

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. Mark Roger Thibert (CPSO #52676)
(the Respondent)

INTRODUCTION

The Committee considered this matter originally in June 2018. The Respondent appealed the Committee's decision to the Health Professions Appeal and Review Board. In its February 4, 2020 decision, HPARB confirmed the Committee's decision generally but directed the Committee review photographs of the Complainant's hand taken during his visit to the Respondent two days after being seen in the Emergency Department (ER) and "thereafter determine what, if any, reconsideration of its conclusions on this issue and its decision to impose a caution may be required."

The Complainant injured his dominant hand when it was caught in a snow blower. He sought care in the ER. The ER doctor treated the Complainant's injuries but also contacted the Respondent, who was the plastic surgeon on call. The Respondent did not attend at the ER to assess the Complainant. Instead, the Respondent saw the Complainant in his office two days later. The Respondent was going away after the appointment and therefore referred the Complainant to another plastic surgeon. There was a further delay before the next surgeon saw the Complainant, who later required surgery to treat necrosis of his injured hand. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent refused to come in on a Saturday and failed to see him in consultation, though he was on call, when the Complainant presented to the ER with severe left hand injuries, and indicated he would see the Complainant on Monday at his office.

The Complainant is also concerned that when he saw the Respondent in his office:

- **the Respondent informed him of his upcoming absence and inability to provide care and failed to provide an urgent referral, which resulted in irreparable damage to the Complainant's fingers**
- **the Respondent's office staff was "brutal" when removing bandages and then failed to rewrap the new bandages appropriately.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of May 22, 2020. The Committee required the Respondent to attend at the College to be cautioned in person with respect to personally attend to patients who have suffered significant hand injuries. The Committee also issued advice to the Respondent to make appropriate efforts to communicate the urgency of the situation when handing over care to another physician.

COMMITTEE'S ANALYSIS

The ER physician consulted the Respondent due to the complexity of the Complainant's injuries, which were to his dominant hand and included partially severed fingers. According to the ER physician, when he spoke to the Respondent on the telephone, he described the injuries and the Respondent instructed him on how to close the wounds. The Respondent maintains the telephone call was cursory; he received only a brief history and confirmed outpatient follow-up. While the Committee cannot know exactly what the Respondent and the ER physician discussed during this telephone call, once the ER physician sent pictures to the Respondent following the repair, it was evident that the Complainant's injury was complex and needed specialist care. The photographs should have prompted the Respondent to attend at the ER at that time, consider revision surgery the next day, and mark the referral as urgent, with a same day assessment required, when he transferred care two days later.

In the Committee's view, the Respondent should have recognized that repairing the Complainant's injury was beyond the expertise and scope of an ER doctor, regardless of whether the ER doctor on shift said they would take care of it. The Respondent was on call, and given the complexity of the injury, he should have attended in person to assess the Complainant when he was consulted.

The Committee's concern was heightened by the fact that the Respondent has been the subject of prior College complaints and/or investigations where similar concerns were raised about his failure to attend the ER when consulted, and his failure to attend in person to see a patient with a serious injury when he was on call.

In light of the identified concerns, the Committee concluded that it was appropriate to caution the Respondent in person to impress upon him the importance of personally attending to patients who have suffered significant hand injuries.

The Committee considered the photographs taken on the date the Respondent saw the Complainant in his office, as well as the opinion of a plastic surgeon retained by the Respondent. The opinion-provider indicated that the photographs do not establish that

there was necrosis present at the time. The opinion-provider also noted that the appropriate management is to use time, usually a matter of days, to assist in making the best judgement possible and to avoid any unnecessary surgery. The Committee accepted that in the circumstances, it was reasonable for the Respondent to refer the Complainant to his colleague given his (the Respondent's) impending absence.

The Respondent asserted that in transferring care to his colleague after seeing the Complainant in the office, he intended the referral to happen the same day. Noting that ultimately the Respondent's colleague first saw the Complainant three days later, the Committee determined that despite his intentions there was a shortcoming in the Respondent's communications. For this reason, the Committee issued advice to the Respondent with respect to communicating urgency when transferring care.

As noted in its original decision, the Committee was unable to know with certainty how the Respondent's staff removed or reapplied the Complainant's bandages. However, even at the best of times, removing dressings can be quite painful. The Committee accepted the Respondent's response that his staff has many years of experience handling wound dressing, and the Committee did not take any action on this area of concern.