

## SUMMARY

### Dr. Cholemkeril Kuncheria Thomas (CPSO# 54092)

#### 1. Dispositions

On April 19, 2017, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered general practitioner Dr. Thomas to complete a specified continuing education and remediation program (“SCERP”), and to attend the College to be cautioned with respect to his inadequate records, and his professionalism, in terms of his responsiveness to his duties of chart completion and to staff concerns. The SCERP requires Dr. Thomas to:

- complete a medical record-keeping course, an opioid prescribing course, an advanced trauma and life support (ATLS) course, and an emergency medicine review course;
- engage in one-on-one instruction in collaboration and professionalism (including respect for colleagues and co-workers, punctuality, responsiveness to calls for patient care and responsiveness to requests from the College), to be facilitated by the College;
- review and provide written summaries of the Clinical Practice Guidelines regarding vaginal bleeding during pregnancy; Choosing Wisely Canada Recommendations for Emergency Medicine; the College’s policies on *Medical Records* and *Physician Behaviour in the Professional Environment*; and the College’s *Practice Guide*;
- meet with a Clinical Supervisor acceptable to the College 8 times over 12 months (at which time the Supervisor will review a minimum of 20 charts to assess for the quality of documentation and care); and
- undergo a reassessment of his practice by an assessor selected by the College approximately six months following completion of the education program.

#### 2. Introduction

The Chief of Staff of a hospital contacted the College with concerns about Dr. Thomas, who had worked as a locum in the hospital’s emergency department (ED) for approximately one year (leaving the hospital in 2013). The Chief of Staff reported that when Dr. Thomas left the

hospital, he left behind approximately 50 incomplete charts, and that despite communications with the administration about returning to complete the charts throughout 2013 and 2014, Dr. Thomas never returned. The Chief of Staff advised that he was required to complete the charts himself, to the best of his ability. The Medical Director of the hospital's ED reported that Dr. Thomas was non-compliant with the hospital chart completion policy during his tenure there. He noted that Dr. Thomas' charting was limited, making it difficult for other staff to follow the care, and he often did not sign his verbal orders. The Medical Director confirmed that when Dr. Thomas left the hospital, he left a number of charts incomplete.

Dr. Thomas responded that he had tried to make arrangements to return to complete the charts but the hospital could not afford to pay his travel expenses and the plans were cancelled. He noted that he felt that it was unfair that the Chief of Staff did not give him a friendly warning that they were going to bring a complaint to the College and give him a deadline for completing the charts.

In October 2015, the Committee approved the Registrar's appointment of investigators under section 75(1)(a) of the Code to examine Dr. Thomas' practice. Under this appointment, the Committee retained a medical inspector (MI) to review a number of Dr. Thomas' patient charts, and interview Dr. Thomas. The MI concluded that Dr. Thomas' care in four out of the 30 charts reviewed did not meet the standard of practice, that that he displayed a lack of knowledge, skill or judgment in those cases, and that his handling of patient encounters in three of the 30 charts had the potential to expose the patients to an increased risk of harm beyond what would normally be expected. The MI also found that Dr. Thomas' clinical documentation in a number of cases was unacceptable.

The College's investigator spoke with staff in the ED at the hospital where Dr. Thomas currently works. They noted concerns with Dr. Thomas' record-keeping and issues reaching him when he was on call, as well as certain issues with his clinical choices, including narcotics prescribing and the ordering of tests.

Dr. Thomas stated that he felt the MI's review was fair, and he noted that the MI and hospital staff had identified concerns with his practice, relating to his record-keeping and his organization (including difficulties staff have had in contacting him, and timeliness of charting), which he

acknowledged. He agreed that there was room for improvement and stated he was willing to take steps to improve his practice, which he outlined. He also provided specific responses to aspects of the MI's analysis of the individual patient charts in which the MI felt his care fell below the standard.

### 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.cpsso.on.ca](http://www.cpsso.on.ca), under the heading "Policies & Publications."

### 4. Committee's Analysis

The Committee's investigation raised concerns regarding Dr. Thomas' medical record-keeping, his care in certain clinical scenarios, and his collaboration skills and professionalism.

Regarding the information from the hospital staff relating to difficulties reaching Dr. Thomas, his tardiness for meetings and rounds, and his delay in completing records, the Committee noted that it too had difficulty in obtaining timely responses from Dr. Thomas in the course of the investigation.

The Committee noted that complete and accurate records are a fundamental aspect of good medical care, and that Dr. Thomas' failure to adequately and legibly document all aspects of his patients' care and management in the record, or to complete such documentation in a timely manner (even when this issue was brought to his attention by hospital administration), was of significant concern.

The Committee also pointed out that a physician's failure to respond in a timely manner, or at all, when on call is a serious breach of professionalism, and has the potential to put the safety of patients at risk.

The Committee had concerns with respect to several critical aspects of Dr. Thomas' practice, and while Dr. Thomas had offered to engage in a number of steps in order to improve his practice, the Committee was not satisfied that the remediation he had suggested was sufficient to address all of the concerns identified in the investigation. The Committee determined that the appropriate disposition in this case was to have Dr. Thomas attend for a caution and to complete the SCERP as outlined above.