SUMMARY

DR. GUNDARS EDGARS ROZE (CPSO #68164)

1. Disposition

On June 10, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required anaesthesiologist Dr. Roze to appear before a panel of the Committee to be cautioned with respect to documenting adequately, providing the correct ASA (American Society of Anesthesiologists) classifications, and not performing ASA IV level cases in an out-of-hospital premises.

In addition, the Committee ordered Dr. Roze to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Roze to:

- provide a written summary of
    - College policy #4-12, *Medical Records;*
    - the College's Out of Hospital Premises Inspection Program (OHPIP) standards for Level 2 and 3 facilities regarding required documentation for the anesthetic record; and
    - the Canadian Anesthesiology Society Guidelines to the Practice of Anesthesia (2016);
- engage in educational sessions with a clinical supervisor focused on the quality of his documentation and care, and the accuracy of the assigned ASA classification for each patient; and
- undergo a reassessment of his practice approximately three months following completion of the education plan.

Thirdly, the Committee directed that information about Dr. Roze's OHIP billing in this matter be directed to the attention of the General Manager of OHIP.

2. Introduction

In June 2015, the College's Premises Inspection Committee (PIC) raised concerns about Dr. Roze's care and management of a 78-year-old patient who underwent colonoscopy in an ambulatory clinic. Dr. Roze provided anaesthesia for the procedure.

The patient experienced abdominal pain after the procedure and was transferred to hospital for suspicion of a bowel perforation. The patient was deemed to be ASA Class IV. The PIC report expressed concern that a procedure was performed in an out-of-hospital facility on a patient that was determined to be ASA IV.

The Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Roze's practice.

3. Committee Process

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

The Surgical 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

Based on its review of the MI's report, the Committee had concerns regarding Dr. Roze's practice. The MI found that, in 12 out of 35 charts, the patient history and health status were inconsistent with Dr. Roze's use of the ASA Class IV category. In addition, the MI identified a lack of proper charting in 34 out of the 35 charts reviewed that made it difficult to comment on the overall quality and safety of the anaesthesia care Dr. Roze provided.

The MI report included the following conclusions:

- Patients deemed to be ASA IV and above are not generally acceptable for anesthesia care in out-of-hospital premises and should be referred for care in a hospital facility.
- There were several incidences of questionable ASA classification of patients to whom Dr. Roze provided anesthetic care.
- Dr. Roze frequently failed to document pertinent clinical information on the anaesthetic record, including the patient's height and weight, intravenous (IV) placement, IV fluids administered, the presence of EKC monitoring, the administration of supplemental oxygen, and oxygen saturation. In addition, Dr. Roze routinely neglected to document vital signs and the specific doses and timing of Propofol.

Dr. Roze acknowledged the deficiencies in his record-keeping, which he attributed to the need to maintain constant vigilance over the patient's condition throughout the procedure, which takes time away from precise record keeping.

Dr. Roze remarked on the MI's opinion that he knows the difference between ASA III and IV and that his care generally appeared to meet the standard. He stated that while the MI might have categorized some patients differently, the important thing is that he applied the appropriate treatment and that his patients were at no risk of harm.

The Committee rejected Dr. Roze's position that thorough documentation is unrealistic in a busy facility. Furthermore, the Committee is of the view that adequate charting is vital to safe anaesthetic care and that one is using too low a standard to determine that anaesthetic care is safe solely on the basis that the patient survived the procedure.

The Committee was concerned that Dr. Roze appeared to be more interested in completing the maximum number of procedures and maximizing billing by inappropriately classifying some patients as ASA IV, rather than providing safe, thoughtful care and charting the required elements.

Consequently, the Committee decided that the three-part disposition described above was warranted.