SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)

Information about the complaints process and the Committee is available at: https://www.cpso.on.ca/Public/Services/Complaints

Dr. Septimiu Cristian Danescu (CPSO #97163) (the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct related to a Patient. The Respondent provided care to the Patient in an Emergency Room (ER).

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to provide adequate care to the Patient. Specifically, the Respondent:

- **Failed to order point-of-care testing (POCT) for glucose levels;**
- **Failed to insert a central line using a sterile field;**
- **Failed to intubate appropriately and in a timely manner;**
- **Failed to diagnose hypoglycaemia; and,**
- **Caused a delay in transferring the Patient to another hospital.**

COMMITTEE'S DECISION

An Internal Medicine Panel of the Committee considered this matter at its meeting of January 7, 2019. The Committee accepted an undertaking from the Respondent, and also required the Respondent to attend at the College to be cautioned in person with respect to adequately managing patients with a decreased level of consciouness in the ICU and assessing blood sugar levels in a patient with diabetes.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an Assessor who specializes in Internal Medicine and Critical Care Medicine. The IO provider opined that the Respondent did not meet the standard of care in his approach to this Patient, and exposed the Patient to a risk of harm or injury. He also determined that the Respondent showed poor judgement in regards to his intubation of the Patient. The Committee agreed with the IO provider's findings.

Re: Clinical Care

In the Committee's view, the Respondent should have recognized the Patient's hypoglycemia earlier, based on his symptoms. It concerned the Committee that the Respondent "believed the

care was appropriate", as this shows poor insight. The Committee expects physicians to be able to recognize when something did go wrong, and to be able to outline the steps they plan to take to prevent future occurrences. While in later correspondence the Respondent did recognize some of his practice deficiencies, the Committee continued to be concerned with the low level of insight he displayed throughout the investigation.

The Committee also noted that the Respondent's approach to patient care in this instance appeared unorganized. Patients presenting with an acute change in their level of consciousness require an organized approach to care, which was not demonstrated in this case.

Based on the Patient's condition, the Respondent should have known that it was going to be a difficult intubation, and should have asked for help earlier.

Given the series of serious errors the Respondent made when caring for this Patient, the Committee is of the view that, in addition to undertaking to compete education in medical record-keeping and to educate himself regarding patients presenting with a decreased level of consciousness (including the role of glucose testing and the administration of dextrose), the Respondent would also benefit from an in-person meeting to discuss the care he provided.

Re: Medical Records

In reviewing the medical record, the Committee found that the Respondent's notes were mostly non-existent, and that his discharge note does not mention several of the Patient's issues. The Committee satisfied their concerns regarding this issue by accepting an undertaking from the Respondent to complete a program in medical record-keeping, and to review and prepare a written summary on the College's *Medical Records* policy.