

SUMMARY

DR. PAKAJ PAPPU CHAND (CPSO# 65048)

1. Disposition

On August 16, 2017, the Inquiries, Complaints and Reports Committee (“the Committee”) required Dr. Chand (Family and Emergency Medicine) to appear before a panel of the Committee to be cautioned with respect to his failure to appropriately gather history, assess, and consider a differential diagnosis in a patient with nausea and diarrhea.

The Committee also ordered Dr. Chand to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Chand to:

- Engage in self-directed learning, wherein he shall:
 - review the criteria for an appropriate history, physical examination and differential diagnosis in the walk-in clinical setting, with particular attention to patients presenting with nausea and diarrhea
 - review the College policy, *Medical Records* (#4-12)
 - review the College policy, *Third Party Reports* (#2-12)
 - provide the College with written summaries of each of the above with reference to how they are applicable to his situation and what changes he has made or plans to make to his practice.

2. Introduction

The patient complained to the College that when the patient saw Dr. Chand at a walk-in clinic for symptoms of vomiting, diarrhea and nausea of several days’ duration and also for the purpose of obtaining a doctor’s note for an absence from school, Dr. Chand did not adequately assess or investigate the patient’s symptoms.

Dr. Chand acknowledged that his note for the visit does not include documentation of any examination. He suggested that perhaps the “red herring” of needing a doctor’s note led to his assumption this was the primary reason for the patient’s visit.

3. Committee Process

A Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College’s professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College’s website at www.cpsso.on.ca, under the heading “Policies & Publications.”

4. Committee’s Analysis

The Committee was extremely concerned that Dr. Chand did not gather a proper history or perform any kind of physical examination of the patient, noting these constitute the most basic aspects of any physician encounter with a patient. The Committee remarked there was nothing in the extremely sparse medical record to support Dr. Chand’s diagnosis at the time. The Committee noted that a cursory approach such as Dr. Chand took in this case could have the potential to lead to more serious repercussions, particularly in a setting such as an Emergency Room, where there is a higher probability of patients having more serious clinical issues. The Committee was concerned that the patient had to attend another clinic after seeing Dr. Chand, to obtain further care.

The Committee was aware that Dr. Chand’s history at the College includes complaints from several patients around communications (although no action arose from those matters) and advice and remediation around clinical issues. To impress upon Dr. Chand the imperative to provide patients with thorough and attentive care, the Committee reached the two-fold disposition set out above.