

SUMMARY

Dr. Raymond Daniel Bowser (CPSO# 32756)

1. Disposition

On September 26, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required general surgeon Dr. Bowser to appear before a panel of the Committee to be cautioned with respect to his documentation.

2. Introduction

The patient complained to the College that, while undertaking Barron ligations of her hemorrhoids, Dr. Bowser incorrectly inserted the scope instrument into her vagina instead of her anus; applied rubber bands to her vaginal wall instead of her hemorrhoids; and failed to provide an explanation or follow up after she notified the office of the complications.

Dr. Bowser acknowledged that the misplaced band was obviously a mistake, for which he was extremely sorry. He noted some difficulties that occurred during the procedure, which may have led to this event. He stated that his colleague followed up with the patient, but that he was unable to do so personally because she did not return to him for a follow-up appointment.

3. Committee Process

A 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

A difficulty for the Committee in reviewing this matter was that Dr. Bowser did not document contemporaneously anything to suggest that he encountered difficulties during the December 2017 procedure, such as those he mentioned in his response to the College. If a physician's treatment of a patient is called into question, as here, the best point of reference is a comprehensive and legible record. If such a record is not available, or is available but inadequate (as in this case), it is much more difficult to investigate and resolve a complaint. Concerns about the lack of detailed operative documentation in this case led to the Committee's decision to caution Dr. Bowser.

With respect to failure to provide the patient with an explanation, Dr. Bowser acknowledged that he now realizes the patient attempted to contact him through his office but was not given an appointment, and she cancelled her scheduled later post-operative visit. The Committee commented that his practice would benefit from reviewing literature related to disclosure of harm, including the College's Policy #5-10, *Disclosure of Harm*.