NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Vijay Sharma, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names or any information that could disclose the identity of the patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Sharma, V. (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. VIJAY SHARMA

PANEL MEMBERS:

DR. W. KING (CHAIR)
D. GIAMPIETRI
DR. P. CASOLA
DR. E. ATTIA (Ph.D.)
DR. P. POLDRE

Hearing Date: September 24, 2014
Decision Date: September 24, 2014
Release of Written Reasons: October 14, 2014

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on September 24, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Sharma committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

2 under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Sharma is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Sharma admitted the first and second allegations of professional misconduct in the Notice of Hearing, that he failed to maintain the standard of practice of the profession; and that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the allegation of incompetence in the Notice of Hearing.

FACTS AND EVIDENCE

The following facts were set out in the Statement of Agreed Facts and Admission that was filed as an exhibit and presented to the Committee:

1. Dr. Sharma is an anesthesiologist whose independent practice certificate was issued by The College of Physicians and Surgeons of Ontario ("the College") on July 1, 1995. At all relevant times, Dr. Sharma practised anesthesiology at Hospital 1.

2. A section 75(1)(a) investigation into Dr. Sharma's practice at Hospital 1 was commenced in about July, 2012, after the College received information that raised concerns about Dr. Sharma's anesthesiology practice.

3. During the course of its investigation, the College retained Dr. X, an anesthesiologist with privileges at the University Health Network and the Kensington Eye Institute, who is also the Director of Undergraduate Education for the Department of Anesthesia at the University of Toronto, to review and opine on Dr. Sharma's standard of care in 26 patient charts. Dr. X prepared a series of reports for the College.

STANDARDS OF PRACTICE

4. The relevant portions of Dr. X's reports are attached at Tab A (to the Statement of Agreed Facts and Admission). She found that Dr. Sharma failed to meet the standard of practice in the following respects:

    (1) His record-keeping fell below the standard of care in respect of eight patients.

    (2) In respect of Patient A, although Dr. Sharma monitored the patient in the PACU between 15:19 and 15:50, he failed, prior to leaving the hospital, to

properly hand over care to the on-call anaesthesiologist of this intubated patient.

(3) In respect of Patient B, a patient undergoing an urgent repair of a hip fracture who was found on preliminary echo study to have moderate aortic stenosis and insufficiency, Dr. Sharma administered spinal anesthesia but did not place an arterial line, which would have permitted close hemodynamic monitoring.

(4) In respect of Patient C, Dr. Sharma intubated the patient by administering a long-acting muscle relaxant (rocuronium) instead of a short-acting muscle relaxant in a patient assessed as having a potentially difficult airway.

(5) In respect of Patients D and E who were undergoing cesarean sections, Dr. Sharma administered 10 units of oxytocin as requested by an obstetrician, in circumstances where this dosage may have caused a drop in blood pressure.

(6) In respect of Patient D, Dr. Sharma administered both intrathecal and epidural opioids (first administering 0.1 mg morphine during a combined spinal epidural prior to c-section followed several hours later in ICU by 0.125% marcaine infusion with opioid starting at 4 cc/hour) in a patient having a classical cesarean section in the presence of fibroids with a large midline incision and with severe hypertension, pre-eclampsia and pulmonary edema.

(7) In respect of Patient F, an asthmatic patient with a history of duodenal ulcer and for whom Dr. Sharma documented a history of GERD, Dr. Sharma used a laryngeal mask airway instead of an endotracheal tube for sinus surgery.

DR. SHARMA'S CONDUCT

5. Dr. Sharma has engaged in conduct which would be regarded by the profession as disgraceful, dishonourable or unprofessional, as set out below.

6. Dr. Sharma has on occasion left the operating room while his patients were undergoing procedures while under anesthesia in a manner not in accordance with the then-current standard of practice in that he sometimes failed to appropriately communicate with others in the operating room.

7. In June 2007, one of Dr. Sharma's colleagues called in sick and therefore was not available to provide anesthesia in the operating room as he was scheduled to do. Dr. Sharma was scheduled to provide anesthesia services in the endoscopy suite that day. Dr. Sharma proceeded to provide anesthesia for the operating room cases rather than the list being cancelled. Instead of giving up the cases in the endoscopy suite, Dr. Sharma also provided IV conscious sedation for some patients in the endoscopy suite.

8. In the past, Dr. Sharma has on occasion used a computer for personal purposes in the operating room during surgery in which he was the attending anesthesiologist.

ADMISSION

9. Dr. Sharma admits the facts set out in paragraphs 1 through 8 above and admits that, based on these facts, he has failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991, and has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional under paragraph 1(1)33 of Ontario Regulation 856/93.

FINDINGS

The Committee accepted as true all of the facts set out in the Statement of Agreed Facts and Admission. Having regard to these facts, the Committee accepted Dr. Sharma's admission and found that he committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession; and that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional

STATEMENT OF AGREED FACTS FOR PENALTY

The following facts were set out in a Statement of Agreed Facts For Penalty and presented to the Committee:

IMPROVEMENTS IN DR. SHARMA'S CONDUCT

1. Dr. Sharma advises that he no longer uses a computer for personal use in the operating room. This is consistent with the evidence of one of the nurses interviewed by the College who said she did not remember Dr. Sharma using a computer for personal use in the OR from the time she started working at Hospital 1 in 2011 until the time she was interviewed in May 2013.

RESPONSE TO INVESTIGATION

2. Through the course of the College's investigation, Dr. Sharma has shown ample promptness and co-operation with requests made of him by the College investigator, and, following receipt of Dr. X's reports, has advised that he has incorporated positive changes into his practice in consideration of Dr. X's opinions. For example, Dr. Sharma has advised the College of the following:

    (a) he began refusing to administer 10 units of oxytocin to patients undergoing cesarean sections when requested by obstetricians;

(b) he has also raised this issue for discussion with the Chief of Obstetrics and some of his colleagues, as well as some other obstetricians;

(c) he has stopped using rocuronium in patients whose airways he has assessed as being potentially difficult;

(d) he has made difficult airways an area of focussed learning by co-ordinating grand rounds at Hospital 1 regarding difficult airway cases at which some of his own cases involving such things as fibreoptic intubation and awake intubation were reviewed and discussed;

(e) he has taken steps to improve his practice such as actively asking the nurse who is the Clinical Manager of the OR and PACU for feedback and whether the nurses have any concerns. Dr. Sharma has advised he has also sought regular feedback from the new Chief of Anesthesiology, Dr. W (who became the Chief effective January 1, 2014), the Chief of Surgery, Dr. Y, and the Chief of Staff, Dr. Z;

(f) he has reviewed many publications, articles and books as a result of the College's investigation. Dr. Sharma has advised that the publications and articles which he has reviewed have come from such sources as The Canadian Medical Protective Association, The College of Physicians and Surgeons of Ontario, the Canadian Anesthesia Journal, the Journal of the American Society of Anesthesiologists, the British Journal of Anaesthesiology, and the Canadian Medical Association Journal, among others. Dr. Sharma has advised he has also reviewed various on-line resources made available by Pubmed, the Canadian Medical Association, and the American Medical Association. Dr. Sharma has advised that the books he has reviewed included Crucial Conversations – Tools for Talking When Stakes are High, by Patterson et al., a book which is focussed on communication, and Doing Right: A Practical Guide to Ethics for Medical Trainees and Physicians, by Hebert, Philip C.

(g) he volunteered to assume the role of CME co-ordinator for the Department of Anesthesia at Hospital 1 and became responsible for organizing grand rounds at Hospital 1 in early 2014. Dr. Sharma has advised he arranged four grand rounds prior to July 1, 2014, featuring speakers from outside Hospital 1.

LETTERS IN SUPPORT OF DR. SHARMA

3. In spite of concerns expressed about Dr. Sharma by a group of nurses at Hospital 1 during the course of the College's investigation, a number of Dr. Sharma's colleagues wrote letters to the College in support of him during the investigation. These letters were provided to the College for consideration and are attached at Tab A.

2014 PERFORMANCE APPRAISAL AT HOSPITAL 1

4. As of January 1, 2014, Dr. W became the Chief of Anesthesia at Hospital 1. Attached at Tab B is a copy of Dr. Sharma's first performance appraisal by Dr. W at Hospital 1 dated April 28, 2014. Dr. W wrote the following in this performance appraisal:

> "Dr. Sharma is cooperating diligently with the CPSO ruling and is functioning efficiently and is continuing to perform competently. He has managed some complex and challenging cases involving difficult airway management and severe comorbidity well, including obstetrical regional cases. He has taken on the responsibility of organizing the Department of Anesthesia continuing education rounds. This involves arranging, documenting and assessing weekly. He has done extremely well since he took over."

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee is aware that a joint submission must be accepted unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

The Committee was provided with two previous decisions of the Discipline Committee to assist in its deliberations. Each of these cases contained some aspects similar to the findings in Dr. Sharma's case. While not bound by these previous decisions, the Committee is aware that similar cases ought to be dealt with in a similar fashion.

The Committee was mindful of the mitigating factors in this case. Dr. Sharma acknowledged his wrongdoing, thus sparing the College the costs of a contested hearing and the need for witnesses to testify. Dr. Sharma also has no prior disciplinary history with the College.

The Committee also recognized that several of the incidents of concern took place a number of years ago and that Dr. Sharma has made considerable efforts to remediate his practices in the interval.

The Committee noted the significant number of letters in support of Dr. Sharma, from a broad base of physicians and nurses who have interacted with Dr. Sharma over the years and more recently.

The Committee considered that the proposed penalty would uphold the relevant penalty principles. Protection of the public is achieved by the appointment of a Clinical Supervisor and the subsequent re-assessment of his clinical practice. These steps will provide further rehabilitation of the member and maintain public confidence in the integrity of the profession. These measures provide specific deterrence to the member and serve as general deterrence to the profession. The public reprimand serves to emphasize to the member and to the profession that all patients are entitled to a physician's full and undivided attention, for the duration of their need, and at an acceptable professional standard.

ORDER

Therefore, having stated its findings in paragraphs 1 and 2 of its written order of September 24, 2014, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Sharma attend before the panel to be reprimanded.

4. the Registrar impose the following terms, conditions and limitations on the certificate of registration of Dr. Sharma:

   (a) Dr. Sharma shall complete, at his own expense, an educational program on communications facilitated by the College within twelve (12) months from the date of this Order;

   (b) Dr. Sharma shall, within 30 days from the date of this Order, retain a College-approved clinical supervisor, who will sign an undertaking in the form attached hereto as Schedule "A" (the "Clinical Supervisor"). The period of clinical supervision shall last for twelve (12) months commencing on the day the Clinical Supervisor is retained. Dr. Sharma will abide at his own expense by all recommendations of his Clinical Supervisor with respect to practice improvements and/or professional development;

   (c) Upon completion of this period of supervision, within six (6) months, Dr. Sharma shall undergo a re-assessment of his clinical practice by a College-appointed Assessor. The results of the reassessment shall be reported to the College, which may use the reassessment results to ground further investigations or proceedings if appropriate; and

   (d) Dr. Sharma shall be responsible for any and all costs associated with implementing the terms of this Order.

5. Dr. Sharma shall, within thirty (30) days, pay the College its costs of this proceeding in the amount of $4,460.00.

At the conclusion of the hearing, Dr. Sharma waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.