SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. David Jang Barrett
(CPSO# 80252)
(the Respondent)

INTRODUCTION

The Respondent (General Practice) was the family physician of the Patient, a man in his early sixties, from July 2018 to December 2019.

In late December 2019, the Patient was admitted to hospital and underwent urgent bowel surgery. Shortly thereafter, the Patient passed away.

COMPLAINANT'S CONCERNS

The Complainant (a family member of the Patient) is concerned that the Respondent failed to appropriately manage the Patient's care, in that he:

- **did not provide any follow-up nor update to the Patient upon receiving his CT scan results in June 2019, which noted that urgent surgical consultation was advised, and also recommended a follow-up CT scan in 3-6 months;**
- **did not appropriately respond and intervene in response to the Patient's ongoing complaints of pain nor arrange further testing to investigate his symptoms;**
- **failed to conduct a comprehensive assessment of the Patient at his appointment in December 2019 and recognize signs of his declining health status.**

DISPOSITION

The Family Practice Panel of the Committee considered this matter at its meeting of August 5, 2021, at which time the Committee decided that it was prepared to accept an undertaking from the Respondent. The Respondent, however, declined to enter into an undertaking.

The Committee considered the matter again at its meeting of October 22, 2021. For the reasons set out below, the Committee decided to require the Respondent to complete a specified continuing education or remediation program (SCERP) consisting of a period of clinical supervision; professional education (including review of the investigation of mediastinal adenopathy and the investigation and management of intussusception in

adults, review of the College's policies, self-study and the completion of the Canadian Medical Protective Association's workshop: Test Results Follow-up"), and, in turn, a reassessment of the Respondent's practice.

COMMITTEE'S ANALYSIS

The Respondent demonstrated poor test management (specifically, appropriate follow-up on test results) at different stages of the care of the Patient. According to the record, the Respondent did not appropriately act upon the October 2018 chest x-ray, showing possibly significant findings. A CT scan should have been ordered in a timely manner with the Respondent advocating for prompt imaging. The record indicates that the Respondent either did not order the CT scan at the time or does not have a system to determine when a test fails to be booked or is booked too far into the future. It took many months and repeated ordering (as per the Respondent) to get the CT scan eventually arranged for June 2019.

The June 2019 CT scan results were highly abnormal and suggestive of an acute abdominal issue that required urgent action. Although the Respondent stated in his response that, in July 2019, he informed the Patient of the CT scan results and that he made a referral to a surgeon (which the Patient allegedly refused), the patient record does not support the Respondent's statements.

The Committee noted that the Respondent should have been very clear in communicating and documenting the significance of the findings. Any failure of the Patient to comply with the referral should have resulted in very detailed notes outlining the Respondent's efforts. There was no such discussion and/or documentation in the patient record, however.

Following the June 2019 CT scan, the Respondent saw the Patient in July 2019 and again in late November into December 2019. The Patient's presentation at the time of the November and December 2019 appointments should have led to a referral to the emergency department. The Committee noted that the Respondent demonstrated a lack of understanding that the Patient's symptoms might be related to the abnormal June 2019 CT scan and that he did not manage the Patient's situation with appropriate urgency. There was still no notation in the patient record of the highly abnormal June 2019 CT scan nor of the suggested urgent surgical consultation that had not taken place.

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In late December 2019, the Patient was admitted to hospital with intestinal obstruction and diffuse metastatic disease. Following urgent surgery, the Patient developed a small bowel perforation, septic shock and irreversible multi-organ failure and shortly thereafter, the Patient passed away.

In light of the above, the Committee considered it appropriate to require the Respondent to complete the SCERP, as set out above, to address the deficiencies noted in this case.