

SUMMARY

Dr. Julie Lee Clowater (CPSO# 86893)

1. Disposition

On November 23, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered Dr. Clowater, a pediatrician, to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Clowater to:

- Successfully complete the University of Toronto’s course in Medical Record-Keeping and the CanREACH Primary Pediatric Psychopharmacology Program
- Review the College’s policies on *Medical Records* and *Prescribing Drugs* and provide written summaries of the policies and how they apply to her practice
- Engage in focused educational sessions with a Clinical Supervisor for six months
- Undergo a reassessment with an assessor selected by the College which is to include a review of at least 25 patient charts and an interview with the assessor

2. Introduction

The College received information raising concerns about Dr. Clowater’s medical record-keeping and subsequently, the Committee approved the Registrar’s appointment of investigators to conduct a broad review of Dr. Clowater’s practice.

Dr. Clowater responded that she acknowledges that there were difficulties with some earlier iterations of her Electronic Medical Record (“EMR”) but that the problems have been resolved and she is working to create a medication record that accurately reflects patients’ medications. She also indicated that going forward, she will take patients’ blood pressure herself and chart it and that she will record patients’ dose change responses using the Side Effects Rating Scale.

3. Committee Process

As part of this investigation, the Registrar appointed a Medical Inspector (“MI”) to review a number of Dr. Clowater’s patient charts, interview Dr. Clowater, and submit a written report.

The Committee, consisting of public and physician members, met to review the relevant records and documents related to the investigation. The Committee 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 on the College's website at www.cpso.on.ca, under "Policies & Publications."

4. Committee's Analysis

The MI found that Dr. Clowater had no consistent procedure to record patients' prescriptions. The College's policy on *Medical Records* states that physicians must document information about the medication they prescribe in patients' charts, including but not limited to the type of drug, dosage, and its material risks or side effects, as soon as possible after the patient encounter.

The MI also noted that Dr. Clowater's medical records did not record patients' blood pressure. The current standard of practice is not only to evaluate children prior to starting any treatment, but also to monitor them during treatment which requires monitoring symptoms, objectives, and functional outcomes such as height and weight measurements, blood pressure, and heart rate. Hypertension may be uncommon in children; however, it has been known to occur at times. There is risk of harm if children have hypertension and medication increases blood pressure. While the consequences may not be apparent until years after the medication prescription, this issue should be discussed with parents as it may influence their decisions around medical care.

The MI was also concerned that Dr. Clowater did not document patients' dose change responses and has been relying on patients' parents to monitor their child's responses to changes in doses. It is the physician's obligation to monitor patients' responses to increases or decreases in doses, and it should not be left to parents to determine when the best clinical result has been achieved.

The MI's final observation was that Dr. Clowater's medical records are at times missing reports. Physicians must ensure that patients' health records are complete and include all reports, particularly when one relies on this information to monitor outcomes in a patient's treatment.

In the Committee's view, these are significant deficiencies in Dr. Clowater's medical records which can have the potential to adversely affect Dr. Clowater's care of a pediatric population,

and in particular a population to whom she routinely prescribes controlled substances. Physicians must have systems in place to ensure that their records meet the expected standard.