

SUMMARY

Dr. Lazar Victor Klein (CPSO# 70489)

1. Disposition

On March 16, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered general surgeon Dr. Klein to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Klein to:

- Practice under the guidance of a Clinical Supervisor acceptable to the College for six months
- Undergo a reassessment of his practice by an assessor selected by the College approximately six months following completion of the SCERP
- Review relevant Clinical Practice Guidelines, including literature for guidelines on early identification and management of sepsis, as well as College policies on *Medical Records* and *Test Results Management*, and provide a written summary of the documents with reference to current standards of practice, how it is applicable to Dr. Klein's situation, as well as how Dr. Klein has made, or plans to make, changes to his practice.

2. Introduction

A family member of a deceased patient complained to the College that Dr. Klein failed to provide adequate care and treatment to the patient during the patient's December 2014 hospital admission with a possible small bowel obstruction, in that he failed to respond to or follow up on the patient's abnormal blood work result (the urinalysis showed >100,000 E.Coli), and failed to follow up on the family's request for an autopsy (which was ultimately not performed). Prior to this admission, the patient had been self-catheterizing for a few years, but was otherwise well and mobile.

3. Committee Process

In August 2016, a previous panel of the Committee issued advice to Dr. Klein on several aspects of his care.

The complainant appealed the Committee's decision to the Health Professions Appeal and Review Board (the Board). In a decision dated November 7, 2017, the Board confirmed the Committee's decision to issue advice to Dr. Klein with regard to documenting his care when he is the most responsible physician (MRP), and bringing this case to morbidity and mortality rounds to raise awareness and provide education. However, it directed the Committee to reconsider its decision to issue advice to Dr. Klein on other aspects of his care relating to test results follow-up and narcotics prescribing.

On March 16, 2018, a Surgical Panel of the Committee, consisting of public and physician members, met again to review the relevant records and documents related to the complaint, following the Board's review. 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.cpsso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee was of the view that the urinalysis results, along with the patient's history of self-catheterization and prior urinary tract infections (UTIs), the significant increase in her white blood cell (WBC) count (from a normal level of 9,000 at admission to 22,000 by 9:00 am on December 4), and her falling oxygen saturation should have alerted Dr. Klein and hospital staff to the strong possibility of sepsis.

The Committee noted that in his response to this complaint, Dr. Klein indicated that he did not consider the possibility of a sepsis diagnosis. Furthermore, although he claimed to have first

seen the patient at approximately 9:00 am on December 4, he failed to document the increased WBC, both at this time and at his subsequent 6:00 pm reassessment.

The Committee was concerned about the significant failure to treat a highly likely UTI with appropriate antibiotics within 12-24 hours of admission, which should have occurred with or without the associated diagnosis of a small bowel obstruction. Furthermore, even if the patient's abdominal examination did not suggest a strangulated small bowel obstruction or other acute intra-abdominal condition, the Committee noted that there was no indication that Dr. Klein considered the reason for the patient's seriously elevated WBC count, which he continued to claim was non-specific.

Given Dr. Klein's failure to offer any explanation for this concerning information in his various responses to this complaint, the Committee felt he demonstrated a lack of insight regarding his failure to properly manage the patient's care. The Committee noted that a prudent physician should have recognized the above mentioned results as highly indicative of an inflammatory response, such as septic shock, and initiated appropriate antibiotics.

The Committee was not in a position to determine what caused the patient's death, but noted that the dose of narcotics the patient received was minimal, and that there was no information to suggest that the narcotics, which were in fact ordered by a different physician, were inappropriate at the time of the initial order.

With respect to medical record-keeping, the Committee was concerned that Dr. Klein did not write any notes at any time during the patient's admission, which does not meet the standard of care and does not comply with the College's policy on *Medical Records*. Furthermore, this lack of documentation made it difficult for the Committee to assess the true extent and quality of care that Dr. Klein provided to the patient. The Committee noted that the involvement of

residents or students does not absolve physicians from their own documentation responsibilities.

The Committee noted that Dr. Klein has a significant history with the College, which include cases raising both clinical and record-keeping issues, for which he has received advice and been cautioned. The Committee agreed with the Board that the repetition of similar concerns in this case appears to indicate that the previous remediation attempts have not been successful. This, along with the Committee's concern about Dr. Klein's persistent lack of insight into his shortcomings in this case, suggested that a more significant disposition was required to adequately protect the public, as outlined above.

The Committee also maintained the advice to Dr. Klein which was issued by the original panel in August 2016 and upheld by the Board, regarding documenting his care when he is the Most Responsible Physician (MRP) and bringing the case to morbidity and mortality rounds to raise awareness and provide education.

This summary was amended following an appeal heard by the Health Professions Appeal and Review Board ("HPARB"), a decision by HPARB dated February 25, 2019, and the Committee's consideration of the matter on June 21, 2019.