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. Mayer Yacowar (CPSO# 70982)
(the Respondent)

INTRODUCTION

The Respondent was the Complainant's family doctor. The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's office management, staff, and conduct.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

a. **uses a bad filing system;**
b. **has no follow-through with lab and hospital test reports, as these remain un-filed in a haphazard manner in large boxes, with no easy access as it is not in Alpha or patient No. order; being quite content to have his practice treat patient's lab reports like so;**
c. **has no follow-through calls to patients to come back to the clinic, in regard to these reports so optimum treatments can be taken immediately, obviously does not care for follow-through once he has billed OHIP for a patient's visit;**
d. **never washes his hands when seeing a patient, (documents in washbasins!), spends only two minutes with every patient, never touches and/or hardly looks at a patient before quickly writing out requisitions for laboratory reports or specialist appointments;**
e. **got angry and vengeful towards the Complainant when she said she was dissatisfied with the way her MRI report is being handled, i.e. no follow-through (The MRI test was done at 7:30 am on January 24, 2019 at Humber River Hospital on Wilson Avenue);**
f. **challenging the Complainant that she would not be able to locate another doctor within the three months and she "would know how difficulty it is to find another doctor!";**
g. **dismissed the Complainant, after she waited for three hours, without giving her copies of her undiscussed laboratory reports (i.e. thyroid, cholesterol, nail fungus) while effeminately, asking his administrative assistant to leave her and attend to something else outside to prolong her visit in a revengeful move;**
h. **refused to discuss the reason the Complainant waited for three hours to see him, a partial paralysis emanating from severe lower back pain (arthritis)!; and**

i. **continued to have his patients contend with a bad-mannered arrogant "Asian man" working in his clinic, despite bad reviews about this particular individual and also other staff, on Google Review and RateMDs websites. This shows a complete disregard to Canadian patients!**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of May 13, 2020. The Committee required the Respondent to complete a specified continuing remediation and education program (SCERP), consisting of three months of clinical supervision, including meeting monthly with a Clinical Supervisor who is to review a minimum of 15 charts to assess for the quality of documentation and care); review of the College policies, *Medical Records Management* and *Managing Tests*; and review of the Canadian Medical Protective Association article, "How effective management of test results improves patient safety." The SCERP also provides that the Respondent's practice will be reassessed six months after completing the education program,

COMMITTEE'S ANALYSIS

Re: concerns a, b, c the Respondent's filing system and follow-up of test results

As part of this investigation, the Committee retained an independent Assessor who specializes in family medicine. The Assessor opined that in general the care the Respondent provided to the Complainant met the standard of practice. The Assessor noted concerns with the documentation in that the cumulative patient profile (CPP) was handwritten and difficult to read; vaccinations for tetanus, diphtheria, shingles, influenza, and pneumonia were not documented; and a test result that was likely to be clinically significant was not appropriately tracked.

The Committee acknowledged that the Assessor concluded that the Respondent met the standard in general in treating the Complainant and with regard to documentation; at the same time, the Assessor identified deficiencies with the Respondent's documentation and test results management.

As set out in College policy, physicians must have an effective test results management system to ensure that appropriate follow-up on test results occurs. Furthermore, when ordering a test for a patient who has a high risk of receiving a clinically significant result, as was the case here, physicians must ensure results are received when expected and tracked if not received. The Respondent did not comply with this policy.

The Committee disagreed with the Assessor's conclusion that the Respondent's medical records met the standard. The handwritten CPP was illegible; vaccinations for tetanus, diphtheria, shingles, influenza, and pneumonia were not documented; and there were ongoing issues with the paper and electronic medical records (EMR) system in place.

The Committee was of the view that the Respondent's records did not comply with College policy on medical record-keeping in that they were difficult to follow, not legible, lacking in detail and content in the electronic medical record was overly reliant on templates.

The Committee's concerns were heightened by the fact that the Respondent has a significant history of prior College investigations, including where concerns of a similar nature (e.g. office administration and/or record-keeping) were raised.

The Committee took no further action on the remaining concerns.