it. Dr. Clark is a young physician and has the potential of a long career ahead of him. He has no other complaint history with the College. The Committee further considered Dr. Clark was biased by the previous physician's assessment of the patient in determining discharge as an acceptable course of action.

During his interview, Dr. Clark acknowledged he failed to appropriately review this patient's blood work results and document his patient encounter in real time. Since this concern has been brought forward, he states he has been hypervigilant in doing these things.

The Committee also considered Dr. Clark has shown insight into some of the errors that occurred. He has attempted to make changes in his department by presenting this case to emergency rounds and has discussed potential changes in reviewing blood work and handover of care.

The Committee also notes Dr. Clark has shown remorse for his actions. During his interview, he stated:

> *"Lastly I really want to apologize to the family. I feel terrible about missing the blood work and especially how they felt I was dismissive of their loved one's complaints. I think I will use this experience to improve my care moving forward."*

Although these mitigating factors contributed to the Committee's decision, the Committee also needed to consider the aggravating factors of the case.

The Committee found Dr. Clark's documentation of the patient encounter was inadequate. Dr. Clark acknowledged during his interview that the only documentation he had contributed on the clinical note was his signature, as well as the orders for blood work and chest x-ray.

The Committee notes the complainant and her family were adamant during their interview that no examination occurred during the encounter with Dr. Clark. This contradicts Dr. Clark's statement during his interview that he would have completed a brief focused physical examination. There is no supporting evidence Dr. Clark performed an examination, as it was not documented on the emergency room record.

The Committee also considered that if Dr. Clark had done a physical examination, there may have been physical findings that would have led him to re-evaluate his discharge disposition.

The Committee further found Dr. Clark's clinical note did not include any details of re-assessment, history taking or discharge planning. It appears to the Committee that Dr. Clark over-relied on the previous physician's assessment and did not discuss with the family if there were any changes from the initial presentation to the emergency department. There are also concerns the patient was unable to walk upon discharge and proper instructions regarding discharge planning were not discussed or documented.

The Committee found Dr. Clark's documentation did not meet the College's *Professional Standard Regarding Medical Records.* The standard states the medical record must reflect all care provided. The Committee also believes it is not appropriate to sign off on a clinical note before the encounter is completed and all aspects of the encounter are documented.

The Committee is further concerned Dr. Clark chose to discuss palliative planning without having a clear diagnosis to support this discussion. Dr. Clark was privy to limited information related to the patient's past medical history and chose to have a long-term care discussion despite limited assessment and knowledge of this patient.

The Committee does not believe Dr. Clark showed insight into this concern. During his interview, he stated:

> *"I really wanted to set up some reasonable expectations for the family going home and, you know, my goal was really to help them come to terms with the fact that possibly her health may continue to decline and this sort of conversation helps to trigger things like increasing supports in the home and things like that. This is a common conversation I have in the emergency department. I think, in this case, there was a bit of a misunderstanding surrounding this and this may have contributed to the feelings that I was somehow dismissing [the patient's] complaints."*

Another aggravating factor in this case relates to the patient's blood work results. The blood work results reviewed by Dr. Clark were not relevant to the patient. The Committee is unclear if Dr. Clark saw another patient's lab results or older results. In any case, this incorrect information was then relayed to the family. It was only upon attending an appointment with the patient's family physician the next day that it was determined the results were not normal and she was informed to return to the emergency department.

During the interview, Dr. Clark offered the following explanation for the error:

> *"Not infrequently, blood work is printed and placed on the wrong chart. This happens more often when patients are changing rooms and chart clipboard numbers are changing. Usually this is caught by the nurse or a physician or the clerical staff. I think this is likely what happened. I think I looked at the wrong result on the patient's chart and I did not double-check that the patient's name was on that blood work. So believing that her blood work was normal, I agreed with the initial physician's assessment that this was likely a side effect of her antibiotics and I advised the patient and her family that after discontinuation of the antibiotics, her symptoms should improve significantly in the*

next day or two and then instructed them to return to the hospital or to follow up with a family physician if her symptoms didn't improve or if they happened to worsen"

The Committee believes Dr. Clark had a number of occasions to catch this error. If Dr. Clark had actively looked for the blood work on Meditech rather than waiting for a printed copy to be attached to a chart, it would be less likely for an error to occur. The Committee also notes Dr. Clark could have cross-referenced the identification band on the patient when he entered the room to ensure he was reading the correct results.

Although the Committee cannot comment on whether the patient's eventual outcome could have been avoided, the fact remains Dr. Clark should have initiated treatment earlier. The complainant and her family left the emergency department hopeful and trusting of Dr. Clark's plan for their mother and later discovered the results they were given were not correct. This delayed their mother's care.

After long consideration and discussion, Investigation Committee "C" was not able to reconcile this complaint without disciplinary sanctions. There were not enough mitigating factors to allow the Committee to offer less than Reprimand.

DISPOSITION

In accordance with section 99(5)(f)(i)(A) of the *Medical Practitioners Regulations*, the Committee has determined there is sufficient evidence that, if proven, would constitute a finding of incompetence and warrants a licensing sanction.

Rather than refer the matter to a hearing, the Committee has determined that the matter can be resolved with the consent of Dr. Clark to the following, pursuant to section 99(7)(a)(i) and (ii):

a) Dr. Clark is ***Reprimanded*** for failing to perform and document an appropriate history and physical examination;
b) Dr. Clark is ***Reprimanded*** for failing to ensure the laboratory results he ordered were appropriately reviewed prior to making disposition decisions;
c) Dr. Clark is ***Reprimanded*** for inappropriately advising the family around comfort care given the limited assessment and knowledge of the patient.

The Committee believes that the disposition outlined above reflects its concerns with respect to Dr. Clark's failure to competently complete all aspects of a patient encounter as listed above.

Dr. Clark agrees to contribute an amount toward the College's costs in this matter.

Dr. Clark agreed to accept this disposition on January 2, 2018.