

SUMMARY

DR. DAVID KENNETH BOYER (CPSO# 58009)

1. Disposition

On December 6, 2017, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered family and emergency medicine physician Dr. Boyer to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Boyer to:

- Attend and successfully complete the Canadian Medical Protective Association (CMPA)’s e-Learning Modules, Documentation I (Charting Medical Records) and Documentation II (Principles of Medical Record Keeping)
- Engage in self-directed learning to include review and written summaries of the following:
 - Canadian Stroke Best Practice Recommendations: Hyperacute Stroke Care Guidelines, Update 2015
 - ER assessment of acute confusion
 - CPSO policy statement, *Medical Records* (#4-12)
 - CMPA Good Practices Module on Communication
- Undergo a reassessment with an independent assessor focussing on patients presenting with neurological symptoms approximately six months after completion of the remediation program.

2. Introduction

A family member of a patient complained to the College about Dr. Boyer’s decision to discharge the patient, who had presented to the Emergency Department (ER) with symptoms of active onset confusion and aphasia. The patient’s family also expressed concern that Dr. Boyer failed to provide appropriate discharge instructions (instead advising the family to take the patient to

an out-patient neurology appointment later that week) and failed to provide further investigation or consultation into the patient's symptoms. Shortly after discharge, the patient suffered a stroke and was taken by ambulance to a different ER. Subsequently, the patient suffered a second, debilitating stroke and died in hospital several weeks after Dr. Boyer's assessment.

Dr. Boyer responded that he disagreed with the family's statements that he discharged the patient in an unsafe manner, failed to provide appropriate discharge instructions or follow-up, and failed to provide further investigation or consultation into the patient's active symptoms. Dr. Boyer acknowledged that, upon reflection, he could improve his practice in the areas of discussion with and documentation of family members' concerns regarding discharging patients. He further indicated that in light of the patient's CT finding, the patient should have been started on ASA (acetylsalicylic acid).

3. Committee Process

A General 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 noted that Dr. Boyer's charting of the care he provided the patient is somewhat difficult to read and contains sparse information with respect to the history and physical examination. The Committee also noted that Dr. Boyer did not order ASA for the patient, despite the possibility of a stroke, instead discharging the patient with arrangements for an out-patient neurology appointment. Although Dr. Boyer did consult by telephone with a neurologist while the patient was in the ER and documented the fact of the call, the Committee was

concerned that no significant details of the discussion were noted in the chart. The patient's family member maintained that she repeatedly advised staff that she was uncomfortable with the decision to discharge the patient. Dr. Boyer states this concern was not communicated to him, and there is documentation about it in the nursing record. The Committee noted Dr. Boyer's acknowledgement that he could improve his documentation regarding discussions with patients' families, including documenting any concerns.

The Committee noted that Dr. Boyer's history of complaints to the College includes a prior written caution for failure to document history and physical examination.

The Committee outlined its concerns about Dr. Boyer's management of the patient, including: the patient should have been seen by a neurologist and admitted to hospital on first presentation to hospital; the CT scan showed prior damage to the brain (indicating previous strokes) and Dr. Boyer himself alerted the patient's family that despite the CT scan results the patient could still have had a stroke not yet apparent on imaging; discharge would have been reasonable if the patient had presented with a cleared mini-stroke, but this was not the case; Dr. Boyer did not prescribe ASA, which would have been appropriate in the circumstances; the charting made it difficult to determine whether Dr. Boyer's assessment was comprehensive and Dr. Boyer's account of the patient's condition is inconsistent with the report of the patient's family member and subsequent events.

Given the concerns about Dr. Boyer's management of the patient, the Committee determined that remediation through a SCERP was indicated.