

**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. Jason Edmund Elliott Murdoch (CPSO #76765)  
(the Respondent)**

**INTRODUCTION**

At an appointment in July 2017, the Complainant informed the Respondent, his family physician, that he had experienced chest pain during a bicycle ride several days earlier. The Respondent examined the Complainant and documented that he found no crackles or wheezes and that the Complainant's chest was clear.

In November 2017, the Complainant experienced a significant ischemic event.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care.

**COMPLAINANT'S CONCERNS**

**The Complainant is concerned that the Respondent:**

- **Dismissed his description of his heart attack symptoms and his concern that he had experienced a heart attack during a bicycle ride and suggested to the Complainant that it was "in your mind"**
- **Failed to perform appropriate investigations, resulting in the Complainant's major cardiac arrest in November 2017, which may have been avoided if he had appropriately addressed the Complainant's concerns earlier.**

**COMMITTEE'S DECISION**

A General Panel of the Committee considered this matter at its meeting of August 20, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his inadequate cardiac care and medical record-keeping. The Committee also requested that the Respondent provide the Committee with a written report regarding office assessment and investigation of patients with new onset chest pain.

**COMMITTEE'S ANALYSIS**

As part of this investigation, the Committee retained an independent Assessor who is a family physician. The Assessor opined that the Respondent's history and physical examination were

insufficient to ascertain the Complainant's cardiac risk profile and to exclude angina as the cause of the Complainant's chest pain.

The Committee agreed with the Assessor's conclusion that the Respondent failed to assess the Complainant adequately upon the Complainant's report that he had experienced an episode of chest pain. The Respondent failed to document a description of the Complainant's risk factors for cardiac disease or the Complainant's blood pressure. It was troubling to the Committee that the Respondent claimed to have discussed investigations, particularly stress testing, with the Complainant but the Complainant declined. There was no documentation in the medical record to support this.

The Respondent instructed the Complainant to return if his pain recurred. On this basis, it appeared unlikely to the Committee that the Respondent told the Complainant that the pain was in his mind. The Committee took no action on this area of concern.

The Committee was unable to conclude that the Respondent's failure to perform appropriate investigations resulted in the Complainant's major cardiac arrest in November 2017.

In light of the Committee's concerns about the Respondent's inadequate cardiac care, the Committee concluded that a verbal caution was warranted in this case.