

# COMPLAINTS & DISCIPLINE UPDATE



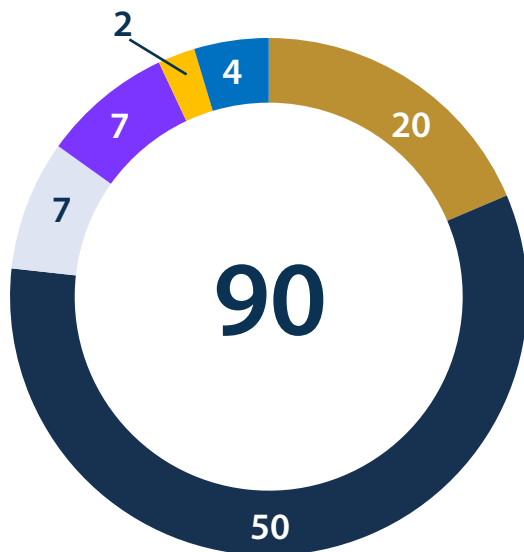
JUNE TO DECEMBER 2019

The *Medical Act, 2011*, requires the College of Physicians and Surgeons of Newfoundland and Labrador (CPSNL) to accept and process all written complaints against physicians licensed in this province.

UPDATES report on the College's complaints and discipline activities. They summarize cases in which the Complaints Authorization Committee (CAC) issues a caution /counsel, a publicized settlement was reached through the Alternative Dispute Resolution process, or a finding was made by the Adjudication Tribunal.

## COMPLAINTS AUTHORIZATION COMMITTEE DECISIONS BY OUTCOME

(Files closed in 2019)



- Resolved/ withdrawn ●
- Complaint dismissed ●
- Complaint dismissed with direction ●
- Cautions /counsels ●
- Referred to alternative dispute resolution ●
- Referred to Tribunal hearing ●

2019 Totals	
Complaints received	77
Complaint files closed	90
CAC decisions	74
CAC meetings	12

## IMPROVING HOW YOU COMMUNICATE HELPS AVOID COMPLAINTS

You know why you make clinical choices, but do your patients?  
Talk to them about why a treatment is or is not necessary.  
Explain the reasons for your specific clinical examination and treatment recommendations.  
Effective communication makes for better care and less misunderstanding.

### REVISED Guideline:

#### Independent Medical Examinations

The College expects that when conducting an Independent Medical Examination (IME) or preparing an IME report, physicians will adhere to the same standards of practice and professionalism as when providing patient care. Physicians who conduct IMEs should review the revised Guideline at [cpsnl.ca](http://cpsnl.ca).

#### NEW Standard: Consent to Treatment

A physician has an ethical and legal obligation to ensure that his/her patient understands a proposed treatment and provides consent. This standard sets out the College's expectations for obtaining consent for treatment (i.e., examinations, investigations and interventions). All physicians should review the new Standard at [cpsnl.ca](http://cpsnl.ca).

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## WHAT ARE “CAUTIONS / COUNSELS”?

The Complaints Authorization Committee issues a caution or a counsel when it finds reasonable grounds to believe a physician has engaged in “conduct deserving of sanction” (as defined in the *Medical Act*) but determines that a referral to a hearing is not warranted. Most cautions/counsels are issued for one of these reasons:

- Failing to maintain the expected standard of practice “such as to indicate gross negligence or reckless disregard for the health and well-being of the patient” (as per the CPSNL Code of Ethics)
- A breach of the CMA Code of Ethics and Professionalism, often in respect to communication
- Persistent or egregious conduct toward colleagues
- Failing to appropriately document a patient encounter

## ALLEGATION : Parents’ legal right to be involved

The father of a patient who was a minor alleged that he was not involved in a meeting with a physician during which his child’s care was discussed with the child’s mother and the physician made recommendations as part of custody proceedings.

### COMPLAINTS AUTHORIZATION COMMITTEE DECISION

The Committee agreed that there were significant consequences to the father’s access to his child as a result of the opinion letter the physician wrote, and that the physician should have foreseen these consequences.

The Committee agreed that physicians have an obligation to interact with both parents of a minor in a respectful manner that recognizes the parents’ legal rights. The Committee also agreed that by not offering to include the father in the conversation, there were reasonable grounds to believe that the physician engaged

in professional misconduct as defined in the College’s Code of Ethics:

*An act or omission made in the course of the practice of medicine that, having regard to all circumstances, is contrary to a standard or expectation of professional conduct generally recognized by the medical profession or generally recognized within the applicable medical specialty or branch of medicine, and which is harmful or potentially harmful to a patient, to the public interest or to the medical profession.*

The Committee went on to consider the physician’s failure to document the encounter with the mother that led to the physician providing the opinion letter. The Committee agreed that, by not documenting the encounter, there were reasonable grounds to believe that the physician acted in contravention of the College’s By-Law 6: Medical Records:

*A medical practitioner must ensure that there is recorded and retained an individual record for each patient which includes:*

...

*The date of each professional encounter of the medical practitioner with the patient, including each occasion on which the patient is seen or spoken to by telephone by the medical practitioner.*

*A contemporaneous record of the assessment and disposition of the patient by the medical practitioner for each visit. . . .*

The physician was counselled by the Committee.

## ALLEGATION : Providing a report in a timely manner

A patient alleged that a physician failed to provide a medical report to his legal counsel in a timely manner, despite numerous phone calls and requests made by him and by his lawyer.

### COMPLAINTS AUTHORIZATION COMMITTEE DECISION

The Committee agreed that there was no evidence to suggest that there was reasonable cause for a delay

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of two years in providing the requested report. The Committee also agreed that there were reasonable grounds to believe that the physician engaged in professional misconduct, as defined in the College's Code of Ethics:

*Failing without reasonable cause to prepare a report or certificate relating to an examination or treatment performed by the medical practitioner to the patient or the patient's authorized representative within 42 days after the patient or the patient's authorized representative has requested such a report or certificate.*

The physician was counselled by the Committee.

## ALLEGATION : Correcting errors in a medical record

A patient alleged that a physician made errors in her medical record that were false and detrimental to her health history. She also alleged that the physician refused to correct the errors.

### COMPLAINTS AUTHORIZATION COMMITTEE DECISION

The Committee noted that the information contained in the medical record appeared to be inconsistent with the remainder of the information contained in the patient's medical records. The Committee agreed that there were reasonable grounds to believe that the physician did not comply with the requirements of the College's By-Law 6: Medical Records, which include documenting a "contemporaneous record of the assessment and disposition of the patient."

The Committee agreed that if a correction to a medical record is warranted, physicians are obligated to record the correct information in the record and ensure that a person accessing the information would be informed that the original record was incorrect and be directed to the correct information. The Committee agreed that the correction authored by the physician was not in compliance with this requirement. As a result, the Committee agreed that there were reasonable grounds to believe that the physician engaged in professional misconduct.

The physician was counselled by the Committee.

## ALLEGATION : Respectful conduct

A patient alleged that a physician was rude and failed to show empathy during an appointment when she experienced symptoms of her diagnosed mental health condition.

### COMPLAINTS AUTHORIZATION COMMITTEE DECISION

The Committee noted that the physician acknowledged that he may have been abrupt and could have taken extra time to ground the patient before ending the clinical encounter.

The Committee agreed that the College expects physicians to treat patients with dignity and respect. The Committee noted that the physician would have been aware that the patient had travelled a distance for the appointment and that she had a documented history of mental health illness. The Committee agreed that, considering these contextual factors, the physician should have approached his discussion surrounding treatment in a more respectful manner and should also have provided support to the patient so that she could understand the clinical decision the physician made.

Taking the above into consideration, the Committee agreed there were reasonable grounds to believe that the manner in which the physician communicated with the patient was not in accordance with the CMA Code of Ethics, which states:

*Always treat the patient with dignity and respect the equal and intrinsic worth of all persons.*

The physician was counselled by the Committee.

## ALLEGATION : Completeness of medical records (1)

A patient alleged that a physician failed to record prescriptions in her medical records, which led to the physician's inability to accurately describe the patient's medical treatment when questioned during legal proceedings.

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## COMPLAINTS AUTHORIZATION COMMITTEE DECISION

The Committee noted that there were numerous instances identified by the College's Investigator where the physician did not appropriately record the medications prescribed to the patient.

The Committee agreed that, based on the information before the Committee, there were reasonable grounds to believe that the physician acted in breach of the College's By-Law 6: Medical Record, which states:

*A medical practitioner must ensure that there is recorded and retained an individual record for each patient which includes:*

...

*(f) A contemporaneous record of the assessment and disposition of the patient by the medical practitioner for each visit, including*

...

*vii. a description of each drug or other treatment prescribed or administered by the medical practitioner, including prescribed drug dosage and duration.*

The physician was counselled by the Committee.

## ALLEGATION : Completeness of medical records (2)

A patient's family alleged that a physician failed to meet the expected standard of practice in managing the care of the patient.

## COMPLAINTS AUTHORIZATION COMMITTEE DECISION

The Committee retained a consultant specialist to assist the members of the Committee in understanding the expected standard of practice. The physician also provided a consultant opinion. Both consultants expressed concern with respect to the physician's documentation of the medical care provided and regarding the clinical decision making.

The Committee agreed it was a clinically difficult case and that it was difficult to determine what issues the physician had considered, due to lack of documentation. The Committee agreed that there were reasonable

grounds to believe that the physician's documentation did not meet the standard required by the College, as set out in the College's By-Law 6: Medical Records.

The physician was counselled by the Committee.

## ADJUDICATION TRIBUNAL HEARING

In a written decision dated July 22, 2019, an Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador found Dr. Aidan Drover, a family physician, guilty of professional misconduct.

The complainant attended Dr. Drover's medical clinic for the purposes of obtaining a Transport Canada Marine Medical examination. During his examination of the complainant, Dr. Drover conducted a breast examination. The Tribunal found that the complainant did not consent, either expressly or otherwise, to Dr. Drover carrying out a breast examination.

The Tribunal found that Dr. Drover did not apply and maintain the standards of practice expected by the profession in these circumstances, resulting in violations of the College's By-Law 5: Code of Ethics, sections 4(pp) and 4(qq). The Tribunal found that Dr. Drover was guilty of conduct deserving of sanction.

The Tribunal reconvened on September 27, 2019, at which time the parties made a joint submission on sanction. On October 1, 2019, the Tribunal ordered as follows:

1. Dr. Drover is reprimanded for his conduct;
2. Dr. Drover's licence to practise medicine is suspended for one month;
3. Dr. Drover is to complete the course "Successful Patient Interactions" offered by Saegis Solutions;
4. Dr. Drover's licence to practise medicine will include a restriction that he must be supervised by a chaperone for all examinations of female patients until he has completed the "Successful Patient Interactions" course;
5. Dr. Drover pays the costs of the College in the fixed amount of \$15,000; and
6. The Registrar will publish a summary of the decision and order of the Tribunal.

# COMPLAINTS & DISCIPLINE UPDATE

## ALTERNATIVE DISPUTE RESOLUTION SETTLEMENT AGREEMENT

Dr. Rasheed Kadhem is a medical practitioner formerly licensed pursuant to the *Medical Act, 2011* to practise family medicine. Dr. Kadhem last practised medicine in December 2012 at the Family Medical Clinic in Lewisporte, NL.

On April 28, 2017, an allegation was filed with the College against Dr. Kadhem. The Complainant alleged, in part, that she and Dr. Kadhem engaged in a sexual relationship and that this relationship commenced at a point in time when the College would have considered her to have been a patient. The Complainant also alleged that Dr. Kadhem prescribed and dispensed opioid medication to her in an inappropriate manner.

Following an investigation of the Complainant's allegation, the CPSNL Complaints Authorization Committee referred the allegation back to the Registrar for Alternative Dispute Resolution in accordance with s. 44(1)(a) of the *Medical Act, 2011*. The Complainant and Dr. Kadhem both agreed to participate in Alternative Dispute Resolution. Both parties were represented by independent legal counsel.

Dr. Kadhem admitted that he engaged in a sexual relationship with the Complainant and that this relationship commenced at a point in time when she would have been considered a patient by the College. Dr. Kadhem also admitted that he prescribed and dispensed opioid medication to the Complainant in a manner that did not meet the expected standard of practice of a family physician in the circumstances encountered by him.

Dr. Kadhem acknowledged that his behaviour constituted professional misconduct. In particular, he acknowledged that his behaviour violated the College's By-Law 5: Code of Ethics, s. 4(ww), which forbids:

*engaging in sexual intercourse or other sexual activity or sexual touching with a patient, or the attempt to engage in such activity . . . whether or not with the patient's purported consent.*

He also acknowledged that his behaviour violated the College's By-Law 5: Code of Ethics, s. 4(l):

*Prescribing to a patient contrary to a standard of practice, policy or guideline of the College or a guideline or standard of practice generally accepted by the profession. . . .*

Dr. Kadhem, the Complainant, and the College agreed to the following disposition of this allegation:

1. Dr. Kadhem was reprimanded for his admitted professional misconduct.
2. Because Dr. Kadhem withdrew from practice in December 2012 and has not practised medicine since, no period of suspension was required.
3. Dr. Kadhem must successfully complete, at his cost, the PROBE "Ethics & Boundaries" course (or a similar course, as approved by the Registrar), as a precondition of any future licence to practise medicine issued to Dr. Kadhem by the College.
4. Dr. Kadhem must successfully complete, at his cost, a course on safe prescribing of opioid medications, as approved by the Registrar, as a precondition of any future licence to practise medicine issued to Dr. Kadhem by the College.
5. Any future licence to practise medicine issued to Dr. Kadhem by the College will include a restriction that he must be chaperoned when seeing female patients for a period of 24 months, beginning on the first date of licensure.
6. This summary will be posted on the College website, cpsnl.ca.