PUBLIC SUMMARY

DR. GERALD ROWLAND (CPSO# 30936)

1. Disposition

On January 27, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered family physician Dr. Rowland to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Rowland to:

- Successfully complete a course in Medical Record-Keeping
- Engage in self-study consisting of review of the College's Policy #4-12, *Medical Records*, and providing the College with a written summary of his learning
- Submit to a reassessment of his practice, six months after completing the education noted above.

2. Introduction

A patient in Dr. Rowland's family practice complained to the College about Dr. Rowland's clinical care when the patient attended his office in follow up to an Emergency Room visit where pneumonia was suspected. Dr. Rowland did not order a follow-up x-ray. The patient's condition deteriorated; he went on to have a heart attack, congestive heart failure and subsequent kidney failure which will require him to attend regularly for dialysis for the rest of his life. The patient's family member went to Dr. Rowland's office approximately ten weeks after the patient's appointment, to discuss matters. Dr. Rowland then realized that he had not completed documentation of the patient's appointment, and proceeded to do so.

Dr. Rowland asserted that, based on the patient's presentation and his examination on the date he attended the office in follow up of the hospital visit, the patient had not needed a chest x-ray. Dr.

Rowland explained why he had failed to document the encounter, and further acknowledged that his office had erroneously issued another patient's prescription to this patient.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider who specializes in family practice. The Independent Opinion provider reviewed the entire written investigative record and submitted a written report to the Committee.

A Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint, as well as College policies and relevant legislation.

4. Committee's Analysis

The Committee found that Dr. Rowland's clinical care on the date the patient attended was adequate. Given that another physician re-started the patient's antibiotics the day after he attended Dr. Rowland, and taking into account the patient's pre-existing medical conditions, ordering an x-ray on the day the patient attended Dr. Rowland would not likely have changed the patient's unfortunate subsequent clinical course.

The Committee was, however, very concerned about Dr. Rowland's office management, specifically with respect to record-keeping and to calling in a prescription in this patient's name, that was intended for another patient. The Committee's concern was increased by the fact that Dr. Rowland's past complaints history with the College included two previous cautions in person with respect to deficits in his medical record-keeping.