

SUMMARY

DR. PETER MICHAEL FENTON (CPSO# 63915)

1. Disposition

On February 21, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required general practitioner Dr. Fenton to appear before a panel of the Committee to be cautioned with respect to his clinical care of a patient.

2. Introduction

A family member of the patient complained to the College that Dr. Fenton (General Practice) failed to provide appropriate care to the patient (failing to adequately assess, monitor and treat the patient), and failed to administer his office practice in a professional manner (in terms of his record-keeping and his transfer of records upon the patient and the family's request). The patient was under Dr. Fenton's care from 2010 to late 2014. In January 2015, the patient was diagnosed with multiple myeloma after investigations ordered by the patient's new family physician. The patient died in April 2015.

Dr. Fenton responded that he provided the best care possible to the patient, noting that the patient had declined recommended testing and treatment because of his religious beliefs. He acknowledged that his record-keeping was lacking in certain respects, but noted that he had recently completed a record-keeping course and had improved his practice in this area. In terms of transferring records to the family, Dr. Fenton stated that he was at first uncertain about providing the patient's records to the family, but later determined that the trustee of the estate of a deceased patient can have the file transferred upon request.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who specializes in family medicine. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

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 IO provider concluded that Dr. Fenton's care of the patient fell below the standard, and that he demonstrated a lack of knowledge regarding his obligations in medical record-keeping and management, a lack of skill in not taking an adequate history or examining the patient appropriately to establish a diagnosis or plan of care, and a lack of judgment in using a particular billing code without appropriate notes to represent the reasons for counselling and the time spent in the counselling process. The IO provider stated that because the issues in this case relate to inadequate history-taking, physical examination, documentation, and office administration, it is likely that similar issues have affected or will affect other patients.

The Committee shared the IO provider's concerns regarding the overall lack of detail and absence of basic elements in Dr. Fenton's records, and Dr. Fenton's acknowledged failure to document important discussions he purported to have had with the patient about his care and management, as well as examinations he purported to have performed. In addition, the Committee noted that even if the patient was devout (which the family disputed), the patient's religious beliefs would not have prevented the patient from undergoing proper blood work or imaging.

While the Committee acknowledged that Dr. Fenton was probably correct in stating that it would be difficult to diagnose multiple myeloma over the course of two visits, it also noted that this would depend on the clinical findings and the patient's history obtained during a thorough, appropriate assessment. In this case, the Committee had concerns about Dr. Fenton's assessment (given the lack of documentation showing a proper history and complete physical examination), and his management of the patient's low back pain. The Committee noted that if an elderly patient attends with new onset back pain, a physician should consider compression fractures and the possibility of cancer (such as infiltrating carcinoma of the vertebra), and should order appropriate investigations to rule out such diagnoses, rather than simply referring the patient to physiotherapy (as occurred in this case). The Committee therefore shared the IO provider's opinion that Dr. Fenton's management in this regard was below standard.

The Committee did not accept Dr. Fenton's explanation for the failure to release the patient's records to the family. The Committee noted that it would be a simple matter to clarify who was the trustee of the patient's estate, and to whom the records could properly be released. The Committee also found it concerning that four pages of another patient's clinical notes were included with the records ultimately released to the family. While the Committee acknowledged that such administrative errors can unfortunately occur in busy practices, the Committee was of the view that the fact that it occurred here might be an indication of improper office management (as would be the difficulties that the family said the patient had in trying to reach Dr. Fenton's office to schedule follow-up visits in the fall of 2014.)

In considering the above issues, the Committee was cognizant of Dr. Fenton's extensive history of complaints with the College, including a recent Discipline Committee proceeding which led to an order that would require Dr. Fenton to undergo a period of supervision if he were to return to practice (he is currently not practising). The Committee was satisfied that if information about this complaint and the concerns identified through the course of this investigation were brought to the attention of Dr. Fenton's supervisor (who, as noted above, he is required to

engage should he choose to return to practice), the concerns would be adequately addressed and the public will be protected in terms of Dr. Fenton's future practice.

Given the nature of the concerns identified in this case, the Committee determined that it was also appropriate to caution Dr. Fenton, as set out above.