SUMMARY

Dr. Jowan Mohammed Rasheed Perry (CPSO# 76342)

1. Disposition

On October 14, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required Dr. Perry (Family Medicine) to appear before a panel of the Committee to be cautioned to perform pelvic examinations in a patient with ongoing vaginal bleeding.

2. Introduction

A family member complained on behalf of a patient who was eventually diagnosed with cervical cancer that Dr. Perry, as the patient's family physician, failed to: perform routine screening Pap tests; provide a thorough physical assessment, including a bi-manual examination and Pap test even when the patient reported vaginal bleeding/clots; take the patient's ongoing reports of vaginal bleeding/clots seriously (including failed to request a specialist referral on an urgent basis); and intervene with the specialist's office and advise them about the patient's worsening symptoms. The family member also described that Dr. Perry attended the patient's home where she discussed with the patient her personal health information in front of family members and hugged the patient and another family member.

Dr. Perry responded that the patient reported that her obstetrician/gynaecologist had performed a Pap test in 2014 and the results were normal, the patient declined physical examinations at several appointments, and when the patient's symptoms of vaginal bleeding changed, she advised her to attend the local Emergency Room, after which the patient reported that she was fine. Dr. Perry also said that she referred the patient to her obstetrician/gynaecologist when she reported spotting, and that she was unaware of a second visit the patient made to the ER. She explained that she attended the patient's home (where she had been before, as she knew the family socially) to take the patient's records to her (after the patient requested a copy of her chart), and she responded to the patient's questions about her care at that time (with other family members present) and hugged both the patient and a family member.

Dr. Perry said she has reflected on this case and will be mindful in the future about physician-patient boundaries and will obtain her own copy of relevant test results and follow up with specialists if necessary.

3. Committee Process

An Obstetrical 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.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee was concerned that Dr. Perry relied on the patient's account about her last Pap test. While the Committee said it could not know with certainty what the patient said at the time, it noted that patients' memories (especially now that screening protocols for cervical cancer have changed relatively recently, to a less frequent schedule) can sometimes be unreliable. The Committee advised Dr. Perry to obtain a documented copy of a patient's most recent Pap test from the specialist rather than relying on the patient's account.

The Committee stated that Dr. Perry erred in failing to perform a pelvic examination, despite multiple opportunities and even a documented plan to do so in follow-up. The Committee was concerned that Dr. Perry did not take this case of abnormal vaginal/uterine bleeding in a pre-menopausal woman more seriously, noting that as the patient's family physician she should have been more proactive and not waited for the specialist consultation. On this basis, the Committee decided to caution Dr. Perry in person.

The Committee also advised Dr. Perry that as the patient's primary care physician, she should have advocated on behalf of her patient; in particular, she should have better conveyed the urgency of the situation to the specialist in her referral note or even considered speaking to the specialist personally to request a more timely consultation.

The Committee was of the view that Dr. Perry showed poor judgement in visiting the patient's home and should have been much more alert to physician-patient boundaries and confidentiality of personal health information. However, given Dr. Perry recognized her mistake and she has committed to being more alert to such issues going forward, and noting this was the first time Dr. Perry had been the subject of a College complaint, the Committee took no action beyond expressing its disapprobation of Dr. Perry's decision to attend the patient's home.