SUMMARY

DR. TIMOTHY GUY NICHOLAS (CPSO# 33515)

1. Disposition

On December 20, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required General Practitioner Dr. Nicholas to appear before a panel of the Committee to be cautioned on failing to properly manage and investigate a breast mass, and altering a chart note in contravention of the College's policy on medical records. The Committee also accepted an undertaking from Dr. Nicholas, as detailed further below.

2. Introduction

Dr. Nicholas was the patient's family physician for approximately eight years. The patient was diagnosed with breast cancer after she left Dr. Nicholas' practice. The patient complained to the College that at the last appointment, Dr. Nicholas diagnosed her breast lump as a cyst and failed to order any diagnostic imaging to confirm this diagnosis. The patient also complained that Dr. Nicholas failed to follow up on abnormal blood work (thyroid-stimulating hormone or TSH) at this last appointment and that he failed to titrate her thyroid medications throughout the years he provided her with care. Finally, the patient expressed concern that the wait times to see Dr. Nicholas were excessive.

Dr. Nicholas responded that there was no discernible abnormality in the patient's breast when he examined her. He also explained that he increased the patient's slightly elevated TSH at their last appointment and that he appropriately adjusted her medications throughout the years until she transferred from his care. Finally, Dr. Nicholas indicated that many of his patients have very complex issues, which can result in long wait times.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who specializes in family medicine. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

A Family Practice 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

With respect to the patient's breast lump, the IO provider concluded that Dr. Nicholas did not meet the standard of practice for the profession, that he demonstrated a lack of judgment, and that there was clear evidence that his management of the patient's breast mass may have exposed her to harm (as she was subsequently diagnosed with breast cancer).

The Committee considered, and agreed with, the IO provider's conclusions. Specifically, Dr. Nicholas' note from the patient encounter reads "breast nodule 2 cm by 2 cm", but there was no further comment in the history or the physical, and no plan for any management of the lump. The Committee found it very concerning that Dr. Nicholas failed to document a comprehensive management plan for the Complainant's newly-reported breast mass.

In reviewing this file, it came to the Committee's attention that Dr. Nicholas made alterations to his chart note for the patient's last appointment on three separate dates. The Committee was of the view that Dr. Nicholas should have delineated clearly in the record which information he

modified on these dates, and indicated that there is no justification to ever modify a patient's record without properly documenting and dating the modifications being made.

The Committee also noted that Dr. Nicholas' records, while legible, were quite scant.

Based on the above, the Committee had concerns about Dr. Nicholas' management of the patient's breast mass, as well as his medical record-keeping.

The Committee found that Dr. Nicholas' chart alterations and inadequate notes were all the more concerning given his prior history with the College, which includes a case where Dr. Nicholas was ordered to complete a medical record-keeping course as part of a specified continuing education or remediation plan. Given that Dr. Nicholas completed this course before he last saw the patient and altered the chart note, the Committee was of the view that he certainly should have been attuned to the requirements for maintaining adequate documentation and properly modifying medical records.

The Committee accepted an undertaking from Dr. Nicholas, in which he agreed to practice under the guidance of a clinical supervisor for six months, review and provide a written summary of the College's medical records policy, and complete two eLearning modules on medical record-keeping, as well as individualized instruction in medical ethics. The undertaking also requires Dr. Nicholas to undergo a reassessment of his practice six months after completing the supervision.

The Committee also concluded that a caution, as described above, would be appropriate.

The Committee took no further action on the concerns respecting Dr. Nicholas' care of the patient's hypothyroid, as it determined that those concerns were not supported on the record, and in particular, the IO provider concluded that Dr. Nicholas' care met the standard with respect to the management of that condition. The Committee also took no further action on

the concern regarding delays, indicating that wait times are unfortunately unavoidable in a busy office practice, and that it would not fault a physician for occasionally being late seeing a patient.