PROVINCE OF NOVA SCOTIA )
COUNTY OF HALIFAX )

IN THE MATTER OF: The ***Medical Act***, S.N.S. 2011, c. 38

- and-

Dr. Samuel Chun

**SETTLEMENT AGREEMENT**

Dr. Samuel Chun, a medical practitioner in the Province of Nova Scotia, and a member of the College of Physicians and Surgeons of Nova Scotia (the "**College**"), hereby agrees with, and consents to, the following in accordance with the provisions of the *Medical Act*:

## I. COMPLAINT TO THE COLLEGE FROM PATIENT G

1. On March 8, 2016, Patient G filed a complaint against Dr. Chun. Patient G alleged that the care he received from Dr. Chun was inadequate and unprofessional. Specifically, Patient G alleged the following:

   (a) Dr. Chun did not perform a physical examination but reported to Patient G's family physician that he had performed the examination;

## II. RESPONSE OF DR. CHUN

2. In response, Dr. Chun stated that he did perform a physical examination and that it is part of his usual practice. He stated that if there had been a reason to not do the examination, he would have recorded this in the clinical record in accordance with his usual practice. He stated that his logs showed that he dictated the consultation report minutes after seeing Patient G. Dr. Chun stated that he found it hard to believe that he would have reported on an exam that he did not conduct when that report was faxed minutes after meeting with the patient.

## III. STEPS TAKEN BY INVESTIGATION COMMITTEE REGARDING PATIENT G

3. In addition to correspondence from Patient G and Dr. Chun, the Committee reviewed the following:

   (a) a copy of Dr. Chun's EMR logs received September 1, 2016;

   (b) an interview with Patient G on September 27, 2016;

   (c) an interview with Dr. Chun September 27, 2016;

   (d) a copy of Dr. Chun's MSI billings for a one-year period;

   (e) copies of office charts from Dr. Chun for specified patients;

   (f) patient survey results; and

   (g) comments from Dr. Chun, dated January 31, 2017, regarding the patient survey.

4. The Committee reviewed Dr. Chun's MSI billings relating to Patient G which revealed that Dr. Chun had billed for a comprehensive examination when Patient G alleged that he did not perform it.

5. During the investigation, the Committee also randomly selected patients identified on Dr. Chun's MSI billings as having had comprehensive consultations, indicating they would have had a physical examination.

6. The Committee found that there was evidence that suggested that there were two patients for whom Dr. Chun billed for a comprehensive consultation that he did not perform.

7. The Investigation Committee determined that there was sufficient evidence that, if proven to be true, would amount to one or more findings of professional misconduct. The Investigation Committee referred this matter to a Hearing Committee.

## IV. COMPLAINT TO THE COLLEGE FROM PATIENT F

8. On March 23, 2017, Patient F filed a complaint against Dr. Chun. Patient F alleged that the care he received from Dr. Chun was inadequate and unprofessional. Specifically, Patient F alleged the following:

   (a) In 2010, Patient F's family physician referred him to Dr. Chun for a scrotal growth that had become uncomfortable. Dr. Chun booked him for surgery, however, after the anesthesia was administered, he did not perform the surgery as Dr. Chun noticed changes on examination under anesthesia and referred Patient F for an ultrasound.

   (b) When Patient F did not hear from him, he assumed the reports were benign. Patient F later learned that Dr. Chun had sent a letter to his family doctor stating that the surgery had been done. Patient F's family physician had been under the impression the procedure had been carried out on July 17, 2010.

   (c) Sometime in 2012 or 2013, Patient F requested another referral from his family doctor because the growth was now larger and more uncomfortable. He was given an appointment with Dr. Chun. Dr. Chun sent Patient F for a CT scan which showed a hydrocele. Dr. Chun later attempted perform the hydrocelectomy at which time Dr. Chun determined that there was less fluid than expected. Dr. Chun referred to it as a 'mystery' and advised he would take care of it.

   (d) During an office visit in 2014, Dr. Chun told Patient F it was still a mystery, and he would follow up with imaging. He waited to hear from Dr. Chun. Hearing nothing, he regularly called Dr. Chun's office but received no response. The growth continued to increase in size. In 2015, Patient F followed up with his family doctor requesting more action. Patient F's family doctor ordered a CT scan and copied it to Dr. Chun.

   (e) The CT scan showed Patient F had an inguinal hernia. He was referred to a surgeon and the procedure was scheduled to take place in May 2016. During the procedure, the surgeon found Patient F did not have a hernia, rather there was a tumor entangling a healthy testicle. Dr. Chun assisted the general surgeon, but they were unable to remove the tumor without removing the testicle. The

procedure was stopped because the surgeon did not have consent to remove the testicle.

(f) In October 2016, the tumor and testicle were removed. The tumor was sent to pathology. On January 17, 2017, Patient F learned that it was a liposarcoma and was referred to an oncologist for treatment.

## V. RESPONSE OF DR. CHUN

9. In response, Dr. Chun stated that although the original clinical diagnosis and ultrasound was consistent with a hydrocoele, the persistent swelling was secondary to an inguinal hernia. This was confirmed on CT scan. As a result, Patient F was referred to a general surgeon for a hernia repair. Intraoperatively, the surgeon found a fatty mass surrounding the spermatic cord. A biopsy was taken but the mass was left in place. The pathology report suggested a benign lipoma. Only after subsequent surgery did subsequent pathology reveal a liposarcoma. Dr. Chun stated that liposarcoma of the cord structures is an extremely rare diagnosis. This was confirmed by the independent review obtained by the College and the independent review obtained by Dr. Chun. Dr. Chun stated that he was saddened by what Patient F had been through and in December 2017 voluntarily attended at the University of Toronto Medical Record Keeping continuing medical education course.

## VI. STEPS TAKEN BY INVESTIGATION COMMITTEE REGARDING PATIENT F

10. In addition to correspondence from Patient F and Dr. Chun, the Committee reviewed the following:

(a) an independent review of Patient F's case by an independent urologist obtained by the Investigation Committee;

(b) an independent review of the case by an independent urologist provided by Dr. Chun's legal counsel;

(c) an interview with Dr. Chun on December 12, 2017.

11. The Investigation Committee determined that there was sufficient evidence that, if proven to be true, would amount to one or more findings of professional misconduct. The Investigation Committee referred this matter to a Hearing Committee.

## VII. ALLEGATIONS IN THE NOTICE OF REFERRAL TO HEARING.

12. In the Notice of Referral to Hearing, the College made the following allegations:

(a) With respect to Patient G, in or around February 1, 2016, Dr. Chun:

(i) Did not perform a physical examination but reported to Patient G's family physician that he had performed the physical examination;

(ii) Billed MSI for a comprehensive consultation when he did not perform one;

(iii) Failed to maintain accurate medical records.

(b) With respect to Patient F during the period July, 2010 through January, 2017, Dr. Chun:

(i) On or about July 17, 2010, prepared Patient F for surgery but did not perform the surgery;

(ii) Reported to Patient F's family physician that he had performed the surgery;

(iii) Billed MSI for conducting a surgery that he did not perform;

(iv) Failed to properly diagnose a liposarcoma that due to the failure, was only diagnosed in or around January 2017;

(v) Failed to respond to Patient F's requests for information;

(vi) Failed to maintain accurate medical records;

(vii) Failed to dictate operative reports in a timely manner.

(c) With respect to matters reviewed in the course of the audit performed by a College assessor Dr. Chun:

(i) Billed MSI for examinations that he did not perform;

(ii) Failed to maintain accurate medical records.

**VIII. CONCESSIONS AND ADMISSIONS**

13. Dr. Chun does not recall whether he did or did not perform a comprehensive consultation, yet for the purposes of this Settlement Agreement, he is willing to admit that:

(a) With respect to Patient G, in or about February 1 2016, he:

(i) Did not perform a comprehensive consultation but reported to Patient G's family physician that he had performed a physical examination;

(ii) Billed MSI for a comprehensive consultation when the visit was a limited one;

(iii) Failed to maintain accurate medical records.

14. Dr. Chun admits:

(a) With respect to Patient F during the period July 2010 through January 2017 he:

(i) Dictated, signed and entered into the patient's medical record an operative procedure that was aborted and therefore, did not take place;

(ii) Reported to Patient F's family physician that he had performed the surgery;

(iii) Failed to take sufficient steps to ensure Patient F was referred to general surgery for possible hernia repair contributing to a delay in diagnosis of lipsarcoma ultimately diagnosed in or around January 2017;

(iv) Failed to respond to Patient F's requests for information.

(b) With respect to matters reviewed in the course of the audit performed by a College assessor, Dr. Chun:

(i) Billed MSI for two examinations that were not documented;

(ii) Failed to maintain adequate medical records; and

(iii) Failed to dictate operative reports in a timely manner.

## IX. DISPOSITION

15. Dr. Chun:

(a) is reprimanded;

(b) his certificate of registration shall be suspended for a period of one month beginning March 18, 2019;

(c) is fined $5,000 for the following:

16. With respect to Patient G, in or about February 1 2016, he:

(a) Did not perform a comprehensive physical examination but reported to Patient G's family physician that he had performed a physical examination;

(b) Billed MSI for a comprehensive physical examination when the visit was a limited one;

(c) Failed to maintain accurate medical records.

17. With respect to Patient F during the period July 2010 through January 2017 he:

(a) Dictated, signed and entered into the patient's medical record an operative procedure that did not take place;

(b) Reported to Patient F's family physician that he had performed the surgery;

(c) Failed to take sufficient steps to ensure Patient F was referred to general surgery for possible hernia repair contributing to a delay in diagnosis of liposarcoma ultimately diagnosed in or around January 2017;

(d) Failed to respond to Patient F's requests for information.

(e) With respect to two matters reviewed in the course of the audit performed by a College assessor, Dr. Chun:

(i) Billed MSI for examinations that were not documented;

(ii) Failed to maintain adequate medical records; and

(iii) Failed to dictate operative reports in a timely manner.

## X. COSTS

18. Dr. Chun agrees to pay costs to the College in the amount of $10,000 inclusive of HST, representing a portion of the College's costs of investigating this matter, including the costs of the previously completed practice audit. These costs shall be payable by Dr. Chun by March 11, 2020.

## XI. PUBLICATION

19. This Settlement Agreement and any decision rendered by a Hearing Committee approving it, as prepared by the Registrar, shall be published on the College's website.

## XII. EFFECTIVE DATE

20. This Settlement Agreement shall only become effective and bindings when it has been recommended for acceptance by an Investigation Committee of the College, and accepted by the Hearing Committee appointed to hear this matter.

Dated at Halifax, Nova Scotia on _____, 2019.

Witness

Dr. Samuel Chun

Dated March 5, 2019

Witness

Jane O'Neill, Q.C.
Counsel for the College of Physicians and Surgeons of Nova Scotia

Dated Mar 6, 2019

Witness

Chair
Investigation Committee, College of Physicians and Surgeons of Nova Scotia

Dated March 11, 2019

Witness

Chair
The Hearing Committee, College of Physicians and Surgeons of Nova Scotia

Dated March 11, 2019