

**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. Keith Taylor Auchinachie (CPSO #27838)
(the Respondent)**

INTRODUCTION

The Respondent has been the Complainant's family doctor for over twenty years. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **Dismissed the Complainant's health concerns, such as left knee pain, and characterized them as anxiety and "just in her head";**
- **Dismissed the Complainant's self-harming thoughts as "nothing to be concerned about";**
- **Failed to release the Complainant's health records to her upon request;**
- **Recorded insufficient information on the Complainant's disability paperwork, causing her paperwork to be rejected;**
- **Failed to assess the Complainant for post-coital bleeding; and**
- **Interacted with the Complainant in a "snippy" manner and made rude comments to her, such as, "You can't answer the question on your own?" when the Complainant's mother accompanied her to an appointment.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of June 27, 2019.

The Committee required the Respondent to complete a specified continuing remediation and education program (SCERP) consisting of:

- Successful completion of the University of Toronto *Medical Record Keeping* course
- Review of the College's policy, *Medical Records*, and the Canadian Medical Protective Association's e-learning modules, *Documentation: Charting Medical Records* and *Documentation II: Principles of Medical Record Keeping*
- Reassessment of his practice approximately six months after the completion of the educational program by an assessor chosen by the College

COMMITTEE'S ANALYSIS

Dismissing the Complainant's self-harming thoughts as "nothing to be concerned about"

In the Committee's view, the Respondent's assessment was reasonable. However, the Committee noted that the Respondent's documentation was brief. When a patient is threatening self-harm, it would be appropriate to document relevant details about the risk and document more comprehensively the characterization of the patient's suicidal thoughts and a plan of action for managing the situation.

Failing to release the Complainant's health records to her upon request

The Committee highlighted the portion of the *Medical Records* policy that encourages physicians to consider a patient's financial circumstances and ability to pay. In this case, we noted that the Complainant had limited resources and it may have been appropriate to consider these circumstances in deciding whether to release her health records.

Recording insufficient information on the Complainant's disability paperwork, causing her paperwork to be rejected

In the Committee's view, the Respondent acted reasonably. However, we noted that there was no documentation of the conversations with the Complainant's lawyer in the chart (who requested assistance for an appeal of the Complainant's rejected claim for disability benefits). The Committee commented that physicians should document in a patient's chart any significant conversations they have with patients or their advocates that relate to the patient's care.

Failing to assess the Complainant for post-coital bleeding

The Committee was satisfied that the Respondent's treatment of the Complainant's concern about post-coital bleeding was appropriate. However, the Committee noted that while the Respondent's consultation was well-documented, his documentation of the visit was very scant and almost non-existent, including little about any discussion that might have taken place with the Complainant about this matter. The Committee recommended that the Respondent ensure full documentation, including the patient complaints, investigations, examination findings, procedures, differential diagnosis, and planned management.

In reviewing the records in this case, the Committee found the Respondent's documentation inadequate. The Committee was disappointed by the quality of the Respondent's medical record keeping in light of his previous history with the College, including his completion of education on medical record keeping in 2011 and receiving a verbal caution with respect to his

medical record keeping in 2016. As such, the Committee believed that it was appropriate to require the Respondent to undergo a specified continuing education or remediation program to address the identified deficiencies.

The Committee took no further action on the other concerns.