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. Clive Snape (CPSO #29919)
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the care she received from the Respondent, her family physician from 2009 to December 2019.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **Failed to inform her of her diminished kidney function, first identified in 2016**
- **Failed to inform her of a referral to Dr. K that he documented in the medical record**
- **Inappropriately told her at her last visit in 2019, when discussing her 17 percent kidney function, "Don't worry, you can get a transplant."**

COMMITTEE'S DECISION

The Family Practice Panel of the Committee considered this matter at its meeting of September 25, 2020. The Committee required the Respondent to attend at the College to be cautioned in person with respect to failing to follow up on abnormal test results.

The Respondent also provided an undertaking to the College which included professional education in medical record-keeping, clinical supervision and reassessment.

COMMITTEE'S ANALYSIS

The Respondent first noticed the Complainant's proteinuria in 2010 and failed to follow up on the specialist referral at that time, simply assuming that the nephrologist had had no concerns. He saw the Complainant several times over the next 10 years, during which time there was evidence of decline in her kidney function, but he did not act. At one point, the Complainant had significant microscopic hematuria that the Respondent did not investigate.

The Respondent provided several possible reasons for his failure to respond to the Complainant's declining renal function. He indicated that he did not receive the nephrologist's report in 2010 (only the original blood tests), his staff failed to follow his

instructions to arrange a consultation with Dr. K and inform the Complainant in 2016, the 2016 blood work came into the office at a time when he was recovering from surgery, and the Complainant did not complete the blood work he recommended in 2018.

The Committee saw no indication that the Respondent recognized the shortcomings in his patient care and the several opportunities he missed to follow up on the Complainant's chronic renal failure and proteinuria. The Respondent's response to the complaint described significant disorganization in his office management and medical record-keeping. This was particularly troubling to the Committee in light of the Respondent's history with the College, which includes complaints about misplacing and/or failing to follow up on, or advise patients about, abnormal test results.

The Respondent confirmed that he advised the Respondent that a transplant was her best treatment option, but the Committee was unable to determine whether he delivered this information in a cold and insensitive manner, as the Complainant claimed. The Committee took no action on this area of concern.

Given the issues regarding the Respondent's failure to formulate an assessment, differential diagnosis and plan for abnormal findings, and the lack of system for tracking abnormal laboratory results and outstanding consultation requests, an undertaking was obtained, as set out above, and the Committee decided to require the Respondent to appear before the Committee to be cautioned in person.