[redacted]

[redacted]

[redacted]

D.C. Board of Medicine
Health Professional Licensing Administration
64 New York Avenue, N.E.
First Floor
Washington, D.C. 20002

Re: Corrective Action Plan

Dear [redacted]

I have had the opportunity to reflect upon the events leading to the patient's complaint, and I understand how my actions were misinterpreted, but more importantly what caused her concerns. While I did take ample time with the patient and I did explain a treatment plan, it is evident in retrospect that I was probably too eager to solve her medical condition, but in doing so I did not consider the patient's level of stress and discomfort since I was seeing her for the first time and we did not have the benefit of an ongoing physician/patient relationship based upon mutual comfort and trust.

In all likelihood I misread the patient's psychological state. She presented with a chronic problem occurring after surgery, and I believed the problem could be solved at that time without using extraordinary care, such as surgery and general anesthesia. I clearly miscalculated when I did not get a written consent prior to initiating a simple biopsy, and I did not follow up with the consent request in the aftermath. This clearly was a relaxation of the rules on consent/informed consent and I have taken steps to ensure that that does not occur again.

In the outpatient setting I am not able to adequately assess the patient's comfort level without performing an exam. I was convinced the patient was not in such discomfort to require general anesthesia with its associated risks. I was misunderstood, and in retrospect I should have presented an option of returning for the exam, while limiting the initial visit to consultation only.

[redacted]

The following corrective actions have been instituted in my practice:

1. Communication devices will be left on silent/vibration and if I need to, I will not answer the device without excusing myself to a private area. If I am anticipating an urgent call, for example, from the hospital concerning a patient, I will communicate that possibility to the patient in my office and ask to be excused to answer the call.

2. Permit forms will be placed on all patient records and I will have it signed for minor procedures.

3. Liberal use of outpatient facilities where anesthesia assistance by other health care providers will be sought if the patient is unable to tolerate a thorough examination in the office.

This episode has given me more insight into the changing face of medical care and reminds me of the fundamental responsibility of establishing effective communications which fosters a healthy physician/patient relationship. It is the absence of that relationship (since she was seeing me for the first time) which probably brought about her reaction, a domino effect. She did not know me, but even though I was taking steps to help her, she felt exposed and from that point everything went downhill. Another physician whom she did not know was brought in to provide a second opinion that my diagnosis was appropriate. In the process she was felt exposed, not exposed to the public, but exposed in the context of feeling vulnerable and being examined by two doctors who she did not know. Add to this the telephone call and her discomfort, the end result was this complaint. Please believe me when I say in some respects this has helped to remind me of the ongoing necessity of establishing and maintaining good communications with patients.

Sincerely,