

## SUMMARY

### Dr. Wayne Albus (CPSO# 57125)

#### 1. Dispositions

On May 11, 2017, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered family physician Dr. Albus to complete a specified continuing education and remediation program (“SCERP”), and to attend the College to be cautioned with respect to his assessment of the patient and his medical record keeping. The SCERP requires Dr. Albus to:

- review and provide a written summary of the College’s policy on *Medical Records*;
- meet with a Clinical Supervisor acceptable to the College six times over six months (who will review a minimum of 20 charts to assess for the quality of documentation and care) to address the following deficiencies in Dr. Albus’ practice:
  - Performing and documenting vital signs for patients
  - Maintaining legible of medical records
  - Ensuring comprehensive narratives – sufficient to tell the patient’ story
  - Documentation of details of physical examinations including vital signs
  - Keeping a pertinent record of positive and negative findings
  - Documentation of diagnosis and management decision; 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 family member of a patient expressed concerns about the care Dr. Albus provided to the patient. The family member stated that Dr. Albus failed to thoroughly assess the patient and incorrectly diagnosed him with the flu, failed to order testing and investigations to properly diagnose his lower right abdominal pain as appendicitis, and also failed to provide proper discharge instructions to the patient. The family member reported that the patient attended the emergency department (ED) a few days later and was diagnosed with appendicitis, and was rushed to surgery where his appendix was found to be gangrenous. The patient died two days later of sepsis.

Dr. Albus responded that he examined the patient, and given the patient's nonspecific symptoms and unremarkable abdominal examination, he felt the most appropriate diagnosis was gastroenteritis. He stated that he considered appendicitis but did not suspect that the patient had this condition. He noted that if he had any suspicion of appendicitis he would have referred the patient to the ED for further evaluation. Dr. Albus stated that he did advise the patient to return for a reassessment if his condition did not improve in one to two days. Dr. Albus admitted that his records do not fully explain his assessment and discharge planning in this case, and he stated that he regrets not documenting his findings in more detail. He also acknowledged that his handwriting was illegible, but noted that he uses electronic medical records in his family practice.

### 3. Committee Process

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.cpsso.on.ca](http://www.cpsso.on.ca), under the heading "Policies & Publications."

### 4. Committee's Analysis

The Committee noted that during the visit in issue, Dr. Albus took the patient's blood pressure, examined his abdomen, and diagnosed the patient with viral enteritis (i.e. a flu). However, it turned out that the patient was in fact in the early stages of appendicitis when he saw Dr. Albus, and he passed away four days later as a result of sepsis.

Overall, the Committee was troubled by the state of Dr. Albus' records in this case. His notes were not only illegible, but also minimal, lacking many of the important details one would expect to see recorded in an encounter of this nature. For example, the abdominal examination is represented by a simple checkmark, with no mention of the pertinent positive and negative findings; and the history documented by Dr. Albus is brief and limited. In addition, while Dr. Albus did chart "FU PRN [follow up as needed]", there is no indication of the actual discharge instructions that Dr. Albus said he provided to the patient, which the patient's family member

(who was present for the visit) disputed. The Committee pointed out that it was not in a position to know with certainty exactly what Dr. Albus said to the patient, but noted that there was no suggestion in the information before it that Dr. Albus advised the patient of any specific signs or symptoms to watch for, which would indicate a need for the patient to seek immediate medical attention.

The Committee found the significant deficiencies in Dr. Albus' records even more concerning given that he was directed to complete a record-keeping course in relation to a previous complaint, which he did in 2013. The Committee observed no indication that Dr. Albus applied any learning from this course in his records in the present case.

The Committee acknowledged that appendicitis can be difficult to diagnose in its initial stages; however, noted that it was not possible to determine how well Dr. Albus considered this diagnosis (in terms of the thoroughness and adequacy of his assessment of the patient and his considerations in ruling out this diagnosis), given the very poor state of his records in this case. The Committee noted that although Dr. Albus checked the patient's blood pressure, he did not check any other vital signs, including the patient's temperature and pulse.

The Committee stated that while it would not necessarily fault a physician for missing an early case of appendicitis if the physician demonstrated a full and complete assessment of the patient (including a proper consideration of the differential diagnoses and a reasonable explanation for the physician's thought process and conclusions), the information available in this case was not capable of satisfying the Committee that such an assessment occurred.