SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "A"

RE: Dr. JAMES ALEXANDER COLLINS

Investigation Committee "A" concluded its investigation into matters arising from a complaint concerning care provided to a patient in 2014. The following is a summary of the Committee's decision issued on May 15, 2016.

SUMMARY OF COMPLAINT AND RESPONSE:

Dr. James Alexander Collins is a physician licensed to practice medicine in Nova Scotia since 1976. Dr. Collins is a general practitioner who works part time in a rural ER department.

Patient X is a man in his mid-fifties, who attended at the ER department of a hospital in January, 2014. He had presented to the department earlier in the day because of increasing pain in his right shoulder, neck and back, together with difficulty walking.

At the first visit, another physician assessed Patient X (the "first physician"). The first physician arranged an appointment for Patient X to be seen by his family physician later that day. Patient X left the ER department to have a meal prior to his evening appointment. On his way into the restaurant, his legs gave out and he fell backwards, hitting his head. When he regained consciousness, he was in an ambulance heading back to the hospital.
Patient X was assessed again by the first physician, and was then transferred to Dr. Collins when he started his shift in the evening.

Dr. Collins states he saw Patient X at approximately 8:30 pm. At that time, he did a limited neurological examination. Patient X was able to lift his arms and legs and walk, although he said it caused him pain. He complained of pain in the back of his head where it had been struck during the fall, but did not mention neck pain. Dr. Collins determined Patient X was safe to go home and discharged him that night.

Patient X advised the College he did not believe he was safe to go home at that time. He states he was unable to dress himself and could barely ambulate. Further, he states the nurse who helped him dress and get to his truck agreed he should not be leaving the hospital.

Two days later, Patient X fell while at home, striking his head, and was taken to hospital by ambulance.

Patient X was subsequently diagnosed with incomplete quadriplegia.

PROCESS OF INVESTIGATION COMMITTEE

The Investigation Committee reviewed the complaint of Patient X, the response of Dr. Collins and other material gathered in the course of the investigation, including interviews.

Patient X also filed a complaint respecting the care provided by the first physician. That matter remains under investigation by the College.

In the course of its investigation the Committee requested an expert report respecting the care provided by Dr. Collins. In addition, the Committee requested an audit of Dr. Collins' practice to determine if this was an isolated case, or part of a pattern.

DISCUSSION:

The documentation shows Dr. Collins saw Patient X at 20:45. He was discharged at 21:00. Dr. Collins did not adequately document his assessment or examination prior to discharge. Patient X was not provided with a follow-up plan.

The Committee found the examination, as described by Dr. Collins in his response and during his interview with the Committee, to be inadequate. Dr. Collins described conducting a brief neurological examination on Patient X, whereby he got him to lift his arms and walk. He stated patient X was able to do these things, although it caused him pain. Nursing notes indicate Patient X left the department in a wheelchair.

The expert opinion report concluded that in this case, Dr. Collin's care fell below the standard expected of a physician working in an ER department. Specifically, the expert noted the following issues:

- Dr. Collins did not review Patient X' history or do a proper physical examination, and therefore did not appreciate an evolving neurological condition; and
- Patient X was discharged without a clear follow-up plan.

The specific concerns related to the care provided to Patient X raised the question of whether Dr. Collins' overall practice was appropriate. The audit of Dr. Collins ER practice comforted the Committee and was generally positive. The auditor stated:

"There was a general appropriate care provided to all patients. I have no concerns about the clinical care Dr. Collins provides and even in the 2 charts that were outliers in terms of charting, once I was able to include these in the chart stimulated recall interview, I was satisfied that these patients had received adequate care."

DECISION:

With the consent of Dr. Collins, in accordance with sub-clauses 99(7)(a)(i) and (ii) of the regulations:

1. Dr. Collins is reprimanded for failing to meet the standard of care expected of him in caring for Patient X, specifically by:

a. Failing to take an adequate history.
b. Failing to conduct an adequate physical examination or investigations of a patient with significant neurological complaints.
c. Failing to adequately document his encounter with the patient.

2. Dr. Collins is required to complete a record keeping course, approved by the College. The cost of the course will be borne by Dr. Collins.

3. Dr. Collins is subject to a re-audit of his ER practice six months after completion of the record keeping course in accordance with direction from the Physician Performance Department of the College. The cost of the re-audit will be borne by Dr. Collins.

4. Dr. Collins shall pay a contribution toward the College's costs in this matter, to reimburse the College for the cost of the audit and expert review, and a contribution toward the remaining costs of the investigation.

The Committee has determined that this disposition reflects the Committee's serious concerns with respect to Dr. Collins' documentation and patient care in this case, while recognizing that the audit of his practice reflected care which otherwise meets the expected standard.