# SUMMARY

## Dr. Christopher Anjema (CPSO# 73372)

### 1. Dispositions

On April 19, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered ophthalmologist Dr. Anjema to complete a specified continuing education and remediation program ("SCERP"), and to attend the College to be cautioned with respect to his clinical care and professionalism. The SCERP requires Dr. Anjema to:

- complete the Canadian Medical Protective Association's (CMPA) on-line learning sessions on *Documentation: Charting Medical Records, Documentation II: Principles of Medical Record Keeping;*

- review and provide written summaries of the University of Manitoba's *Ophthalmology Guidelines for the Emergency Department*; the New South Wale's Agency for Clinical Innovation's *Eye Emergency Manual*; Chapter 241: Eye Emergencies, *Tintinalli's Emergency Medicine*, at Access Medicine; the College's policy on *Medical Records* and the College's *Practice Guide* as it relates to professionalism; the CMPA's *Good Practices Guide* with respect to communication, and The Canadian Patient Safety Institute's *The Safety Competencies*; and

- undergo a reassessment of his practice by an assessor selected by the College approximately six months following completion of the education program.

### 2. Introduction

A patient and her family member expressed concerns about the care the patient received from Dr. Anjema when she attended the Emergency Department (ED) a week following cataract surgery with pain in her eye and loss of vision. They stated that Dr. Anjema, who was the on-call ophthalmologist consulted by the emergency physician, failed to attend in person to assess the patient, and did not prescribe proper treatment. They reported that the patient saw her regular ophthalmologist (who had performed the cataract surgery) the following morning, and he

diagnosed a serious eye infection and performed immediate surgery. The patient was left with very limited vision in her eye.

Dr. Anjema responded that he met his obligations as the ophthalmologist on call, and relied on the information he received from the emergency physician in determining that he did not need to attend to assess the patient that evening. He said that he spoke directly to the emergency physician (which is contrary to what the emergency physician stated) and prescribed medication for increased intraocular pressure and arranged to see the patient two days later in his office. Dr. Anjema said that if he was told of any symptoms indicative of an infection or need for urgent care, he would have attended the ED.

## 3. Committee Process

A 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 while it was undisputed that Dr. Anjema was the ophthalmologist on call the evening the patient attended the ED and that he spoke with the ED about the patient, it was a matter of dispute as to whom he spoke with in the ED. The Committee indicated that it is crucial in these types of situations for the referring physician to speak directly to the specialist, and expressed concern at the suggestion in the record in this case that this direct physician-to-physician communication may not have occurred. Given that Dr. Anjema stated he could not recall the specifics of his conversation with the ED that evening, and the emergency physician definitively stated he did not speak directly to Dr. Anjema, the Committee felt it was quite possible that Dr. Anjema did not follow what he says is his usual practice, and that he did not speak directly with the emergency physician. Further to this point, the Committee noted that the hospital's review concluded that there was an "apparent lack of communication between the two physicians".

The Committee pointed out that the ED record clearly documented that the patient reported severe pain and a loss of vision seven days following cataract surgery (clear signs of infection in the eye, which should be considered an ocular emergency until proven otherwise), and found it hard to accept that whomever reported the case to Dr. Anjema would have omitted this important information. Even if the individual speaking with Dr. Anjema had failed to mention the above symptoms, the Committee would have expected Dr. Anjema to have specifically inquired about whether the patient had a decrease in vision, pain, and a red and angry-looking eye, all of which are cardinal features of endophthalmitis (which the patient was subsequently diagnosed with the following morning).

In the Committee's view, if Dr. Anjema did speak with the emergency physician, he failed to extract adequate historical information and sufficient information of a thorough physical examination to make a diagnosis, and failed to appreciate an ophthalmologic emergency. If, on the other hand, Dr. Anjema spoke only with the clerk/nurse, he failed to meet his professional obligation to communicate directly and appropriately with the emergency physician about a patient on whom he was consulting in order to obtain sufficient information to form an opinion and direct care.

The Committee was also concerned by the complete absence of any documentation of the discussion that Dr. Anjema had with the ED that evening – either in the ED records or in Dr. Anjema's own notes/records, which it viewed as a clear failure to adhere to the record-keeping practices expected of a competent physician.

The Committee was of the opinion that the patient's situation was one that required Dr. Anjema to be far more comprehensive and careful in his review and consideration of the patient's history and presentation, and to attend personally to assess her in a timely manner. They concluded that he showed very poor judgment in failing to do so.