SUMMARY

DR. MICHAEL CHUNG (CPSO #69070)

1. Disposition

On August 17, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required emergency medicine physician Dr. Chung to appear before a panel of the Committee to be cautioned with respect to his failure to appreciate vertebral injuries and to document his care adequately. The Committee also directed that Dr. Chung provide the Committee with a written report, approximately 2-4 pages in length, with respect to vertebral injuries from low-impact collisions.

2. Introduction

A patient complained to the College that Dr. Chung failed to perform a complete and thorough assessment of her on November 9, 2016, when she presented in the emergency department (ED) after being involved in a motor vehicle accident (MVA), and discharged her home with a diagnosis of muscle pain and whiplash. The patient stated that she returned to the hospital three days after the MVA and was diagnosed with T1, T2, and T12 spinal fractures.

The patient also expressed concern that Dr. Chung did not properly examine her knee, which resulted in a three-month delay in diagnosis of a left fibula fracture, or listen to her concerns regarding her leg pain and difficulty walking before he discharged her from the ED.

3. Committee Process

A Family Practice 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 found Dr. Chung's notes to be scant and, for the most part, illegible. There was little indication in the record that Dr. Chung conducted an appropriate assessment of the patient. If Dr. Chung log-rolled the patient and palpated her thoracic spine, it was not apparent from his notes, which did not include any useful physical findings. Dr. Chung indicated he performed a neurological examination of the patient, but the record did not support this statement.

The record included only five lines regarding the patient's position in the car and the circumstances of the accident. In his response to the complaint, Dr. Chung indicated that the patient did not inform him that the car she was in had been t-boned. This was an indication to the Committee that Dr. Chung did not take an adequate history.

In the Committee's view, Dr. Chung missed the diagnosis in this case, and it could have been a significant miss. The damage to the patient's spine was not extremely serious (she was hospitalized for more than one week and was discharged home on bed rest and with a back brace), but low impact MVAs can result in serious injuries and it was fortunate that the patient did not have a spinal cord injury as a result of the collision.

With regard to the concern that Dr. Chung did not properly examine the patient's knee, Dr. Chung indicated in his response to the complaint that the patient was ambulating prior to discharge. The patient denied that this was the case and indicated that she had to be wheeled out of the hospital by her mother because she could not walk.

The Committee considered it unlikely that Dr. Chung examined the patient's extremities. There was no documentation in the medical record of such an examination. If Dr. Chung had

conducted a secondary survey, he would likely have detected the fracture of the patient's proximal fibula.

The Committee decided that the caution and homework were warranted in this case in light of the concern about Dr. Chung's assessment and diagnosis of this patient and his inadequate documentation.