

SUMMARY

DR. PAUL GIBBONS GOMEZ (CPSO# 94483)

1. Disposition

On April 13, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) required family physician Dr. Gibbons Gomez to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Gibbons Gomez to:

- complete the CMPA e-modules on Medical Record-Keeping and to document completion of the course
- review College policy #4-12, *Medical Records*, and provide a written report to the College
- engage a Clinical Supervisor for a six-month period, to focus on ensuring Dr. Gibbons Gomez can produce a comprehensive, legible emergency record
- undergo a reassessment approximately six months following the completion of the Education Plan.

2. Introduction

A family member of a deceased patient complained to the College that Dr. Gibbons Gomez may have failed to follow up on an x-ray he ordered in the ER, and may have failed to communicate concerns to the oncoming physician at the end of his shift. The patient was admitted, and died in hospital less than two days after Dr. Gibbons Gomez’s ER care.

Dr. Gibbons Gomez responded that the x-ray result was not reported until after he had handed over care, and that he had appropriately consulted with the internal medicine service, which took over care.

3. Committee Process

An Internal Medicine 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 was satisfied that Dr. Gibbons Gomez's care of the patient as her initial ER physician was adequate.

In the course of investigating this complaint, the Committee noted that Dr. Gibbons Gomez's ER chart documentation was sparse and very difficult to read. The Committee was aware that in June 2013, this Committee required Dr. Gibbons Gomez to attend at the College to be cautioned in person with respect to inadequate documentation and assessment, given an ER patient's presenting complaint. Dr. Gibbons Gomez attended for this caution in November 2013. Dr. Gibbons Gomez's care of the patient in the present case took place approximately a year later, in December 2014. The Committee was quite concerned to note that Dr. Gibbons Gomez's documentation in the ER did not improve in the interim period. Further, the Committee was concerned that Dr. Gibbons Gomez has now had two complaints investigations identifying serious problems with his documentation, although he has been in practice only since 2010.

It is important to ensure that Dr. Gibbons Gomez improves his ER documentation to meet the expected standard of a competent ER physician, and the Committee imposed the SCERP, including a reassessment, to achieve this end.