

## **PUBLIC SUMMARY**

### **Dr. David John Hancock (CPSO# 22993)**

#### **1. Disposition**

On September 23, 2015, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered general practitioner Dr. Hancock to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Hancock to engage in focused educational sessions with a clinical supervisor acceptable to the College in the topics of thorough assessment (specifically completeness of history and physical examinations), documentation, and adequacy of communication; and undergo a reassessment approximately 6 months following completion of the clinical supervision.

In addition, the Committee required Dr. Hancock to attend the College to be cautioned with respect to inadequate assessment, documentation and communication.

#### **2. Introduction**

Patient A brought a complaint against Dr. Hancock, alleging that he failed to perform a proper physical assessment during her hospital admission in February 2015, and that he failed to form a proper diagnosis, adequately explain test results and his diagnosis to her, and provide discharge instructions. Patient A was later diagnosed with an infection and admitted for care and treatment at another facility.

Dr. Hancock explained that he believed that Patient A’s presenting condition was due to extra medication that she had taken at home (with slight dehydration exacerbating her symptoms), and that he saw no need for further investigation, based on her improvement in the emergency department. He noted that although Patient A developed a urinary tract infection one week later, he did not think there was any indication for treatment at the time that he saw her.

#### **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, as well as College policies and relevant legislation.

#### 4. Committee's Analysis

While the Committee felt that Dr. Hancock's ultimate diagnosis of narcotic over-use was likely correct, it had significant concerns about the quality of Dr. Hancock's assessment and documentation in this case. The Committee found nothing in the record that would indicate that Dr. Hancock performed an appropriate physical or neurological examination of the patient. The Committee noted that Dr. Hancock's report only indicates that he performed a chest examination, when Patient A's Glasgow Coma Scale and her reduced level of consciousness should have prompted him to, at minimum, perform a thorough central nervous system examination.

The Committee was also concerned that Dr. Hancock did not reassess Patient A before discharging her home, despite the laboratory tests indicating possible acute renal failure and low sodium.

In terms of Dr. Hancock's communication, the Committee noted that there was nothing in the medical record to indicate that he discussed Patient A's diagnosis, or the laboratory or imaging results, with her, or that he provided her with appropriate discharge or follow-up instructions. As there was no urine analysis in the chart before the Committee, it was unable to assess Dr. Hancock's treatment decision in that regard.

The Committee was of the view that even though Dr. Hancock formed a correct diagnosis, it does not excuse his poor assessment and documentation in this case. In addition, the Committee also considered the fact that it received a concurrent complaint against Dr. Hancock from another patient raising similar concerns with respect to inadequate assessment, documentation, and communication. The Committee's concerns in this case were heightened by the fact that Dr. Hancock has a significant history of complaints with the College, and has been cautioned in the past about his inadequate diagnosis, treatment and documentation; as well as his assessment of/communication with a patient. He has also been found by the College's Discipline Committee to have failed to maintain proper records and the standard of practice of the profession.

In addition to the SCERP, the Committee required Dr. Hancock to attend at the College to be cautioned in person with respect to his inadequate assessment, documentation and

communication in this case.