SUMMARY

Dr. Donald Hastings (CPSO# 32594)

1. Dispositions

On April 19, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") ordered general practitioner Dr. Hastings to complete a specified continuing education and remediation program ("SCERP"), and to attend the College to be cautioned with respect to his clinical care and medical record-keeping. The SCERP requires Dr. Hastings to:

- complete a medical record-keeping course and an emergency medicine review course;
- review and provide written summaries of the University of Manitoba's *Ophthalmology Guidelines for the Emergency Department*; the New South Wale's Agency for Clinical Innovation's *Eye Emergency Manual*; Chapter 241: Eye Emergencies, *Tintinalli's Emergency Medicine*, at Access Medicine; the American Academy of Ophthalmology's Guidelines on *Referral of Persons with Possible Eye Diseases or Injury;* the College's policy on *Medical Records*; and The Canadian Patient Safety Institute's *The Safety Competencies*; and
- undergo a reassessment of his practice by an assessor selected by the College approximately six months following completion of the education program.

2. Introduction

A patient and her family member expressed concerns about the care the patient received from Dr. Hastings when she attended the Emergency Department (ED) a week following cataract surgery with pain in her eye and loss of vision. They stated that Dr. Hastings did not adequately examine the patient, failed to access a specialist when required, and discharged the patient home in worse condition than when she arrived. They noted that they asked Dr. Hastings to contact the ophthalmologist who had performed the surgery, but Dr. Hastings said he had to adhere to the call schedule. The patient reported that she saw the ophthalmologist who had performed the cataract surgery the following morning, and he diagnosed a serious eye infection and performed immediate surgery. The patient was left with very limited vision in her eye.

Dr. Hastings responded that he assessed the patient and asked the clerk to contact the on-call ophthalmologist to come to the ED to assess the patient. He said he learned that the on-call ophthalmologist offered to see the patient two days later in his office. Dr. Hastings stated that he did not speak directly to the on-call ophthalmologist. He stated that he spoke with the patient about her options, which included waiting to see the local ophthalmologist or going to a neighbouring city to seek after-hours services.

3. Committee Process

A 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 noted that while it was undisputed that Dr. Hastings had the on-call ophthalmologist paged about the patient and that the ophthalmologist offered to see the patient two days later, it was a matter of dispute as to whom the ophthalmologist spoke with in the ED. The Committee indicated that it is crucial in these types of situations for the referring physician to speak directly to the specialist, and expressed concern at the suggestion in the record in this case that this direct physician-to-physician communication may not have occurred. Given that the ophthalmologist stated he could not recall the specifics of his conversation with the ED that evening, and Dr. Hastings definitively stated he did not speak directly to the ophthalmologist, the Committee felt it was quite possible that the physicians did not speak directly to one another in this case. Further to this point, the Committee noted that the hospital's review concluded that there was an "apparent lack of communication between the two physicians".

The Committee was of the view that Dr. Hastings failed to recognize the patient's ocular emergency, and to appropriately advocate on her behalf by ensuring that the on-call ophthalmologist attended, or referring her to a nearby facility that offered after-hours ophthalmologic care so that she would receive the urgent care she required.

The Committee was concerned by the complete absence of any documentation of the ED's communication with the on-call ophthalmologist that evening – either in the ED records (written by Dr. Hastings and other ED staff) or in the ophthalmologist's notes/records, which it viewed as a clear failure to adhere to the record-keeping practices expected of a competent physician.

The Committee noted that the patient asked Dr. Hastings to contact the ophthalmologist who had performed her cataract surgery and was knowledgeable about her situation, and the Committee felt that it would have been reasonable in these circumstances for Dr. Hastings to have placed a call to this physician. Even if this physician could not attend the ED that evening, he may have been able to provide further helpful information/direction to Dr. Hastings.

The Committee was concerned about the adequacy of Dr. Hastings' assessment of the patient – in terms of the history and physical examination performed. It noted that there was no relevant history documented, and no clear indication of what physical examination Dr. Hastings performed. The Committee pointed out that even if Dr. Hastings did feel that the patient was experiencing acute glaucoma (indicated by a spike in her intraocular pressure (IOP)), there is no indication in the ED record that he tried to measure her IOP, do visual field testing or examine her eyes, and it was not even clear whether he reviewed the nursing notes documenting the visual assessment the nurse performed at triage.