SUMMARY

DR. JORDAN DAVID THOMAS CRANE (CPSO# 91775)

1. Disposition

On August 11, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered family physician Dr. Crane to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Crane to:

- Attend and successfully complete a Medical Record Keeping course
- Reflect on his management of this case through self-directed learning by reviewing and providing written reports to the College in the following areas:
    - Management of opioid prescribing (Canadian Guideline for Safe and Effective Use of Opioids for Non-Cancer Pain)
    - Management of pre-malignant skin lesions
    - Cervical cancer screening
    - Bone health screening
    - CPSO policy statement #4-12, *Medical Records*
- Undergo a reassessment of his practice approximately six months following completion of the program outlined above.

2. Introduction

The College received a public complaint from a patient about Dr. Crane's management of post-operative dental pain and failure to ensure thorough physical examinations while the patient continued to receive episodic care from a nurse practitioner ("NP"). The patient also alleged that Dr. Crane accused the patient of being drunk and stealing, and that Dr. Crane had a partially full bottle of liquor in his office.

Dr. Crane addressed each of the concerns. He advised the patient to stop narcotics and did not prescribe further narcotics for tooth pain because the patient appeared sedated and lethargic; he offered to help manage acute withdrawal symptoms. He recalled that the patient did not appear upset at the time. (The chart documents a subsequent visit at which the patient was upset that Dr. Crane thought she had been drinking when she had used mouthwash.) Dr. Crane acknowledged having a bottle of alcohol in his private office which he indicates he has since removed. He explained that he had legitimate concerns about the patient diverting medications from another, more vulnerable patient.

3. Committee Process

As part of this investigation, the Committee requested review of the investigative record by an independent opinion ("IO") provider.

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 acknowledged that, for a number of reasons, the patient was challenging for Dr. Crane to manage. The Committee also noted that another factor creating confusion in the patient's care was that there were two primary care providers, Dr. Crane and the NP at his office. The Committee noted that NPs are independent health care providers, regulated by the College of Nurses of Ontario, who make independent treatment decisions in a patient's care, within their scope of practice.

The IO provider, after reviewing the matter and considering further commentary from Dr. Crane, opined that Dr. Crane's care of the patient did not meeting the standard of practice of the profession in that Dr. Crane demonstrated a lack of skill and judgement in the assessment of dental pain and allowed the patient to leave the office while intoxicated, without a plan for the

patient to get home safely. Dr. Crane disagreed with aspects of the IO provider's opinion; while he acknowledged the lack of detail in his medical records, he maintained that he would have given the patient appropriate advice about non-narcotic pain medication for dental pain and he also noted that the patient walked to his practice.

In addition to the IO provider's review and commentary, the Committee felt that other aspects of Dr. Crane's care of the patient were concerning, including: inadequate follow-up of cholesterol levels; inappropriate preventative prescribing to a patient with multiple cardiac risk factors; treatment of an elbow lesion with a differential diagnosis of melanoma (given that care was fragmented between Dr. Crane and the NP [who also applied a topical treatment—liquid nitrogen—contraindicated for melanoma]); management of preventative care (which should have included better and more consistent documentation of Pap smears and bone mineral density testing); and lack of a narcotic contract in the chart.

Overall, the Committee shared the IO provider's concerns and also felt that Dr. Crane's medical record-keeping required improvement. The Committee's concern was heightened given that Dr. Crane has been in practice just over five years and has previously been the subject of a complaint related to his overall management of a patient and inadequate records. The Committee also felt that Dr. Crane required education with respect to the management of patients on opioids, with cardiac risk factors, with skin lesions, and for appropriate screening modalities (such as bone mineral density and Pap smears).

Regarding the issue of the liquor bottle, the Committee noted that prudent physicians would not have alcohol visible in the office. Given that Dr. Crane indicated that he had removed the liquor from his office, the Committee felt his response was reasonable.