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. Ikhimhiagie Felix Asekomhe (CPSO #80123)
(the Respondent)

INTRODUCTION

The Complainant saw the Respondent as a walk-in clinic patient on an ongoing basis. In 2018, the Complainant was diagnosed with Stage IV metastatic colorectal cancer. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the care the Respondent provided her from 2016 to 2018. In particular, the Complainant is concerned that the Respondent failed/delayed signing and sending referrals/requisitions to specialists, which prolonged her diagnosis of cancer, resulting in its metastasizing to the degree where she was no longer eligible for treatment.

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of April 11, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to test results management; inadequate work-up, assessment, and treatment of anemia; management and follow-up of frequently seen patients in the walk-in clinic setting; and medical record-keeping. In addition, the Committee requested that the Respondent provide the Committee with a written report, approximately 2-4 pages in length, with respect to the investigation and management of iron deficiency anemia in the older adult.

COMMITTEE'S ANALYSIS

The Respondent saw the Complainant on a regular basis over a two- to three-year period, following her for her chronic illnesses, administering vaccines, filling out forms, providing repeat prescriptions, and being copied on hospital documentation for the Complainant. Despite this, the Respondent deflected responsibility for the Complainant, noting that she was not a rostered patient and was just a walk-in patient for whom he provided episodic care. In the Committee's opinion, under the circumstances the Respondent had more responsibility towards the Complainant, who clearly saw the Respondent as her family physician, than towards another patient seen more casually in the walk-in clinic setting.

The Respondent's records for the Complainant were confusing, generally of poor quality, and failed to set out a very clear narrative about the patient. Better records would have ensured better continuity of care for the Complainant.

The Respondent failed to arrange and ensure proper follow-up for the Complainant beginning with a report of a CT scan in January 2018, and failed to follow up on subsequent visits when he had further opportunity to do so, or refer the Complainant to a gastroenterologist despite documenting his intention to do so.

The Respondent also did not investigate the Complainant for iron deficiency anemia for at least four months, despite concerning blood test results and a remarkable drop in hemoglobin that strongly suggested internal blood loss, like from a gastrointestinal site.

Given its concern about the Respondent's poor management of a patient with a serious clinical condition, and his failure to recognize the issue and ensure proper follow-up and referral, the Committee decided to caution the Respondent as set out above, and also request homework related to the investigation and management of iron deficiency anemia.