SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Mohammad Reza Golrokhian Sani (CPSO #97179)
(the Respondent)

INTRODUCTION

In April 2018, the Respondent (Otolaryngology- Head and Neck Surgery) performed surgery on the Patient. Post-operatively, the Patient developed new voice hoarseness. The Respondent identified a mass under the vocal cord and followed the Patient for several months. The Patient ultimately chose to seek care elsewhere out of country, where he received treatment for cancer.

A family member of the Patient contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

- **The Complainant is concerned with the medical care and conduct of the Respondent in 2018, when the Respondent failed to follow up on the Patient's concerns regarding the hoarseness of his voice.**

- **The Complainant was also concerned that the Respondent dismissed a request for a second opinion.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of February 24, 2023. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to following the College's Medical Records Documentation policy when amending records.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in otolaryngology. The Assessor reviewed two different versions of the Respondent's medical records for the Patient and opined that in both versions the Respondent's care met the standard. The Assessor noted that the Respondent promptly performed appropriate investigations when the Patient complained of hoarseness, identified a lesion, and conducted proper follow-up. Once the lesion was identified as a possible malignancy, the Respondent acted quickly in recommending and scheduling further investigations/interventions. The Assessor did not identify any lack of

knowledge, skill, or judgment, nor did he identify a risk of harm or injury to the Respondent's patients.

The Committee agreed with the Assessor's conclusions and had no concerns about quality of the Respondent's clinical care in this case. However, the Committee did have concerns about late alterations that the Respondent made in the medical record, which led to the two different versions before the Committee.

The Respondent acknowledged that he added information to the record after the fact. In particular, he made changes to three encounter notes, some of which were made after he was notified of the complaint. He also acknowledged that he did not record the date and time of the changes. The Respondent explained that this was an oversight, and that he was delayed in reviewing and changing his transcribed notes due to staffing issues.

The Committee was concerned that the Respondent added material information to the chart many months after the visits in issue (in some instances after he was notified of this complaint), at a time when one could expect recall of the details of the visits to be questionable. The Committee felt that accuracy in recollecting specific details of discussions and observations so long after the events could inevitably be an issue. Given the fundamental importance of thorough, accurate records, the Committee was of the opinion that this was a significant failing on the part of the Respondent.

The Committee recognized that the Respondent has taken steps to improve his medical record keeping, including attending courses. However, given the significance of the deficiencies in this case, the Committee was of the opinion that the Respondent should be cautioned as set out above.

The Committee took no action regarding the concern about the Respondent dismissing a request for a second opinion.