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. John Douglas Strang (CPSO# 63719)
(Family Medicine)
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care of a family member (the Patient) between October 2018 and August 2020.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the care the Respondent provided to the Patient at the Patient's retirement home from October 2018 to August 2020; for example:

a) **the Respondent failed to appropriately communicate with the Complainant, who holds power of attorney for personal care (POA) for the Patient, by refusing to provide medical updates and by scheduling appointments without notifying the Complainant, despite her request to be present**
b) **the Respondent failed to appropriately care and follow up with the Patient's medical concerns between October 2018 and August 2020 (i.e., geriatric psychiatry referral, chiropodist appointment, ongoing agitation and cognitive decline).**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of August 19, 2021. The Committee required the Respondent to attend at the College to be cautioned in person with respect to failure to cooperate with the College and ongoing concerns about documentation. The Committee also requested that the Respondent complete homework (a written report) with respect to documentation of evaluation and management of suicidal ideation.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in family medicine. The Assessor opined that: the Respondent's care of the patient met the standard of practice of the profession; the Respondent did not display any lack of knowledge, skill, or judgement; and the Respondent's clinical practice,

behaviour, or conduct did not expose nor was it likely to expose his patients to harm or injury. The Assessor commented that some of the Respondent's handwritten notes were poorly legible and scant, and his electronic medical record (EMR) notes were not very detailed. The Assessor indicated that more fulsome documentation about the conversations with the Complainant would be recommended, and documenting collateral history obtained from the staff at the retirement home, along with the Respondent's own observations, would be beneficial.

Regarding communications concerns, the Committee noted the Assessor's view that it would be impractical for physicians to see residents of retirement homes only when their POAs are present. The Committee discussed ways in which adequate communications could be arranged. The Committee noted the Complainant's strong advocacy for the patient. The Committee noted that the Respondent could have initiated telephone calls to the Complainant to provide updates in light of the Complainant's concern about the Patient's medical issues and known history of cognitive impairment. The Committee determined that the Respondent would benefit from review in this area, particularly with respect to documentation of his communications with POAs, and requested the homework outlined above.

Regarding care and follow-up of the Complainant's medical concerns about the Patient, the Committee accepted the Assessor's opinion that, in most aspects, the Respondent's management of the Complainant's medical care was adequate. The Committee noted, however, the difficulty in stating this definitively given the poor legibility of the Respondent's handwritten chart entries and scant details in the EMR, which the Assessor also noted.

The Committee had particular concern about the adequacy of the Respondent's management in March and June 2020, noting that it could not be certain of the Respondent's rationale for care given the poor documentation. The Committee felt that some attempt should have been made to see the Patient or make enquiries, and that this should have been documented, especially in light of the Patient's history of suicidal thoughts. The Committee noted that care should not have stopped notwithstanding the COVID-19 pandemic restrictions. The Committee also requested the Respondent complete homework related to documentation of evaluation and management of suicidal ideation.

The Committee remarked that the Respondent had failed to provide requested information to the College (transcription of charts and clarification of dates). The Committee determined that it was appropriate to caution the Respondent on the basis that this behaviour was consistent with a pattern of complaints to the College related to

the Respondent's failure to communicate, medical record-keeping, and lack of response to requests for information from his medical regulator. The Committee indicated its concern that the Respondent had again failed to cooperate with reasonable requests from the College.