SUMMARY

DR. OLANREWAJU DAVID OGUNMODEDE (CPSO# 87840)

1. Disposition

On September 15, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required family physician Dr. Ogunmodede to appear before a panel of the Committee to be cautioned with respect to communications and test results management.

2. Introduction

A family member of the patient complained to the College that Dr. Ogunmodede misdiagnosed a foot fracture, provided the patient with a prescription for naproxen and an air cast without verification of the fracture, and failed to follow up with the patient and her family regarding normal x-ray results.

Dr. Ogunmodede responded that his treatment strategy was acceptable and consistent with the standard of care in every respect. He noted that he appropriately copied the patient's family physician on the imaging report, and the patient's family had the chance to discuss management with their family physician. Dr. Ogunmodede submitted another physician's opinion in support of his care.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider ("IO provider") who specializes in family medicine. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

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 IO provider opined that Dr. Ogunmodede failed to meet the standard of practice of the profession by not informing the patient of the normal x-ray finding. In addition, the IO provider stated that Dr. Ogunmodede did not display the communication skills expected for a patient-centred approach, given that the normal x-ray finding should have been shared with the patient.

The Committee agreed with the IO provider's conclusion, and did not find compelling the opinion which Dr. Ogunmodede had provided from another physician. While agreeing that Dr. Ogunmodede's clinical care and management of the fracture was acceptable, the Committee noted that: having diagnosed a fracture and recommending immobilization for up to six weeks, it was incumbent upon Dr. Ogunmodede to advise the patient and the patient's family when no fracture was in fact evident; that an earlier recovery was therefore expected; and that an expedited follow-up for the patient with the family physician was indicated. The Committee noted that in failing to convey the radiologist's report of the x-ray to either the patient's family doctor or to the patient and the patient's family, Dr. Ogunmodede contravened College policy on test results management. The Committee's concern about Dr. Ogunmodede's care in this instance was amplified by his significant history of prior complaints to the College, and two concurrent matters before the Committee in which concerns about his clinical care, record-keeping, and prescribing are in issue.