COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "C"

Dr. John Kirkpatrick

Investigation Committee "C" of the College of Physicians and Surgeons of Nova Scotia (the College) concluded its investigation into a complaint against Dr. Kirkpatrick by Decision dated June 26, 2017. The Investigation Committee reached agreement with Dr. Kirkpatrick with respect to the disposition of the complaint. A summary of the complaint and its disposition appears below.

PARTIES

Dr. John Kirkpatrick is a family physician, licensed to practise medicine in Nova Scotia since 1983.

Patient X is from Nova Scotia.

SUMMARY

Key points as reported by the Complainant

Patient X states he had complained to Dr. Kirkpatrick about severe lower back pain on a few separate occasions. Around Christmas 2015, Patient X was sent for scans at Northside General Hospital. It was confirmed Patient X suffered from a disk herniation.

Patient X saw Dr. Kirkpatrick 2 or 3 times after the scans took place. Patient X discussed seeing a pain specialist with Dr. Kirkpatrick. Dr. Kirkpatrick prescribed a non-steroidal anti-inflammatory drug.

During the February 22, 2016 visit, Patient X reports his pain level was 10/10 and he could barely walk. Dr. Kirkpatrick prescribed Morphine. Dr. Kirkpatrick told him to return to the office if the pain persisted. Patient X felt, in his opinion, the pain level should have been worthy of a scan at the hospital.

By February 24, 2016, Patient X's pain had increased. Patient X was having trouble urinating. His lower extremities were beginning to go numb so he decided to make another appointment with Dr. Kirkpatrick. Patient X states Dr. Kirkpatrick prescribed a type of nerve medication and told him to go home.

When Patient X woke up the next morning he was completely numb from the waist down. Patient X called an ambulance and then called Dr. Kirkpatrick's office to make him aware of the situation. When Patient X arrived at Cape Breton Regional Hospital and informed the physician on call of his symptoms, he was sent for a scan.

Following the scan, Patient X was rushed to Halifax for an emergency surgery. When he awoke from the surgery, he was informed he suffered from an extreme disc herniation which had crushed his spinal nerve. Patient X states the pressure was relieved by the surgery but it was too late and he now suffered from Cauda Equina Syndrome.

Patient X believes Dr. Kirkpatrick should have taken his case more seriously when he described his pain level at 10/10. He also believes he should not have been sent home when he complained that his lower extremities were numb. Patient X states his diagnosis of Cauda Equina Syndrome has ruined his career, family life, bowel and bladder, sensation from the waist down and his sex life.

Key points reported by the Respondent

Dr. Kirkpatrick states Patient X has been his patient for greater than 20 years. In addition to seeing Patient X for chronic back pain, he has been seen for asthma, various injuries and illnesses including severe pneumonia in March 2014. Dr. Kirkpatrick states he has treated Patient X with respect, and to the best of his ability, has taken all his medical complaints very seriously.

Patient X was diagnosed with leg length discrepancy in November 2013. This was felt to be the cause of mechanical low back pain. Patient X was prescribed custom orthotics for his 2cm shorter right leg. Patient X did not return to Dr. Kirkpatrick's office until June 2015 in relation to his back pain.

Patient X attended an appointment at Dr. Kirkpatrick's office on June 29, 2015. Patient X was having chronic low back pain. Patient X advised Dr. Kirkpatrick he was unable to tolerate the orthotics and felt the adjustment in the lift was causing more pain. Dr. Kirkpatrick recommended further stretching exercises and gave Patient X an x-ray requisition for a lumbar spine and sacroiliac joints x-ray to rule out any abnormalities.

Patient X completed the x-ray on November 2, 2015 and returned to Dr. Kirkpatrick's office on November 3, 2015. Patient X continued to work in his physically demanding job. Dr. Kirkpatrick states, based on the x-ray findings, he felt Patient X should try again to use his custom orthotics both at work and in his home. Dr. Kirkpatrick also prescribed nonsteroidal anti-inflammatories and advised Patient X to continue with his stretching exercises, and to practice proper lifting technique.

Patient X returned on November 13, 2015 with ongoing complaint of low back pain. Patient X was getting some relief with Celebrex that his father provided to him and was attempting his stretching exercises, including proper posture. As Patient X was not improving, he was booked for a CAT scan of his lumbar spine as well as bone scan with the possibility of facet joint arthritis. Dr. Kirkpatrick also considered a consultation with a physician at the pain clinic for possible localized injection.

The CAT scan was completed on December 8, 2015 and showed a central to right sided L4-5 disc herniation. Patient X returned to the office on December 16, 2015 with a complaint of

continuous low back pain, with pain to the right leg. The bone scan report had not yet returned.

Dr. Kirkpatrick states there was no history of numbness to the legs and on examination there was no radiculopathy and no evidence of weakness. It was recommended Patient X continue with his stretches and use his orthotics while awaiting the results of the bone scan. The Bone scan showed mild uptake in the L3-L4 but no other abnormalities of facet joint arthritis.

Patient X was next seen February 22, 2016 with symptoms of severe back pain. With his previous history of disc disease, it was Dr. Kirkpatrick's medical opinion that Patient X needed further analgesic control. Examination showed no evidence of radiculopathy and normal straight leg raising but he was limited with his pain. Patient X was prescribed long acting MSContin 15-30 mg twice a day.

Dr. Kirkpatrick felt Patient X needed better control with medications, in addition to bed rest, moist heat and no lifting. Patient X was recommended to follow-up if he had no pain relief. There was no indication for repeat CT scan based on clinical presentation and Dr. Kirkpatrick's examination. It was stressed to Patient X to return if his condition worsened.

Patient X contacted Dr. Kirkpatrick's office on February 24, 2016 and was seen immediately with his symptoms of severe back pain.

Patient X was having great difficulty sitting. Dr. Kirkpatrick was unaware Patient X had great difficulty getting to the office from his vehicle. Patient X had numbness down his left leg to the foot. Patient X had no loss of bowel or bladder control .Dr. Kirkpatrick states Patient X was difficult to examine with constant shifting and his pain.

Patient X was having increasing leg spasms with numbness to his foot. After examination, Dr. Kirkpatrick's medical opinion was that Patient X was suffering from an acute lumbar disc at the L4-L5 level. Dr. Kirkpatrick discussed adequate pain control and further medication was added to adequately control his pain.

Dr. Kirkpatrick states a consultation with a neurologist was requested as soon as possible for immediate EMG studies as well as MRI examination. Dr. Kirkpatrick further states he discussed with Patient X that immediate consultation with a neurosurgeon would be done if his symptoms were not controlled with analgesic and bed rest. Dr. Kirkpatrick prescribed additional medication of Cymbalta 60mg daily and Flexeril 10 mg bid for Patient X's muscle spasms. With Patient X's inability to rest and sleep, he was prescribed Nortriptyline 10mg 2 tablets at bedtime.

At the end of the appointment, Dr. Kirkpatrick accompanied Patient X to the reception desk to fill out the patient related questions on the MRI requisition. Patient X was able to walk with no weakness but in considerable spasm and severe pain. It was at this time that Patient X stated there was numbness in his groin area.

Dr. Kirkpatrick states with the benefit of hindsight, he wishes he had asked Patient X to return to the examining room and attempt a rectal examination. Dr. Kirkpatrick believes the spasms and uncontrolled pain may have made this very difficult to complete. Dr. Kirkpatrick also states he

wishes in hindsight he had attempted to reach a neurosurgeon for immediate referral.

On February 25, 2016, Patient X contacted the office and Dr. Kirkpatrick spoke to him on the phone. Patient X informed him of the rapid change in his condition and the plan to go to emergency. Dr. Kirkpatrick advised Patient X to attend Cape Breton Regional rather than the local hospital in North Sydney so emergency imaging/scanning could be done. Dr. Kirkpatrick contacted the Emergency Department to notify them of Patient X's pending arrival.

Patient X had repeat CAT scan which Dr. Kirkpatrick received on his electronic medical record that afternoon. At approximately 6:00 p.m., Dr. Kirkpatrick went to the Emergency Department to see Patient X. Dr. Kirkpatrick was told Patient X had already been transferred to Halifax as there was no neurosurgeon available locally that day.

Dr. Kirkpatrick had no contact with Patient X following this event but did receive a copy of the discharge summary and learned Patient X was transferred to the Nova Scotia Rehabilitation Center following surgery. At the time of discharge, Patient X had regained bladder control and was up walking with a walker.

On May 3, 2016, Dr. Kirkpatrick received a memo from the MRI Department at Cape Breton Regional with regards to attempts made to contact Patient X. Dr. Kirkpatrick's office contacted Patient X who informed them he was having great difficulty with mobility. Dr. Kirkpatrick was not aware Patient X did not want him to be his family doctor anymore. Dr. Kirkpatrick's office attempted to contact Patient X on May 5, 2016 to let him know Dr. Kirkpatrick would see him at home and asked that he call back.

Dr. Kirkpatrick was going to arrange further rehabilitation, including Occupational Therapy and Physiotherapy. Dr. Kirkpatrick was unaware Patient X had made a formal complaint with the College until he received the letter on May 9, 2016.

Dr. Kirkpatrick believes his medical judgment is sound and that he provides good care to his patients. Dr. Kirkpatrick has never had a patient or become aware of a patient with acute and chronic disc disease that so rapidly progressed to this rare Cauda Equina Syndrome.

Further Comments

In further comment, Patient X states he communicated to Dr. Kirkpatrick that he was unable to urinate normally. Patient X also states there was no communication made to him regarding an MRI or scan to be done as soon as possible.

Dr. Kirkpatrick reiterates his notes reflect no loss of bowel or bladder control and he has no recollection of anything different. Dr. Kirkpatrick also states a copy of the MRI requisition is on the chart and includes patient related questions that were completed by Patient X.

CONCERNS/ALLEGATIONS OF COMPLAINANT

Patient X alleges Dr. Kirkpatrick did not take his complaints of pain seriously. He further alleges Dr. Kirkpatrick should not have sent him home when he complained of numbness in the groin area but rather sent him for an urgent scan. Patient X alleges it is his belief that his nerves may not have died and his chances of recovery would have been significantly greater if this was done.

CONCERNS OF COMMITTEE

As with all complaints, the Investigation Committee is not limited to investigating only the concerns set out in the complaint. The Committee has the responsibility to look into all aspects of a physician's conduct, capacity or fitness to practise medicine that arise in the course of the investigation.

In this matter, after reviewing all available information, the Committee identified the following concern arising from this complaint:

- After reviewing written submission and the interview, Dr. Kirkpatrick, upon reflection and hindsight, does not appear to acknowledge the extent of his role in missing this significant diagnosis.

DISCUSSION

The Committee acknowledges the significance of the diagnosis of Cauda Equina Syndrome on Patient X's life.

Although Cauda Equina Syndrome is a rare diagnosis, the consequence of missing this diagnosis is significant. Despite this being an uncommon condition, Patient X's presentation had enough classical features that the Committee believes it should have been considered in the differential diagnosis. Patient X's presentation included difficulty voiding and numb groin in association with escalating back pain.

The Committee feels that given the devastating consequences of missing this diagnosis, it must always be considered in the setting of severe back pain and urogenital findings.
The Committee concludes that Dr. Kirkpatrick failed to recognize significant findings in the history and clinical presentation which should have resulted in earlier intervention.

In coming to its decision, the Committee considered the mitigating factors presented before them. Dr. Kirkpatrick has had a long service career of being a good doctor with no past history of complaints with the College. The Committee further considered Patient X's previous history of benign back pain as a factor in Dr. Kirkpatrick's decision on treatment and follow-up.

The Committee also considered the findings of the assessor. The audit report indicated Dr. Kirkpatrick had exemplary clinical care in the management of acute and chronic back pain in general practice. The assessor further noted excellent medical record keeping and appropriate examinations and follow-up of patients.

The assessor concluded Dr. Kirkpatrick is likely an excellent family doctor.

Although the audit report was favourable, the Committee had to consider the rarity of Cauda Equina Syndrome and the fact the assessor would likely not have reviewed a similar chart during the audit.

The Committee had to further consider the fact Patient X was seen twice in February 2016 and how Patient X was not examined on February 24th despite his complaints of severe back pain and numbness in the leg and genital area. The Committee remains concerned Dr. Kirkpatrick did not recognize these symptoms as potentially being Cauda Equina Syndrome and chose not to investigate further during that appointment.

The Committee acknowledges Dr. Kirkpatrick indicated, in hindsight, he wishes he had asked Patient X to return to his office and attempted to perform a rectal examination. Dr. Kirkpatrick also wished in hindsight he had attempted to reach a neurosurgeon for immediate referral.

After long consideration and discussion, Investigation Committee C was not able to reconcile this complaint without disciplinary sanctions. There were not enough mitigating factors to allow the Committee to offer less than a Reprimand.

DECISION

In accordance with section 99(5)(f)(i)(A) of the *Medical Practitioners Regulations*, the Committee has determined there is sufficient evidence that, if proven, would constitute a finding of incompetence and warrants a licensing sanction.

Rather than refer the matter to a hearing, the Committee has determined that the matter can be resolved with the consent of Dr. Kirkpatrick to the following, pursuant to section 99(7)(a)(i) and (ii):

> Dr. Kirkpatrick is ***Reprimanded*** for failing to recognize a rare but serious condition (Cauda Equina Syndrome) and arrange emergency care as required.

The Committee believes that the disposition outlined above reflects its concerns with respect to Dr. Kirkpatrick's failure to diagnose Cauda Equina Syndrome.

Dr. Kirkpatrick has agreed to accept this disposition and to contribute to the College's costs of investigation.