SUMMARY

DR. JASON KEITH YUE (CPSO# 76401)

1. Disposition

On October 23, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered Dr. Yue (Emergency and Family Medicine) to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Yue to:

- undergo a three month period of clinical supervision;
- complete a Medical Record-Keeping Course, through a course provider indicated by the College;
- review the College's Policy on *Medical Records* and the Canadian Medical Protective Association (CMPA) Good Practices Guide – Handovers, and review the documents with his clinical supervisor, which will include a discussion of the documents, how they apply to his situation, and how he has made, or plans to make, changes to his practice; and
- undergo a reassessment of his practice with an independent assessor selected by the College within six months of completing the remediation set out above.

2. Introduction

The College received a complaint from a patient who had concerns about the care Dr. Yue provided in the ER when the patient attended with a distended stomach, severe abdominal pain, nausea, and vomiting. Specifically, the patient was concerned that Dr. Yue failed to examine her abdomen, failed to listen to her complaints of discomfort and severe pain, failed to review and act on the results of a CT scan in a timely manner, and behaved in a rude and dismissive manner.

Dr. Yue stated that he did perform an abdominal examination, and that in response to the patient's concerns and pain, he ordered intravenous fluids and medications, and arranged a CT scan. He explained that the results of the scan were not available at the time his shift ended, and he therefore handed over the patient's care to the next physician coming on shift. The next physician on shift reviewed the CT scan results and referred the patient to a surgeon, who proceeded with urgent surgery. Dr. Yue denied the statements attributed to him by the patient, and stated that he was sorry the patient found him to be rude and dismissive. He indicated that he would use this case as a learning experience to further improve as a physician and provide a better patient experience.

Dr. Yue also provided comments on his records in this case, along with a transcription of his handwritten notes. He acknowledged that his documentation in this case was not ideal and does not represent his standard practice with respect to documenting patient interactions. He also acknowledged that his handwriting can be difficult to read. He indicated that he was working on the issue, and noted that the hospital was in the process of moving to an electronic medical record (EMR) system.

3. Committee Process

A 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 struck by the illegibility and brevity of Dr. Yue's documentation of the clinical encounter with the patient. It noted that the poor quality of the record made it challenging to determine what discussions Dr. Yue had with the patient, the extent of any

examination he may have performed (which the patient maintains did not occur), and the summary he provided to the next physician when he handed over the patient's care.

The Committee expressed that Dr. Yue's documentation of an abdominal examination lacked the relevant details they would expect to see, and raised questions as to what actually occurred. The Committee stated that if Dr. Yue had performed a thorough, appropriate abdominal examination, he would likely have noted significant, concerning signs that would have prompted further action (for example, an immediate surgical referral and possibly more urgent imaging).

The Committee noted that while Dr. Yue acknowledged that his notes were deficient in this case, and indicated that they are not reflective of his usual standard, the College advised Dr. Yue in 2015 regarding his record-keeping and ensuring that his notes are legible. The Committee was troubled that despite this advice, the records in this case were deficient, both in content and legibility, which made it challenging to determine the quality of the care Dr. Yue provided. For example, because Dr. Yue did not document anything about his handover of care to the next physician, it was unclear what he told this physician about his clinical findings and the outstanding CT scan. The Committee expressed that it would have been better if Dr. Yue had reassessed the patient prior to ending his shift, so that he could provide the next physician with updated information regarding her condition and the status of the CT scan.

The Committee noted that Dr. Yue's intention to improve his penmanship and the hospital's move towards typed notes in an EMR system, would not improve the content of Dr. Yue's notes.

In terms of the patient's concern about Dr. Yue's demeanour and communications with her, the Committee could not come to any conclusions, given the parties' conflicting recollections of their encounters. However, it stated its expectation that a physician will communicate with patients in an attentive and professional manner at all times.