COMPETENCY HEARING COMMITTEE REPORT FOR DR. J. STEYN

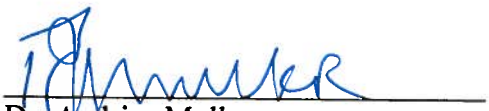
The competency hearing committee met on January 7, 2013 in the presence of Bryan Salte, counsel for the Registrar's office, and Dean Stanley, counsel for Dr. Steyn.

The only information provided to the hearing was the competency committee report in which the committee concluded that "In the unanimous opinion of this Competency Committee, Dr. Steyn does not currently possess adequate skills and knowledge to safely practice medicine as a family physician or general practitioner."

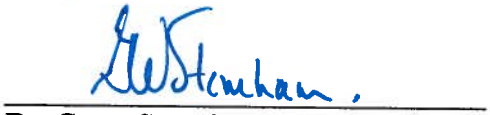
The Committee accepts the report of the committee and concludes, as required by section 45(8) of **The Medical Profession Act, 1981**, that Dr. Steyn does not have adequate skill and knowledge in the practice of medicine.

Signed this 7th day of January, 2013 in the city of Saskatoon, SK.

Marcel de la Gorgendiere



Dr. Andries Muller



Dr. Grant Stoneham

Competency Committee Report
to the College of Physicians and Surgeons of Saskatchewan

RE: Dr. Johan Wilhelm Steyn

November 17, 2012

Competency Committee Members:

Dr. K. Ogle (chair)
Dr. R. Kamrul

Methodology:

Our assessment consisted of five major components, as described below. These components are similar to some of those used to assess the skills and knowledge of Family Medicine residents in the Academic training program. They are used in training programs throughout the country and are accepted and reliable evaluation tools.

The assessment included the use of SOOs (Simulated Office Orals) and SAMPs (Short Answer Management Problems). SOOs are intended to duplicate, insofar as possible, the actual setting in which the family physician conducts a medical practice. There is an expectation that physicians will employ a patient-centered approach, as this clinical method has been shown to best meet patients' needs. SAMPs are intended to test a physician's recall of factual knowledge and problem solving abilities in the areas of defining health problems and managing health problems. Successful completion of the SAMPs component requires an understanding of and employment of current management guidelines and best evidence.

It might be argued that the two assessment components described in the paragraph above are meant to be used in the assessment of resident physicians and those undertaking certification in Family Medicine, and not for the assessment of experienced physicians. Our response would include the following: 1) Many experienced family physicians do undertake the certification process and many are successful. 2) Certification by the College of Family Physicians of Canada is increasingly recognized as the minimal standard for practice in this country. 3) An experienced family physician should be more comfortable than novices with patient interactions, whether simulated or real. 4) Up-to-date factual knowledge is a reasonable expectation with respect to maintenance of system safety standards as well as optimal patient care.

Component 1

The first component of our assessment consisted of a chart review undertaken in Dr. Steyn's office November 1, 2012. Paper charts were reviewed by both committee members for approximately 8.5 hours.

Dr. Steyn and his office receptionist, whom he introduced as his daughter, were fully cooperative. A work space was provided for our chart review and Dr. Steyn did not book clinic patients that day, although phone calls were answered by his receptionist throughout the day.

Clinic charts were observed to be filed in paper envelopes and organized alphabetically. A selection of charts was pulled in a random fashion by committee members, with no attention to chart identifiers. Following initial review of each chart, our only rejection criterion was evidence of little or no office contact with Dr. Steyn in the preceding two years. For rejected charts, including those containing evidence of minimal contact, general observations were nonetheless occasionally recorded, even if a formal chart audit tool was not employed. Observations from both audited and non-audited charts will be summarized later in this report.

Attention was paid to chart organization and legibility. Efforts were made to determine whether appropriate tests had been ordered and results observed, followed and signed off. We assessed the adequacy of Dr. Steyn's medical management and the accuracy and comprehensiveness of his patient records. A chart audit template was used and a sample has been attached for your records. In all, thirty-six templates were completed in a detailed manner.

Component 2

The second component of our assessment consisted of a chart review undertaken at the Kipling Memorial Health Centre, which until recently has housed an after-hours outpatient (urgent care) service along with an inpatient ward. This evaluation took place on November 2, 2012. With the very recent departure of one of the town's two remaining doctors, it was our understanding that the Centre no longer admits patients to hospital nor operates an urgent care outpatient service. It is still operational with respect to certain other health care services and laboratory functions.

It was our assumption that patients seen after-hours and patients admitted to hospital were experiencing more serious and urgent medical problems. Therefore, definitive diagnostic and management strategies were evaluated with added attention to safety, expediency, and usual standards of hospital care.

Health Centre staff were fully cooperative with our investigation. A private room was provided for our chart review. We directed Centre staff to randomly pull patient charts from the hospital records; the only criterion was that the chart must contain records of medical management provided by Dr. Steyn during the past two years. The charts were evaluated using the same chart audit tool as that used for clinic charts. In all, twenty-nine templates were completed in a detailed manner.

Component 3

The third component consisted of direct observation of Dr. Steyn's interaction with standardized patients in the Family Medicine Unit, Regina. This evaluation took place during the morning of November 3, 2012. A total of four SOOs were used, two of them conducted with the assistance of standardized patients having previous experience in this setting. Committee members alternated as the standardized patient for the remaining two SOOs. Dr. Steyn was informed that each patient interaction would be observed by one or both of the committee members in real-time and also recorded for our records.

Before beginning this component of the assessment, Dr. Steyn was provided with a general information sheet regarding the conduct of SOOs. He had also been provided with the opportunity to view background information regarding SOOs and SAMPs, including practice examples of each, as illustrated on the College of Family Physicians of Canada website. The link to that website was contained in a letter from the CPSS dated October 16, 2012. Dr. Steyn was

reminded of this link and advised to visit the website during the course of our clinic chart review on November 1, 2012.

The committee used a standardized grading tool for evaluation of each simulated patient interaction. A pass/fail score was assigned by each committee member to Dr. Steyn's performance on each of three components for each SOO. These components are as follows: 1) problem identification 2) problem management 3) interview organization and process. An overall pass/fail score was assigned for each SOO and the majority committee opinion recorded. Full agreement between committee members regarding scores was achieved.

Component 4

The fourth component of our evaluation consisted of a written examination. Some questions were drawn from practice booklets developed by the College of Family Physicians of Canada to aid Family Medicine Residents as they prepare to write their qualifying exams. The questions were structured as either True/False or best possible choice. Many of these had been used previously in competency assessments undertaken by the chair of this committee.

Others were created *de novo* by the assessment committee. All of the questions were reviewed by a third family physician prior to use. Correct answers were verified in the relevant medical literature. Although some of the questions addressed medical issues discussed only recently in the literature and in practice guidelines, committee members believe that they covered a body of knowledge any up-to-date family physician might reasonably be expected to possess in its majority if not its entirety.

In all, forty-eight questions were selected. Each question was judged to be relevant to the sorts of medical concerns that might commonly arise in any modern family medicine practice. The exam was completed by Dr. Steyn on November 3rd, 2012, in less than one and one-half hours. It was marked by one committee member using an answer sheet reviewed and verified by both committee members.

Component 5

The fifth component of our evaluation consisted of six SAMPs. The SAMPs were either created *de novo* by the committee or adapted from SAMPs previously used in the Department of Family Medicine, U of S, as practice tools. Each of the SAMPs was reviewed by a third family physician and correct answers were verified in the medical literature.

As the name implies, SAMPs require the examinee to provide short written answers to common medical management problems. In some cases, there is only one correct answer to the question posed, while in others, the answers provided are marked correct according to their presence in a limited list of acceptable answers to the corresponding problem.

Dr Steyn was provided with verbal and written instructions on how to complete the SAMPs and was able to do so in approximately one and one-half hours on November 3rd, 2012.

RESULTS:

1: Clinic Chart Audit

The process of chart review has been described earlier. The following comments are presented in summary form and have been discussed and agreed upon by both committee members.

Of the thirty-six charts reviewed in detail, one (2.8%) was judged "Adequate", seventeen (47.2%) were judged "Marginal" and 18 (50%) were judged "Unsatisfactory." No charts were judged "Good."

Dr. Steyn's chart organization was simple, but not user-friendly. For the most part, all pages, whether clinic notes, consultation requests, lab results, or referral notes, were inserted chronologically, most recent on top. On occasion, the chronology was reversed, but only for a portion of the chart's record. Some of the most recent results were placed near the back of the package while other recent results were placed near the front. In many charts, we noticed duplicate records, particularly for lab test results.

There were no chart binders or folders, apart from the paper envelope into which all patient records were inserted. We took care to replace these records in their envelopes in the order we found them, but recognized the significant likelihood of pages becoming disarranged with regular use.

None of the charts we reviewed contained medical profiles, problem summaries, or amalgamated past histories. We did not come across any records detailing periodic health exams (formerly known as "completes").

None of the charts contained a summary sheet outlining current medications or allergies. Details regarding medications and in some cases, allergies, could occasionally be gleaned from consultant reports but were not recorded in any recognizable summary fashion. There was no ongoing summary sheet for INR's and dosages for those patients taking warfarin.

We could not make out any consistent charting format such as the popular "SOAP" note format. The presenting complaint was often listed first, although very briefly. Recent past histories were largely absent, as were recordings of objective clinical findings. Prescribed investigations and treatments were often recorded, but there was little or no detail provided as a rationale for these choices. Even the most basic of further follow-up plans were generally absent. No preventative health advice was recorded in the charts we reviewed.

The committee consistently observed that chart notes were extremely brief and unhelpful. If a diagnosis was recorded, it was rarely obvious to us why that choice had been made. Apart from referral letters and specialist consult letters contained in some of the charts, we did not think the patient records would be useful to another physician taking over ongoing care of the patient.

Prescribed medications, including dose and frequency (and less often, duration) were usually recorded, but it was sometimes difficult to judge the appropriateness of these management choices due to lack of substantiating data. Occasionally, the reason for the management choice could be inferred from the recorded presenting complaint.

Charts contained a relative abundance of lab test results. For the most part, these were not clearly linked to any particular visit and we struggled to find explanations for why they had been

obtained. Similarly, we rarely found any subsequent reference to these test results, whether normal or abnormal, however we were occasionally able to infer a rationale for subsequent medication changes.

We were able to read Dr. Steyn's handwritten notes almost in their entirety. We struggled with brief portions. We noted that some of the charts contained somewhat lengthier notes, but only for clinic visits occurring during the last two to three months. Some chart notes were not dated.

We had numerous concerns regarding the appropriateness of Dr. Steyn's medical management. The following examples, drawn from the chart audit summaries, are offered as illustrations:

- A patient with a lesion on the nose was prescribed ciprofloxacin, hydrocortisone and Fucidin.
- Rheumatoid factor levels were apparently used as a measure of methotrexate treatment efficacy.
- A diagnosis of rheumatoid arthritis was recorded but treatment for "skin lesions" was provided, including Fucidin and Nerisone.
- A visit note recorded only "possible rash on hand (lesion for 4 months) → bx in morning" with no record of history, physical exam or differential diagnosis.
- A specialist recommendation for 6-month follow-up CT of the chest could not be verified as having occurred.
- An abdominal Xray was requested for a known cancer patient with a history of weight loss; other workup was not apparent.
- PTH levels, ANA, RF, CRP and CEA tests, as well as complete iron studies were frequently ordered for no apparent reason.
- Serum iron levels were inappropriately used as markers of iron deficiency, even in some cases where hemoglobin levels were normal. If serum iron was below the lab's "normal range" patients were often prescribed iron supplementation.
- A patient was diagnosed with "UTI ?" while no physical exam was reported. Numerous lab tests were ordered, including PTH, B12, and iron, none with adequate explanation.
- A consultation was requested for a patient who was described as having "some lung problem" but no recent or past history was provided in the referral letter.
- A patient on warfarin had an INR described as "therapeutic" but there was no record of dosing or subsequent follow-up testing.
- A follow-up chest Xray was ordered for a patient whose previous Xray showed chronic osteoporotic fractures, but no clear reason was provided for the test and no clear follow-up was documented. Numerous blood tests were ordered without explanation.
- An increased dose of thyroid replacement was prescribed for a 74 year old female with a near-normal TSH and a normal T4. Thyroid antibody testing and iron studies were requested, along with CEA, ANA, Antistreptolysin O and RF.
- A patient with "overactive bladder" was referred to a specialist but also had blood drawn for iron studies, albumin, PTH, CA-125, CEA, ASO titre, RF, B12.
- HgA1C was ordered in several non-diabetic patients (we recognize that 2013 CDA recommendations will likely include the use of HgA1C as a diagnostic tool for DM but its use for diagnostic purposes was not common practice at the time of testing).
- A 47 year old male presenting with "headache" had no record of pertinent positive or negative symptoms, no neurological exam, no fundoscopy, and no mention of neck rigidity or its absence, but was transferred to Regina where probable bacterial or fungal meningitis was diagnosed. The diagnosis in Kipling was "heat exposure" and Toradol, Arthrotec, and Morphine were prescribed.

- A patient was described in a chart note as being allergic to Benedryl, with no further explanation provided.
- An elderly patient was prescribed the maximum daily dose of Celebrex (800 mg) for six months with no renal monitoring recommended.
- A patient with Type 2 diabetes had only one HgA1C ordered in the last 16 months.
- A digoxin level of 0.4 was apparently not followed and there was no subsequent evidence of dose adjustment.
- A patient with myasthenia gravis was taking daily prednisone for an unspecified period and at an unspecified dose, while no mention of concurrent acetylcholinesterase inhibitor use was readily apparent.
- An ECG showing atrial fibrillation did not appear to have been followed up and there was no record of any discussion about anticoagulation.
- A patient with Type 2 diabetes was frequently prescribed medications and had numerous blood tests but had no regular HgA1C tests or proteinuria monitoring.
- An 8 year old female was referred to a pediatrician for a rash on her arm described only as "infected eczema."
- A patient with chest pain and an ECG showing "ventricular bigeminy" was started on Ampicillin for no obvious reason.
- Despite previous normal iron studies, further iron studies were ordered for a patient with hemachromoatosis.
- A chest Xray and sinus Xrays were ordered for a 79 year old female presenting with "cold symptoms, cough and sputum." The Xray showed minor patchy RML infiltrates and the sinuses were clear. There was no recorded follow-up in the chart.
- A 29 year old male was prescribed metronidazole for sinusitis. He was already on Lipitor 40 mg daily and gabapentin, for unrecorded reasons.
- A patient presented with "chest pain/insect bite" and had numerous labs ordered, including stool for occult blood, abdominal Xray and chest Xray. The rationale for these tests was not described.
- A PSA was ordered for an 88 year old male with no apparent history of prostate cancer.
- An SGI form mentions "diabetic – on tablets" but the chart contains no record of diabetic testing or medications.
- A patient had a normal FAQ six months after having a MMSE score of 18.
- A patient with "back pain" was investigated using numerous blood tests and an abdominal Xray.
- A patient with test results showing Hep A/B non-immune and Hep C negative had a hand-written note on the lab saying "recall – what to do?" The same patient was seen later but there was no mention made of these results. He was also treated with Eltroxin while having a TSH of 4.74.
- A 23 year old patient with low-normal LDL and normal TC/HDL was prescribed atorvastatin 20 mg. The same patient had a normal Hg but underwent iron studies.
- 3 ECG's were performed over the course of 2 months on a 96 year old male with a pacemaker.
- The same patient had azithromycin prescribed for "cold symptoms and sore throat."
- A 20 year old with acute back pain had Xrays of the lumbar spine and SI joints performed in the absence of any history of trauma or record of neurological findings.
- A specialist's recommendation from August 30, 2011 to check a patient's TSH in 6 weeks did not appear to be followed.

- A 26 year old with a diagnosis of "pharyngitis" was referred for admission to the local hospital for IV fluids and antibiotics. The patient was also treated with Tylenol #3 and Advil. There was no record of fever and no temperature was recorded.
- A patient with a normal Hg of 130 was diagnosed with "microcytic anemia." Subsequent iron studies were normal. Numerous anemia workups were performed later when the patient truly was anemic, although the cause, a liver bleed following a MVA, seemed obvious.
- A patient was noted to "still have angina pains" but no further description, plan, medications, or new advice was recorded, apart from "waiting for Dr. W."

In our view, each of the preceding is an example of substandard diagnosis, medical management, or follow-up. In more general terms, we observed evidence of specialists' advice not being followed. We observed a pattern of over-investigation, particularly with respect to blood tests and Xrays. We observed a pattern of non-medical language being used for diagnoses (e.g. "sore throat"). We observed drugs being frequently prescribed with little or no explanation and no duration of therapy recorded. We observed that physical examination results were often absent. In many instances, we were unable to determine whether test results had been followed up. At no time could we locate an INR tracking system for patients on Warfarin. We observed that chronic illnesses such as diabetes and hypertension were not followed in the manner recommended in current guidelines and that no CDM flowsheets were used.

The Competency Committee has determined that a review of Dr. Steyn's clinic charts would support a judgment that he lacks adequate skill and knowledge to practice in a community-based family medicine or general practice.

2. Hospital Chart Audit

The process of chart review has been described earlier. The following comments are presented in summary form and have been discussed and agreed upon by both committee members.

Of the twenty-nine hospital charts reviewed in detail, ten (34.5%) were judged "Marginal" and nineteen (65.5%) were judged "Unsatisfactory." No charts were judged "Good" or "Adequate."

The charts we reviewed were well organized neatly arranged in typical folders with the usual patient identifiers on the covers. System safeguards were evident, such as medication reconciliation pages and standardized locations for allergies notations. Hospital charts also contained lab test and medical imaging results for outpatients from the local outpatient clinics. Hospital admissions could easily be distinguished from ambulatory/urgent care visits. We evaluated both records for urgent care episodes, where the patient was not admitted to hospital, and visits resulting in hospital admission, a few of which were direct admissions following clinic assessments.

Our inclusion criteria for evaluation included: 1) the urgent care visit or hospital admission must have occurred during the past two years, and 2) the MRP was solely or primarily Dr. Steyn.

A standardized admission history and physical record sheet was present for most records of hospital admissions. This was typically filled out very briefly. We noted many instances of missing diagnoses or differentials. We rarely saw an initial investigation and management plan recorded and apart from the occasional physical examination recorded briefly on the registration sheet, adequate observations of physical findings were notably absent.

Of particular note was the general absence of adequate progress notes. In many cases, there were no progress notes at all. In other cases, very brief progress notes were placed alongside Dr. Steyn's orders on the physician's orders sheets. Occasionally, a note describing the patient's current condition was embedded within the order itself, making it difficult to discern which part of the record was the order and which part was simply an observation.

For the most part, if Dr. Steyn's inpatients were to have received shared care with another physician, or were to be handed over to another physician's ongoing care, it would be difficult if not impossible to develop an accurate picture of what had occurred to date. This would undoubtedly have a negative impact on continuity of care and would very likely present a significant safety risk for the patient involved.

We had numerous concerns regarding the appropriateness and safety of Dr. Steyn's medical management provided to urgent care and hospitalized patients. The following examples, drawn from the chart audit summaries, are offered as illustrations:

- A 95 year old female patient admitted with a diagnosis of "CCF, infected toe" had no cardiovascular exam recorded, no ECG done until the second day after admission, no chest Xray done until day seven of admission, and was not diuresed. The recorded observation for the "infected toe" diagnosis was "sore on toe." The toe was treated with Clavulin, although there was no mention of the patient being diabetic.
- An 89 year old female admitted from a nursing home with "confusion, swollen left knee" was treated with ciprofloxacin 500 mg BID for six days, while having no urinalysis performed. There was no mention of genitourinary signs or symptoms on the admission history and physical sheet, and it was unclear what happened with regard to the sore knee and the confusion.
- An 85 year old female was seen as an urgent care outpatient and described as having "severe spasms in her back and some nose bleeds" but the only recorded physical examination was "tender over SI joints." She was prescribed 5 mg Oxy IR, 375 mg Tramacet one tablet BID (no duration stated) and also injected with 80 mg Depomedrol IM (location of injection not stated), none of which are appropriate therapies for back pain, particularly in the absence of a diagnosis.
- An urgent care patient's presenting complaint was recorded as "lesion L upper lower arm, ? neoplasia → biopsy" but she was diagnosed with "UTI" and "skin lesion." She was treated with 3 doses of Gentamycin 80 mg IM and had no urine culture and sensitivity performed. The urinalysis showed positive nitrates and leukocytes but no blood and there was no record of urinary tract symptoms or signs. The skin biopsy result showed "spongiotic dermatitis."
- A patient with known CAD was admitted for "chest pain" but there was no cardiovascular exam recorded in the chart. There was no stat dose of ASA ordered, but thankfully, a subsequent troponin level was normal. The patient's hemoglobin was normal on admission but iron supplementation was ordered nonetheless.
- A 69 year old male diabetic patient was seen as an outpatient with an "infected L foot/toe ulcer" and treated with Amoxil after the wound was cleansed with "antiseptic" and Flamazine. No follow-up plans were recorded.
- An 81 year old male patient presented with "lung infection, abscess mid R foot" but the admission history and physical sheet records "LRTI and URTI" as the differential diagnosis. The order sheet admitting diagnosis was "lung infx", even though the patient WBC was not elevated, CXR was unchanged from previously and showed no acute problems, and his oxygen saturation was 95% on room air. He was treated as an inpatient

with oral Azithromycin and Diflucan, with no rationale recorded for use of the antifungal. An autoimmune workup was performed. Management of the foot infection was not described.

- An 81 year old male patient was admitted for treatment of "severe sacroiliac joint pain – for pain control" described only as "severe R sided SI joint pain" in the admission history and physical. Duration, presence or absence of radiation, and presence or absence of neurological symptoms was not documented. The patient was given Toradol and Depomedrol 80 mg IM injection. The injection site was not recorded. The discharge diagnosis was recorded as "severe SI jt pain" but no SI joint Xrays were performed, even though C-spine, left and right shoulders, and left and right hips *were* Xrayed, for reasons unstated.
- The same patient was noted to have had tympanic membrane surgery 25 years earlier but still having blood in his left ear and deafness on that side, yet he was treated with Gentamycin otic drops and no physical examination of the ear was recorded.
- An 80 year old female patient was admitted to hospital after a fall and laceration to her left forearm. The laceration was repaired in outpatients but she was then admitted and started on IV Ceftin. There is no record of the rationale for this management and no description of the wound or the cause for her fall.
- A patient was admitted for treatment of postpartum depression and treated with Largactil. There was no mention of psychotic features and several other important elements of the history were missing. The same patient was also apparently treated for URTI with IV Ancef, Zantec and Maxeran.
- A 25 year old female was admitted for treatment of "acute back syndrome." Demerol 100 mg q6h was used for pain control. Xrays of the lumbosacral spine, hips, and SI joints were performed. No neurological signs or symptoms were described to justify these tests.
- A patient who was diagnosed with "gastroenteritis and dehydration" was admitted for rehydration and had stool cultures performed after a one-day history of nausea, vomiting and diarrhea. Although a C dif stool culture was negative, the patient was sent home on a course of oral Flagyl.
- An 86 year old female patient was seen in outpatients for cauterization of a "lesion on nose" but there are no notes describing the appearance of the lesion, its history, or a diagnosis. There is no record of medications or allergies.
- A patient was admitted for "program of reduction of addictive medicine" but there was no evidence in the chart of a standardized tapering protocol for the benzodiazepines and narcotics recorded and the patient eventually was discharged home on the same medications. Nursing notes indicate that the patient believed she had been admitted for treatment of her "low iron."
- A patient was contacted by telephone and asked to return from British Columbia so that he could be admitted for treatment of "INR >8." While the chart did contain a brief history and physical, there was no mention of active bleeding, and the patient was not prescribed vitamin K. He was, however, started on Celexa because of "wife concerns", although no other records are available to rationalize this decision.
- A patient was admitted for what we presume was an acute exacerbation of asthma, described as "tight chest", but was treated with Keflex, then switched to Rocephin 1 gm BID for 3 days, then switched again to Ceftin. Digoxin was added to his regimen although there was no mention of heart failure or heart rate problems. He was also given Depomedrol 80 mg IM with no rationale provided. The discharge summary was 3 lines long.

The committee can provide numerous other examples of substandard and inappropriate medical management, both acute care and inpatient. Documentation was grossly inadequate, rationale for pharmacotherapeutic choices was rarely provided, and discharge summaries were disorganized, generally brief, and uniformly unhelpful.

We were relieved to learn that acute care outpatient services and hospital inpatient services are no longer being provided in Kipling. Should these services be reintroduced at the Kipling Memorial Health Centre, it is our strong recommendation that Dr. Steyn not be permitted to provide such services.

The Competency Committee has determined that a review of Dr. Steyn's hospital charts would support a judgment that he lacks adequate skill and knowledge to practice as MRP in an urgent care/acute care/hospital setting.

3. Simulated Office Orals

As described earlier, Dr. Steyn underwent 4 direct-observed and digitally recorded simulated office orals. Two of these made use of experienced standardized patients and the other two were performed alternately by members of the competency committee.

The committee privately interviewed the standardized patients following completion of the examination. They both stated that they felt comfortable during the interaction and that Dr. Steyn had treated them professionally and with respect. The committee did not note any significant concerns regarding doctor-patient interactions portrayed during the course of all four SOOs. In each of these, we observed that Dr. Steyn appeared friendly, relaxed, and ready to help.

Simulated office orals generally consist of two distinct medical and/or social and/or psychological problems. Hence, two management plans are expected to evolve throughout the course of the interview. The examinee is expected to adopt a patient-centered approach that recognizes the patients' feelings and ideas about their illnesses, as well as their expectations for the visit. Part of the interview is directed towards achieving an adequate understanding of the patient's social and developmental context, along with the effects of the illness on current function. Finally, the overall interview process and organization is assessed.

Dr. Steyn was allowed fifteen minutes to complete each interview. By the end of each interview, he was expected to have accurately identified and discussed both problems, and suggested management plans for both. He was specifically instructed not to examine the patient, but was advised to make explicit any plans he had for tests, investigations, or therapies. The simulated patient was provided with a list of "cues" to be employed at various points during the interview in the event certain topics had not yet been discussed.

Dr. Steyn's performance on the SOOs was rated as follows:

SOO 1: rheumatoid arthritis flare-up and hypertension

- one of the two problems well identified
- one of the two problem adequately managed
- common ground not achieved on management of either problem
- social and developmental context marginally addressed
- overall interview process and organization adequate
- Score: **19/36** (marginal pass)

SOO 2: polycystic ovarian syndrome and acute recurrent sinusitis

- neither problem accurately and adequately identified
- neither problem adequately managed
- common ground not achieved on management of either problem
- social and developmental context largely absent
- overall interview process and organization inadequate
- Score: **14/36** (fail)

SOO 3: hypertension and plantar fasciitis

- one of the two problems adequately identified
- one of the two problems adequately managed
- common ground not achieved on management of either problem
- social and developmental context largely absent
- overall interview process and organization adequate
- Score: **17/36** (fail)

SOO 4: bipolar disease and carpal tunnel

- neither problem accurately and adequately identified
- both problems adequately managed
- common ground achieved on management of one problem
- social and developmental context marginally addressed
- overall interview process and organization adequate
- Score: **21/36** (pass)

Interpretation: While each interview was reasonably well organized, conducted politely and non-confrontationally, the medical problems were rarely named as probably diagnoses and were only partially managed or not managed at all. Patients were not allowed adequate discussion and question time and there was no obvious achievement of common ground. Little emphasis was placed on understanding the patients' social and developmental context.

Dr. Steyn was assessed a passing grade on two of the SOOs (one of them only marginally) and a failing grade on the other two. In terms of total possible marks, he achieved a score of **71/144** and his average score per SOO was **17.75/36** or **49%**.

The Competency Committee has determined that Dr. Steyn's performance on the Simulated Office Orals would support a judgment that he lacks adequate skill and knowledge to practice in a community-based family medicine or general practice.

4. Written Examination

The written examination has been described in detail earlier. Dr. Steyn scored **22/48** or **46%** on this exam. The committee determined this was a failing score.

The Competency Committee has determined that Dr. Steyn's performance on the Written Examination would support a judgment that he lacks adequate skill and knowledge to practice in a community-based family medicine or general practice.

5. Short Answer Management Problems

The short answer management portion of the evaluation has been described in detail earlier. Dr. Steyn scored **24.5/57** or **43%** on the SAMPs. The committee determined this was a failing score.

The Competency Committee has determined that Dr. Steyn's performance on the Short Answer Management Problems would support a judgment that he lacks adequate skill and knowledge to practice in a community-based family medicine or general practice.

CONCLUSION:

We have been instructed by the College of Physicians and Surgeons of Saskatchewan to make our evaluation comprehensive, thorough, valid, reliable, and fair. In our estimation, we have achieved that goal.

In the unanimous opinion of this Competency Committee, Dr. Steyn does not currently possess adequate skills and knowledge to safely practice medicine as a family physician or general practitioner.

We wish to comment on the limitations of our investigation. We recognize that our evaluation of Dr. Steyn's medical charts was limited in number and that this limitation might pose a potential theoretical risk, i.e. our conclusions regarding those charts might be challenged as not being generalizable. We also realize that while we can think of no fairer method than random chart selection, it might be suggested that only "inadequate" charts were reviewed by pure happenstance. In our opinion, neither of these theoretical risks are significant.

The charts were randomly selected, screened for the presence of recent contact, and reviewed in detail. They contained patient records for both sexes and for patients of all ages, with a broad range of medical problems. We believe that any limitations regarding generalizability do not seriously affect our overall conclusion.

We recognize that we were not in a position to observe Dr. Steyn's performance under duress, such as in medical emergencies. This limits the comprehensiveness of our investigation and may have some bearing upon the College's decisions regarding our assessment of component #2, hospital chart review.

We wish to comment on three aspects of our evaluation we find troubling. First, we learned from Dr. Steyn that many if not most of his patients previously had electronic medical records but that the server on which patient data was stored was destroyed by lightning earlier in 2012 and has not yet been replaced. We were not clear on why the data was not backed up or could not be accessed now and the records reconstituted. Obviously, access to an electronic medical record system would greatly improve record-keeping and avoid some of the serious deficiencies we noted in the paper-based chart system.

Second, we inferred that Dr. Steyn practices in a solo practice after experiencing disharmony of various degree with one or more previously associated physicians. The potential for substandard management habits becoming entrenched is significantly magnified in the absence of shared care and daily collegial interaction. The likelihood of ongoing CME and CPD occurring is also seriously limited by the lack of available alternate care providers.

Finally, we observed a problematic systemic issue relating to the ordering of laboratory tests. The Health Centre's "Requisition for Diagnostic Services" lumps several tests together such that one check mark results in multiple blood tests being ordered, some of them only loosely related to each other. The natural tendency would be to simply check the corresponding box when in fact, only one of the tests is truly desired. This system fault could explain, in small part, Dr. Steyn's observed tendency to over-investigate many patients.

We wish to thank the Department of Academic Family Medicine, Regina Unit, for providing the use of its facility and digital recording capabilities free of charge to the CPSS. We also wish to thank the Department for enabling one of its faculty members to participate in this process. We thank Dr. Lees of the Saskatoon Unit for providing assistance and advice regarding the selection of the SOOs and the SAMPs. Finally, we express thanks to the two standardized patients for contributing their skills and time on the morning of November 3rd, 2012.

Respectfully submitted,

Keith Ogle MD, CCFP, FCFP
Chair, Competency Committee

Regina Kamrul MD, CCFP
Competency Committee Member

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CHART AUDIT TOOL

Date: _____ Auditor: _____ Chart #_____

Scale:	Unsatisfactory	Marginal	Adequate	Good	Not Applicable
1. Are the chart notes **legible**?					
2. Is there a summary sheet (**medical profile**) recorded?					
3. Is there a summary **medication** sheet?					
4. Are **allergies** easily locatable or noted?					
5. If the patient is on Warfarin, are **INR's** tracked?					
6. Organization • is some **recognizable note format** used? (eg "SOAP") • are **presenting complaint** and **history** recorded? • are **observations** recorded? • is the **management plan** recorded?					
7. Are **prescribed medications** accurately listed (doses, frequency, duration) and are they appropriate choices?					
8. Are appropriate **labs and other tests** ordered?					
9. Are labs and other tests **followed up**?					
10. Are **consultations** requested appropriately?					
11. Are consultation **recommendations followed up**?					
12. If there is a **preventative health visit** in the chart ("complete"), are the required components recorded?					
13. Overall **impression** of this record?					

Comments:

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