SUMMARY

DR. ALVIN NEWMAN (CPSO# 26232)

1. Disposition

On October 12, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required gastroenterologist Dr. Newman to appear before a panel of the Committee to be cautioned with respect to pre-operative risk assessment; documenting communication, including pre- and post-procedure discussion with patients and/or family, and including appropriate discharge instructions, particularly where a procedure was complicated; and ensuring that his office has a dated call log.

2. Introduction

A family member of the patient complained to the College that Dr. Newman had ruptured the patient's esophagus when performing an endoscopy, had failed to inform the patient of the extent of the procedure on discharge and failed to perform an x-ray, had failed to inform the patient of the possible gravity of his findings (malignant cancerous tumour) and had failed to provide care or show concern for the patient when his office was contacted regarding her extreme pain, two days after the procedure.

Dr. Newman responded that he arranged expediently to undertake the patient's endoscopy as he was concerned about her presentation. He stated that, at the endoscopy, he encountered a circumferential malignant-looking stricture. After taking biopsies, he removed the endoscope and passed a 52 French bougie through the stricture, in order to temporarily improve the patient's ability to swallow. He noted that he did not see the patient after this, but that when he received her concerning pathology results, he unsuccessfully tried to contact her, then contacted her family physician to ensure that she received the results. Dr. Newman stated that he and his staff had no recollection or record of receiving calls from the patient or her family. Dr. Newman stated he had no knowledge that the patient had sustained a complication of the endoscopy.

3. Committee Process

An Internal Medicine 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

Although the chart contained a consent form for the procedure, signed by the patient, it did not contain any documentation of risk assessment or pre-procedure discussion to inform the patient's consent, as described in the College's Policy on *Consent to Treatment*. The Committee questioned the safety of having to push hard to pass a scope and then dilating with a bougie and was unsure, in the absence of documentation of a reassessment, how Dr. Newman knew that the patient's condition was stable at discharge. The Committee noted, however, that it is not routine to do an x-ray following endoscopy.

The Committee noted that Dr. Newman saw the tumor and questioned why, at the very least, he did not communicate to the patient or her family along the lines that there seemed to be a growth, but they would need to await results of the biopsy to be certain.

This patient would have been at a higher than usual risk for complications due to the dilatation, yet there is no indication in the documentation that Dr. Newman so advised the patient or her family. Given that it was a difficult procedure, Dr. Newman should have discussed possible complications and upon discharge he should have instructed the patient as to what to do in the event she experienced concerning symptoms; he should aslo have documented this discussion.

Dr. Newman's staff acknowledged that they did not date documentation respecting telephone calls. This does not comply with the College's Policy on *Medical Records*, which sets out that telephone calls should be documented and dated.

The Committee reviewed Dr. Newman's history of complaints with the College, and noted that he had three previous complaints raising concerns about communications, and had previously been required to complete a communictions course. This information heightened the

Committee's concerns in this case, as Dr. Newman's failure to communicate adequately was woven through this complaint as well.