SUMMARY

DR. JEAN MALAN OOSTHUIZEN (CPSO# 77166)

1. Disposition

On December 15, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required family physician Dr. Oosthuizen to appear before a panel of the Committee to be cautioned with respect to with respect to the documentation, assessment, and management of patients who present with undifferentiated abdominal pain (including the importance of conducting a thorough functional inquiry at the index visit, considering a broad differential diagnosis, and providing clear discharge instructions with respect to follow-up care and when to return to seek care).

2. Introduction

A member of the patient's family complained to the College that Dr. Oosthuizen conducted an inadequate assessment, and failed to perform indicated diagnostic testing and follow-up instructions during a walk-in clinic visit. The patient had been experiencing abdominal pain, diarrhea, and discomfort with oral intake and had reported frequent urination and a concern about diabetes to a family member. Dr. Oosthuizen thought that the patient likely had reflux and prescribed a proton pump inhibitor. Three days later, the patient was discovered at home without vital signs. An autopsy revealed that the patient had undiagnosed Type I diabetes.

Dr. Oosthuizen responded that if the patient had reported symptoms of increased thirst and urination to the walk-in clinic triage staff, this would have triggered automatic urine and blood tests. Dr. Oosthuizen reviewed the care he provided and described his usual practice in assessing patients. He explained his rationale for reaching his diagnosis of the patient. Dr. Oosthuizen apologized for the untimely production of the patient chart which delayed the Coroner's Report. He explained that administrative staff at the clinic's head office is responsible for responding to records request.

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/investigation. 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 agreed with the IO provider's conclusion that Dr. Oosthuizen's care of the patient did not meet the standard of practice of the profession, particularly with respect to shortcomings in documentation which did not reflect the necessary elements of history-taking, red flags, physical examination, pertinent positive and negative findings, and discharge instructions.

The Committee noted that Dr. Oosthuizen had shown some insight in his response to the College regarding the importance of better documentation and had enrolled in a medical record-keeping course.

Given the preventable nature of the death in this case, and the concerns identified by the IO provider, the Committee felt that a caution in person was appropriate.