

SUMMARY

Dr. Milind Gunvantrai Desai (CPSO# 61125)

1. Disposition

On April 13, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Desai (Gastroenterology, Internal Medicine) to appear before a panel of the Committee to be cautioned with respect to his deficiencies in office and practice management. The Committee also ordered Dr. Desai to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Desai to:

- Successfully complete the next available session of the following courses:
 - the Canadian Medical Protective Association Good Practices Guide online module on Professionalism
 - the Canadian Medical Protective Association's online learning programs on *Documentation: Charting Medical Records* and *Documentation: The Principles of Medical Record Keeping*
- Review and submit written summaries of the following policies/guidelines:
 - The Practice Guide
 - *Medical Records* (#4-12)
 - Test results Management (#1-11)
- Engage in focused educational sessions with a Clinical Supervisor acceptable to the College for a period of six months to address the following deficiencies in his practice:
 - Timely provision of patient test results
 - Medical record keeping
 - Communication with referring physicians
 - Office management and office practices

2. Introduction

A patient complained to the College that Dr. Desai caused an active bleed during her gastroscopy, failed to provide her family physician with the results of the gastroscopy, and failed to provide proper follow-up despite multiple attempts to contact his office. Specifically, she expressed concern that Dr. Desai caused her to require emergency care three days after her gastroscopy due to a bleed, informed her not to return to his clinic after she had her polyps biopsied and indicated that he would send the reports to her family physician, failed to send her family physician the endoscopy report, despite several requests (i.e. 15 faxed requests and several calls from her family physician asking for the report), and falsely informed her family physician that she had refused a follow-up appointment. The patient also expressed concern that Dr. Desai fails to maintain the confidentiality and security of his patients' medical records, fails to post signage on his office door to indicate to patients when the office is closed and employs a receptionist who is rude and unprofessional.

Dr. Desai responded that the patient had some hemorrhoidal bleeding after the gastroscopy, but that he promptly saw/assessed the patient when she went to the Emergency Room ("ER"). He stated that he reassured the patient about the absence of any serious acute problem. Dr. Desai further indicated that it is his usual practice to discuss gastroscopy findings with patients, his diagnosis, as well as treatment options. He stated that he sent the operative report, pathology report, and his proposed treatment to the individual whom he understood was the patient's primary health care provider. Dr. Desai said that occasionally, repeated calls from anxious patients challenge the capacity of his voicemail system such that it cannot store further voicemail messages. He said he has addressed this by encouraging his staff to answer messages promptly. Dr. Desai said the patient declined further follow-up with him, as her concerns were addressed. According to Dr. Desai, all patient records are properly and safely stored, including staff attendance at the front desk (he provided details). Dr. Desai did not comment on the concerns about office signage and denied his staff are rude.

3. Committee Process

A Surgical Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee had no concerns regarding the care that Dr. Desai provided in this particular case. The record confirms the bleeding was hemorrhoidal, and not related to the gastroscopy. Dr. Desai's clinical notes reflect that he followed up the gastroscopy procedure with a discussion with the patient about treatment for hemorrhoids.

The patient's family physician confirmed there was a four-month delay in obtaining Dr. Desai's report, which was a significant delay, in the Committee's view.

The Committee noted issues related to the absence of the contact information for the family physician on the report. However, the Committee did not accept Dr. Desai's explanation that this was a hospital "system's error" Dr. Desai must take measures to ensure that he sends his operative reports to the referring physicians in a timely manner.

The Committee further noted that one reason for the delay in Dr. Desai sending the gastroscopy report is that he waits until the pathology is back before dictating operative notes. In the Committee's view, this is not an acceptable practice and reflects poor office management and it can also lead to unreliable records, when the notes are made so long after a procedure. Dr. Desai should dictate his operative notes immediately following procedures and dictate a follow-up note when he receives the results of investigations.

The Committee was also concerned about the fact that Dr. Desai apparently did not respond to numerous requests (for the gastroscopy report from the office of the patient's family physician. and blames his full answering machine on his "anxious patients".

With respect to concerns about Dr. Desai falsely informing the patient's family physician that she had refused a follow-up appointment and the rudeness of Dr. Desai's staff, given that the Committee is limited to a review of documentation in the investigative record and had no independent information to support either party's account of what occurred, it did not take any further action regarding these areas of concern. The Committee does, however, expect physicians to ensure their staff speak professionally to patients.

The Committee accepted that Dr. Desai ensures the confidentiality of patients' medical records. The Committee noted that two recent peer assessments confirmed the adequacy of his clinic's confidentiality and security arrangements for patients' records.

In the Committee's view, the lack of signage on the clinic door reflects poor office management

The Committee noted that this is not the first time issues have been raised regarding Dr. Desai's office and practice management in other College investigations.

The Committee thus concluded that the appropriate disposition in this case was to require Dr. Desai to attend at the College to be cautioned and complete the SCERP, as described above.