SUMMARY

DR. WALTER WILLIAM ROMATOWSKI (CPSO# 32386)

1. Disposition

On January 17, 2018, the Inquiries, Complaints and Reports Committee directed Dr. Romatowski (Gastroenterology) to appear before a panel of the Committee to be cautioned on his management of sedation and the monitoring of his patient during a gastrointestinal procedure.

2. Introduction

The College received information raising concerns about the dose of propofol Dr. Romatowski provided to a patient, Patient A, during an endoscopic retrograde cholangiopancreatography (ERCP), potentially contributing to the patient's death. Patient A had presented to the outpatient endoscopy clinic for an ERCP with painless obstructive jaundice. Dr. Romatowski performed the procedure, during which the patient received a significant amount of propofol. Post-procedure, the patient had respiratory and cardiac compromise leading to cardiac arrest. He was resuscitated and transferred to the intensive care unit. However, his condition did not improve over the next eight days, with evidence of anoxic brain injury related to hypotension and hypoventilation. The patient eventually died.

The Committee approved the Registrar's appointment of investigators to conduct review of Dr. Romatowski's practice, including his care in the case of Patient A.

Dr. Romatowski provided detailed responses to the investigation, including an overview of the care he provided to Patient A and a report from another gastroenterologist opining on his care. Dr. Romatowski advised that he had taken proactive steps to improve the deficiencies identified during the investigation, by taking a number of courses, and he agreed to enter into an undertaking to address the Committee's concerns regarding his practice.

3. Committee Process

As part of this investigation, the Registrar appointed a Medical Inspector to review a number of Dr. Romatowski's patient charts, interview Dr. Romatowski, and submit a written report to the Committee.

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the investigation. 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

The Committee had concerns about several aspects of Dr. Romatowski's practice, including poor documentation and inpatient follow-up visits, and providing propofol to patients during procedures without having a second physician present.

The Committee recognized that Dr. Romatowski had already completed several courses and that he no longer provided propofol to patients without an anesthetist being present. The Committee also noted that Dr. Romatowski had expressed his intention to take necessary steps to restrict and improve his practice pursuant to an undertaking. An undertaking is a voluntary, binding promise which the physician makes to the College that is posted on the public register while it is in effect. The College monitors a physician's compliance with his/her undertaking and requires proof of successful completion. Breaches may result in further action by the College.

Dr. Romatowski provided the College with a signed undertaking which indicates that:

- he will not perform any procedures in which a patient is sedated to a Ramsey Sedation Scale (RSS) of 4-6 and/or administer propofol unless an anesthesiologist is present, and that during all other procedures where his patient is sedated, he will have a qualified regulated health professional present in the room whose primary responsibility it is to monitor the patient's airway;
- he will practice under the guidance of a clinical supervisor acceptable to the College for a minimum of six months, which will include chart reviews and direct observation;
- he will successfully complete professional education as outlined in an individualized education plan; and
- he will undergo a reassessment of his practice approximately six months after the clinical supervision is completed.

The Committee was satisfied that the concerns identified in the investigation were adequately addressed with the above-noted undertaking, and that the public would be protected.

The Committee also felt that it was appropriate to issue a caution to Dr. Romatowski (as outlined above), given the MI's conclusions that Patient A's hypotension and hypoventilation (that led to the cardiac arrest and subsequent anoxic brain injury) were likely related to excessive propofol given during the ERCP, and that the case required closer monitoring and more appropriate intra-procedural supervised sedation with propofol.