COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "A"
RE: DR. ERIN MACLEAN-FRASER

Overview

The College received a complaint alleging substandard care of three patients by Dr. MacLean-Fraser, and administrative and charting deficiencies. Dr. MacLean-Fraser is an obstetrician/gynaecologist practicing it at St. Martha's Regional Hospital in Antigonish. She has been practicing in the field of obstetrics/gynaecology for approximately 10 years.

In response to the complaint, Dr. MacLean-Fraser provided explanations for her care of the three patients and acknowledged some administrative and charting deficiencies.

Steps taken by Investigation Committee

The Investigation Committee ordered an audit of Dr. MacLean-Fraser's practice, and upon receipt of the audit ordered an interim suspension of Dr. MacLean Fraser's license to practice medicine on September 30, 2014. The Committee later met with a colleague of Dr. MacLean-Fraser and conducted a further interview with her, following which the suspension was lifted and replaced with a restriction, limiting her practice to OR-assists with a designated physician approved by the College.

Conclusions of Investigation Committee

With respect to the complaint involving the first patient, the complainant raised concerns about a delay in scheduling surgery for a patient and a missed diagnosis. Dr. MacLean-Fraser explained that she relied on the history provided by the patient without verifying this information, and she also placed too much reliance on a referral from a familiar and reliable referral source. She acknowledged that her failures in this case led to a delay in the patient's proper diagnosis and treatment and acknowledged that this case will change the way she practices with respect to placing trust in histories and test results. She acknowledged that she had failed to examine the patient during two office visits, where during the first visit the patient had requested no exam. She advised that she will become more insistent on examining patients in the future. Dr. MacLean-Fraser also acknowledged that she could have expedited this patient's visit to the OR. Finally, she acknowledged that she made a late entry on this patient's chart without properly documenting that it was a late entry.

With respect to the complaint involving the second patient, the Committee was concerned there was no consult letter from Dr. MacLean-Fraser to the family doctor. While Dr. MacLean-Fraser had indicated to the patient that a procedure would be required, she did not complete the appropriate booking form to make the arrangements for the procedure. Following a second visit from the patient Dr. MacLean-Fraser again failed to communicate with the family doctor, following which the family doctor sent the patient for consultation with a different physician.

With respect to this patient, the Committee found there was inadequate communication from Dr. MacLean Fraser to the family doctor, and a delay in completing the OR booking forms.

With respect to the complaint concerning a third patient, this complaint arose when another physician was seeing this patient for counselling regarding future pregnancy risk. The patient had previously been under the care of Dr. MacLean-Fraser, but there was no operative or discharge summary found on the chart. The health records in the hospital were reviewed and there were no outstanding dictations respecting Dr. MacLean-Fraser's earlier care of this patient.

Dr. MacLean-Fraser acknowledged that she failed to dictate the operative and discharge summaries on this chart in a timely way. The Committee noted that the accuracy of documents depends to a degree on the timeliness of their dictation. In the type of circumstance involved with this patient, the prior history was relevant to the ongoing care of the patient. The Committee was concerned with the lack of documentation and the failure to complete the appropriate summaries in a timely way.

In addition to its review of the complaint involving these three patients, the Investigation Committee reviewed the findings of the practice auditor. The Committee had concerns with respect to the number of times patients had not been examined, but were nonetheless booked for surgery. The audit also identified numerous examples of failure to follow-up with booking OR dates after indicating to the patients that the bookings were in progress. The Committee also noted the audit identified Dr. MacLean-Fraser's use of some non-standard treatment modalities, without documenting a reason for such use. Dr. MacLean- Fraser also failed to provide appropriate monitoring while using these non-standard treatment modalities. The Committee noted that in the absence of thorough or adequate documentation, the Committee is unable to determine whether the non-standard modality was appropriately initiated.

Finally, in reviewing the audit the Committee noted a pattern of deficiencies arising from failures to complete the necessary paperwork including consultation reports, discharge summaries, operative bookings and reports. It was the conclusion of the Committee that Dr. MacLean-Fraser’s charting failed to adhere to the College's Policy on the Content and Maintenance of Medical Records or the Guidelines for Physicians Regarding Referrals and Consultations.

The Committee met with Dr. MacLean-Fraser to review the reasons for some of the identified deficiencies. After receipt of additional information, the Committee concluded there were a number of personal factors influencing Dr. MacLean-Fraser that contributed to some of the difficulties she had encountered. Some of these personal difficulties caused Dr. MacLean-Fraser to have poor, undisciplined professional habits whereby she documented poorly, fell behind in her paperwork and experienced challenges with time management.

The Committee concluded that the overriding concerns identified from the complaint and practice audit relate primarily to performance (the actual delivery of care) as opposed to competence (the ability to deliver appropriate care). The personal factors influencing Dr. MacLean-Fraser to have poor organizational and time management skills played an important role in her performance. Supervision of the management and administration of her practice will be required to ensure improvement upon return to practice.

Disposition

The Committee directed the following:

1. Dr. MacLean-Fraser is reprimanded for a variety of practice issues including failing to examine patients or documenting that the patient’s declined examinations; failing to book

OR dates after telling patients she had done so; failing to complete appropriate paperwork, including consultation reports, discharge summaries and operative reports, failing to review past medical information on patients prior to reaching a diagnosis, and using non-standard treatment modalities without documenting a reason for them. In addition, she was reprimanded for inappropriately altering a medical record without a late entry and for failing to adhere to the College's Policy on the Content and Maintenance of Medical Records and the Guidelines for Physicians Regarding Referrals and Consultations.

2. In addition to the reprimand, Dr. MacLean-Fraser's license is subject to a number of conditions including a requirement to participate in a follow-up audit at her expense six months after returning to practice. She must also complete at her expense the record-keeping course offered at Western University, within three months of returning to practice. Finally, she is subject to a program of supervision to be overseen by the College's Physician Performance Department pending her follow-up audit. The primary purpose of the supervision will be to ensure that Dr. MacLean Fraser is meeting her professional responsibilities with respect to charting, documentation and dictations.

It was the view of the Committee that this disposition reflects an appropriate balancing of the aggravating and mitigating factors in this case. The Committee was satisfied that Dr. MacLean-Fraser has learned from the complaint and now accepts and recognizes she must improve her areas of deficiency. The interim restriction requiring her to practice only in OR assists is removed. The follow-up audit in six months will test to see whether the appropriate and necessary changes have been made.

In addition, Dr. MacLean-Fraser is required to pay a contribution toward the College’s costs of the investigation and conclusion of this matter.