OVERVIEW

Investigation Committee A of the College of Physicians and Surgeons of Nova Scotia (“College”) concluded its investigation into complaints against Dr. Jeffrey Champion by issuing its decision dated January 6, 2020. The Investigation Committee reached agreement with Dr. Champion with respect to the disposition of the complaint.

Investigation Committee "A" has addressed two complaints against Dr. Champion.

The first complaint was sent to the College from an 81 year-old patient of Dr. Champion, who will be referred to as Patient “A”.

The second complaint was submitted to the College from the mother of a child who was a patient of Dr. Champion's. The child will be referred to as Patient B, and the mother of the child will be referred to as "the mother”.

Investigation Committee "A" formed in accordance with the Medical Act of Nova Scotia, 2011, was responsible for the investigation of both complaints.

In addition to the complaints and the responses from Dr. Champion, the Committee interviewed Dr. Champion, the mother, Patient A and a family member of Patient A. Investigation Committee "A" also conducted reviews of Dr. Champion's practice.

SUMMARY OF COMPLAINTS AND RESPONSES

Dr. Jeffrey Champion is a family practice physician, licensed to practice medicine in Nova Scotia since 1986.

Patient A reported to the College that she attended seven appointments with Dr. Champion over a six month period for a number of health-related matters. At the first of these eight appointments Patient A was accompanied by a daughter, and one of the matters discussed with Dr. Champion involved Patient A's relationship with a boyfriend, which was described as abusive. At a separate meeting one week after this appointment, two daughters of Patient A met with Dr. Champion to discuss their mother’s relationship, without Patient A in attendance.

At five subsequent visits between Patient A and Dr. Champion, there were no further discussions about the abusive relationship.

At the final appointment, Patient A saw Dr. Champion at a walk-in clinic and the meeting was also attended by one of Patient A’s daughters.

Patient A complains of Dr. Champion being rude to her and her family member at this meeting where he indicated he did not want to become involved in the situation involving Patient A's boyfriend. The conversation escalated, leaving Dr. Champion to tell Patient A to find another
doctor, which she agreed to do. The encounter continued to deteriorate where Dr. Champion told Patient A and her daughter to get out of his office, and he threatened to call the police. Patient A and her daughter responded that if he did so they would tell the police about his behavior.

In Dr. Champion’s response to the College, he advised that during this last encounter the conversation deteriorated when Patient A’s daughter indicated the family wanted Dr. Champion to support them, but there was some lack of clarity about the nature of the support. Dr. Champion states he recommended a social worker after which the daughter became more agitated. Dr. Champion indicates he asked the daughter to leave at that point and indicated that he would call the police if necessary.

**DISCUSSION REGARDING COMPLAINT OF PATIENT A**

In the course of its investigation, the Investigation Committee reviewed the chart kept by Dr. Champion respecting the visits of Patient A. As a result of concerns about the lack of documentation, the Committee ordered an audit of Dr. Champion's practice. The audit revealed deficiencies in the manner in which Dr. Champion documented his encounters with Patient A and her family, as well as with respect to other patients. The audit noted in a number of instances that Dr. Champion could improve the quantity and quality of his charting and that he did not appear to make use of commonly used assessment or diagnostic tools. The Committee found Dr. Champion's documentation to be incomplete, but otherwise found that the audit established Dr. Champion's practice was generally positive of his care.

**SUMMARY OF COMPLAINT REGARDING PATIENT B**

The mother of Patient B attended a duty clinic with her daughter who had a fever, headache, cough, sore throat and a swollen eyelid.

While Patient B and her mother waited to see Dr. Champion, they could overhear him in the next room, as both the door to the next room and the door to the room in which Patient B and her mother were waiting, were open. The mother describes hearing Dr. Champion "dropping F-bombs" every second or third word. The mother reports that when it was time for her daughter to see Dr. Champion he was dismissive of their concerns.

In his written response to the complaint regarding Patient B, Dr. Champion reported on the clinical encounter and explained his medical treatment. With respect to the use of obscenities, Dr. Champion acknowledged using foul language. He advised he was unable to recall exactly what was said but recalls that he was joking with the patient in the other room. She advised that while the language heard by Patient B and her daughter was spoken in jest with no offense intended, he acknowledges the use of profanity in a medical clinic is unacceptable. He assured the College that the concerns were taken seriously.

In a later meeting with the Investigation Committee after filing his written response, Dr. Champion initially indicated he had no recollection of any foul language. He then indicated to the Committee that he thought he knew what he said to the other patient, but could not recall it. Finally, when asked again, Dr. Champion advised he was able to recall the use of “F-bombs” when speaking to the other patient.

**DISCUSSION**
With respect to Patient A, the Committee had concerns about the final appointment between Patient A and Dr. Champion where the encounter deteriorated with each party threatening to call the police.

The Committee also had concerns about the incomplete manner in which Dr. Champion documented the visits of Patient A and her family members, and the incomplete documentation revealed by the audit.

With respect to Patient B the Committee had a variety of concerns. Firstly, Dr. Champion did not document Patient B’s heart rate, blood pressure and respiratory rate and did not document whether he examined her eye and throat, despite Patient B having attended the clinic with complaints of fever, headache, cough, sore throat and a swollen eyelid.

With respect to the use of foul language, the Committee noted that Dr. Champion had a history of previous complaints concerning inappropriate communication. It was very concerning to the Committee that despite prior advice from the College about appropriate communication, he used profanities when speaking to a patient, within earshot of another patient.

In view of the clinical concerns regarding his examination of Patient B, the Committee ordered a chart assessment of patients seen by Dr. Champion in both his duty clinic and office practice. The assessor noted that 20 out of 30 charts reviewed had concerns. Less than half of the charts reviewed contained a complete family history, and consultation letters were brief. Documentation of amounts that were prescribed through the duty clinic were missing from the record. The assessment and plan portion of his office notes lacked important details regarding diagnosis, differential diagnosis and the amount of medications prescribed.

After meeting with Dr. Champion and assessing his practice, the assessor stated:

"Insight into charting deficiencies appeared to be somewhat limited and this may pose a challenge in implementing any recommendations that may come as a result of this assessment."

**DECISION**

The Investigation Committee reviewed the complaints of Patient A and Patient B in the context of Dr. Champion’s history with the College. His history established that Dr. Champion has had previous findings calling his communication style into question. Despite these previous findings, Dr. Champion engaged in the type of profane comments outlined by Patient B. This type of behavior requires remedial action to address this issue and the issuing of a licensing sanction to express the College’s denunciation of this type of behaviour.

The Committee was concerned about Dr. Champion’s record keeping, and to address the deficiencies in his record keeping, Dr. Champion again must undergo remediation in the form of a record keeping course approved by the College, at his cost. In light of the concerns about insight into charting deficiencies, a follow up audit will be required.

Finally, the Committee notes their concerns respecting the clinical care provided by Dr. Champion to Patient B where he failed to document Patient B’s vital signs, including her heart rate, blood pressure and respiratory rate, among other things.
As a result, the Investigation Committee orders the following, pursuant to clause 99(7)(a)(i) and (ii):

1. Dr. Champion is reprimanded for:
   (a) failing to appropriately document his interactions with Patient A and her daughter;
   (b) failing to appropriately document his interactions with Patient B;
   (c) failing to perform a physical examination of Patient B in accordance with accepted standards;
   (d) using profane language in the presence of patients;
   (e) attempting to downplay or obscure the language he used when meeting with the Investigative Committee;
   (f) in the case of Patient B, failing to demonstrate improvement with regard to clinical assessment and record keeping since his previous audit arising out of the circumstances involving Patient A.

2. Dr. Champion is ordered to do the following:
   (a) Complete a record keeping course approved by the College, the cost of which will be borne by Dr. Champion;
   (b) Undergo a re-audit of his practice within six months of the date of this decision to determine whether appropriate record keeping standards have been met. The cost of the audit will be borne by Dr. Champion;
   (c) Complete a communication course approved by the College, within the next three months. The cost of the course will be borne by Dr. Champion;
   (d) Pay agreed upon costs to the College arising from the investigation of these two complaints.

The Committee determined that the disposition outlined above reflects its serious concerns with respect to Dr. Champion's documentation and communication, while recognizing that the audit of his practice reflected care which otherwise meets the expected standards.

Dr. Champion agreed to accept this disposition on January 13, 2020.