File # 15-CRV-0793

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Taivi Lobu, Vice-Chair, Presiding
Sheldon Cohen, Board Member
Norma Grant, Board Member

Review held on October 11, 2016 at Toronto, Ontario

IN THE MATTER OF A COMPLAINT REVIEW UNDER SECTION 29(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act*, *1991*, Statutes of Ontario, 1991, c.18, as amended

B E T W E E N:

A.P.

Applicant

and

G.E.N., MD

Respondent

Appearances:

The Applicant:	A.P.
For the Respondent:	Sara Kushner, Counsel
For the College of Physicians and Surgeons of Ontario:	Gail Buss (by teleconference)

DECISION AND REASONS

I. DECISION

1. It is the decision of the Health Professions Appeal and Review Board to confirm the decision of the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario to take no further action.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by A.P., (the Applicant) to review a decision of the Inquiries, Complaints and Reports Committee (the Committee) of the College of Physicians and Surgeons of Ontario (the College). The decision concerned a complaint regarding the conduct and actions of G.E.N., MD (the Respondent) in caring for the Applicant's mother (the patient). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. The Applicant is the daughter and Power of Attorney (POA) of her late mother (the patient). She accompanied her mother to medical appointments, advocated for her and was involved in all decisions regarding her mother's care.

4. The patient's medical history included non-insulin dependent diabetes, hypertension, coronary artery disease, a paralyzing stroke in 2003, DVT, end-stage renal failure requiring dialysis three times per week and dementia. The patient developed advanced uterine metastatic cancer with metastatic lesions in the liver and lungs.

5. The patient was referred to Princess Margaret Cancer Centre (PMCC) where consultation with Surgery, Internal Medicine and Anesthesia clinicians took place. In June 2013, it was decided by these clinicians that the risk of surgery outweighed the benefits. At the same meeting it was also explained to the patient and Applicant that chemotherapy would not be an option. Palliative radiation was the only option deemed appropriate by the clinicians at PMCC.

6. On August 26, 2013, the patient was taken to the emergency department at Humber River Hospital (HRH) and admitted. Daily dialysis commenced, followed after a few weeks by dialysis three times per week. Shortly thereafter the patient was discharged from hospital. She attended for dialysis three times per week.

7. The patient had a number of emergency department visits at HRH thereafter, due to weakness and "failure to thrive." On one such visit March 21, 2014, the patient was also experiencing hypotension and was admitted. During this admission it was found that the patient's uterine cancer had metastasized to her liver and lungs with moderate pleural effusion which was not symptomatic at that time. The patient and Applicant were advised by the admitting nephrologist that a thoracentesis could be considered if she became symptomatic.

8. The Respondent, a nephrologist and Physician Director and Chief of the Nephrology Program at HRH was the patient's MRP from March 31 to April 6, 2014. An oncologist at HRH began consulting with the patient on March 27, 2014. The Respondent submitted that he and the HRH oncologist advised the Applicant that neither medical nor radiation therapy were indicated.

9. On March 31, 2014, the Applicant sought a second opinion from the patient's oncologist at PMCC. The Applicant wanted to discuss: her dissatisfaction with the care the patient was receiving for her lungs at HRH; receiving palliative radiation; and an in-patient transfer to PMCC.

10. The Applicant took a CD ROM of the patient's lungs to this meeting but the oncologist at PMCC could not open it. This oncologist was not willing to initiate palliative radiation due to the risks outweighing the benefits and did not facilitate an in-patient transfer to PMCC. After this meeting, the oncologists at PMCC and HRH liaised and on April 3, 2014 the PMCC oncologist agreed to reassess the patient as an outpatient with regard to palliative radiation.

11. On April 5, 2014, the Respondent noted that the patient had developed a cough. The Respondent ordered a chest x-ray, broad spectrum antibiotics, a respirology consult and thoracentesis. Unfortunately before completion of these orders the patient's condition worsened. Nephrology staff recommended comfort measures but the Applicant wanted

full resuscitation of the patient and transfer to ICU, if necessary. The Respondent reports that the patient "passed away the following day, and then received 20 minutes of CPR."

The Complaint and the Response

12. The Applicant is concerned about the care provided to her late mother (the patient) by the Respondent in 2013-2014; specifically, she is concerned that the Respondent:

- failed to take concerns of her mother's bad cough seriously while attending for dialysis;
- failed to provide the family with an opportunity to participate in informed decisions that would have optimized the patient's life;
- failed to order a thoracentesis in a timely manner;
- actively tried to discharge the patient from hospital without support in place; and
- did not discuss the procedure with her or her mother, and did not offer or discuss suctioning the lungs as a potential option.

13. The Respondent provided a detailed response to the Applicant's concerns including the following:

- When he was advised of the patient's cough and rising white blood cell count he immediately ordered antibiotics and a chest x-ray. Upon receiving the results the following day he ordered a respirology consult and thoracentesis.
- He and other physicians raised the issue of palliative care many times and meetings and communication towards palliative care planning options were attempted. The Applicant missed the meeting with the patient's HRH oncologist, arrived late to another meeting which was organized to definitively address palliative care and did not return phone calls. "She balked at all proposed discharge options for her mother that involved a

palliative approach. She wanted to explore transfer to PMH for cancer treatment or a complex continuing care facility, even though she was advised on many occasions that this was not medically appropriate."

- By ordering a thoracentesis and consulting with the respirologist at the same time he attempted to get the patient the fastest access to the procedure.
- He, the HRH oncologist and others recommended palliative care at home since this is an option preferred by most patients. No discharge order was ever written for the patient.
- He would not have ordered thoracentesis without speaking to the Applicant about it; however, consent is usually obtained by the performing physician. The patient was never in need of suctioning.
- During her final admission to HRH the patient's cancer was metastatic and radiation was not an option.

The Committee's Decision

14. The Committee investigated the complaint and decided to take no further action.

III. REQUEST FOR REVIEW

15. In a letter dated November 21, 2015, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

16. After conducting a review of a decision of the Committee, the Board may do one or more of the following:

a) confirm all or part of the Committee's decision;
b) make recommendations to the Committee;

c) require the Committee to exercise any of its powers other than to request a Registrar's investigation.

17. The Board cannot recommend or require the Committee to do things outside its jurisdiction, such as make a finding of misconduct or incompetence against the member, or require the referral of allegations to the Discipline Committee that would not, if proved, constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

18. Pursuant to section 33(1) of the *Health Professions Procedural Code* (the *Code*), being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider either the adequacy of the Committee's investigation, the reasonableness of its decision, or both.

19. The Applicant provided written submissions prior to the Review and made oral submissions at the Review. The Respondent's counsel made oral submissions at the Review.

20. The Board has considered the submissions of the parties, examined the Record of Investigation (the Record), and reviewed the Committee's decision.

Adequacy of the Investigation

21. An adequate investigation does not need to be exhaustive. Rather, the Committee must seek to obtain the essential information relevant to making an informed decision regarding the issues raised in the complaint.

22. The Committee obtained the following documents:

- the Applicant's communications about the complaint;

- the Respondent's first response;
- the Applicant's comments on the first response;
- a second response from the Respondent;
- the Applicant's comments on the second response;
- a third response from the Respondent;
- a final response from the Applicant;
- the patient's medical records from HRH and PMCC; and
- information from a senior radiation oncologist at the PMCC who saw the patient and treated her with antibiotics.

23. At the Review the Applicant submitted that the Committee did not consider the "defamatory, speculative comments" made by the Respondent about her mental health.

24. The Applicant submitted that regardless of what her health condition was or was not, the Respondent did not conduct a professional assessment of her; he was a nephrologist and not a psychiatrist; and he erroneously characterized obtaining a second opinion as "bizarre" behavior. She was concerned that, given the Respondent's stature, his defamatory comments could be accepted as true even though they were assumptive and speculative. Furthermore, if he did believe she had a disability, she would have been entitled to some form of accommodation under the *Human Rights Code*, which he did not offer.

25. The Committee was aware of the Applicant's concern and its decision reiterated the Respondent's response, which was, "It was not his intention to provide a medical opinion regarding [the patient's] medical status and he was only trying to set out the events and context for his involvement in [the patient's] care. He apologizes if [the Applicant] was offended or upset by his comments."

26. The Board concludes this issue is outside of the main complaint considered by the Committee and did not affect the Committee's ability to investigate the Applicant's

complaints and render a reasonable decision regarding the issues raised as to the patient care provided by the Respondent.

27. The Board finds the Committee's investigation covered the events in question and yielded relevant documentation to assess the Applicant's complaint. In addition to considering the parties' submissions, the Committee appropriately considered the medical records from HRH for the duration of the patient's admission and out-patient visits, the out-patient records from PMCC and information from the consulting physicians at PMCC. The Board finds there is no indication of further information that might reasonably be expected to have affected the decision, should the Committee have acquired it. Accordingly, the Board finds the Committee's investigation was adequate.

Reasonableness of the Decision

28. In considering the reasonableness of the Committee's decision, the question for the Board is not whether it would arrive at the same decision as the Committee, but whether the Committee's decision can reasonably be supported by the information before it and can withstand a somewhat probing examination. In doing so, the Board considers whether the decision falls within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.

a) Failed to take concerns of her mother's bad cough seriously while attending for dialysis; c) failed to order a thoracentesis in a timely manner; and, e) did not discuss the procedure with her or her mother, and did not offer or discuss suctioning the lungs as a potential option.

29. The Committee found that the Respondent did take the patient's symptoms seriously and acted appropriately in a timely fashion. The Board notes that in reaching this conclusion, the Committee relied on the information appearing in the Record including the Respondent's Physician Notes of April 5 and 6, 2014, which confirm that the patient had a cough, chest x-rays and blood cultures were ordered and that a respirology consult was requested.

30. The Board notes that the Applicant states that the patient had a cough for an extended period and was upset that this had not been looked into previously. The information in the Record is that the Respondent became the MRP on March 28, 2014, and the cough was first reported to him on April 5, 2014, at which time he took immediate and appropriate action. In addition, the patient's oncologist at HRH reported on March 28 and April 2, 2014, that he explained to the Applicant that given the size of her pleural effusion therapeutic thoracentesis would be considered if she became symptomatic. Regardless of how long the patient suffered a cough, her treating physicians did not find that this symptom had progressed to the point where thoracentesis should be considered an appropriate treatment until the Respondent on April 5, 2014, initiated the testing which led to the decision to order this procedure.

31. The Applicant's complaint that the Respondent did not discuss or explain the procedure to her was contested by the Respondent who suggested that he would not have ordered the procedure without discussing it with her. He further stated that consent is usually obtained by the physician performing the procedure which would not have been the Respondent.

32. The Board observes that there is no documentation of a discussion between the Applicant and Respondent confirming an explanation of thoracentesis. However, the Board notes the patient's treating oncologist at HRH in his Patient Notes from March 28, 29, 30 and 31, 2014 states, "Patient appeared comfortable. If worsening SOB [shortness of breath] from enlarging effusion, may consider therapeutic thoracentesis at that time" and a Consultation Report from April 2, 2014 stating, "I have also mentioned that given she has a moderate sized pleural effusion, therapeutic thoracentesis can be considered in the future, if she becomes symptomatic." The Respondent and the patient's family physician were both copied on the above reports.

33. Regarding suctioning as a separate procedure than thoracentesis, the Committee in its decision commented that the Applicant might have mistaken sucking fluid from the

pleural space for suctioning, and noted that this would not be appropriate for a conscious patient.

34. The Board finds there was support in the medical records for the Committee's decision to take no action on these aspects of the complaint.

b) failed to provide the family with an opportunity to participate in informed decisions that would have optimized [the patient's] life; and, d) actively tried to discharge [the patient] from hospital without supports in place.

35. The Applicant expressed that she was not informed that the patient's status was palliative and that the family was not presented with a palliative care plan, end of life discussions or realistic hospital discharge options. The Applicant submitted that this was the state of affairs up until the last week of the patient's life when the Respondent, a HRH social worker and the patient's HRH oncologist began to make this diagnosis clear and initiated imminent discharge intentions for the patient.

36. The Respondent submitted that the Applicant did not make herself easily available for planned family and staff meetings, resisted the advice of her treating physicians and staff in favour of her hope that aggressive treatment would be offered even though she was repeatedly told by her clinicians at PMCC and HRH that such treatment was not appropriate for the patient, based on her clinical presentation. The Respondent stated that no discharge or transfer order was ever formalized or demanded. He explained that discharge is always contingent on the patient's medical stability and prognosis. Furthermore, if a patient is physically stable but palliative, it is often preferable for them to confront the end of life at their home or in a palliative care environment as opposed to in an acute care bed in hospital.

37. The Committee found that the Applicant "did not accept the palliative status of her mother and therefore meaningful end of life discussions would have been difficult." The Committee concluded that the Applicant "resisted many options of supportive care only, but rather wanted discharge dialysis and other options." It found that the Respondent and

staff at both PMCC and HRH, who worked collaboratively on the patient's oncological care, had discussed palliative care with the Applicant. Additionally, the Committee noted that no discharge order was ever given and the patient remained "Full Code."

38. The Board observes from the Record that in July 2013, clinicians at PMCC reported that surgery and chemotherapy were not appropriate in the patient's case, her cancer was not "curative" and if the symptoms worsened, they would proceed with palliative treatment. By November 2013, the patient's primary oncologist at PMCC explained to the Applicant that palliative radiation was no longer indicated as beneficial based on the patient's condition, rather, antibiotic treatment would be more beneficial. It is clear that the patient's symptoms progressed from advanced uterine cancer in November 2013 to metastasis of the liver and lungs by March 2014.

39. The patient was assigned another MRP, a respirologist at HRH, on April 8, 2014 who stated, "I explained to her daughter [the Applicant] that if we believe she is symptomatic from the point of view of her effusion, insertion of a small-bore chest tube would effect some degree of palliative benefit. I then participated with Dr. Hercz in which we both explained that the provision of ICU care to this unfortunate woman would not alter her prognosis and really from my perspective would prolong her suffering. I have strongly advocated against this." The Applicant did not take this advice. The Respondent noted that the patient passed away the next day after receiving full resuscitation and transfer to ICU where she received CPR for twenty minutes after passing.

40. The Record confirms that the Applicant had notice from many sources that the patient's cancer was not curative, severe and spreading and that palliative care was indicated. From March 21 to April 8, 2014, the rate at which the patient's cancer progressed increased. The Applicant submitted that her mother wanted to fight her disease aggressively and was not concerned with the risks if there was any chance. The Board recognizes how difficult this period must have been for the Applicant who was dedicated to advocating for her mother in her struggle with cancer.

41. The Board observes that on March 27, 2014 the patient's oncologist stated in his Consultation Report that, "I have discussed with her daughter in terms of her diagnosis, prognosis and treatment options. I have informed that her condition is not curative with a poor prognosis. Palliative management is recommended with the focus on symptom control…The application for palliative care unit is also recommended." On April 2, 2014, the same physician wrote, "Meeting with daughter 8:40 to 9:00am. Counselled on diagnosis in range of weeks to few months." He also charted the next day, "Discussed recommendations of palliative management with PMH team and daughter." On April 1, 2014, the Respondent charted "No viable treatment options. Family has questions for oncology. Family meeting tomorrow." In all cases the Respondent was copied and the Record shows that the Respondent worked within a team caring for the patient, which included the oncologist, respirologist and social worker amongst others.

42. In light of all of the above the Board finds the Committee considered the information in the medical record, and there is no indication in the Record that the Committee inappropriately applied its expertise in considering these aspects of the complaint.

VI. DECISION

43. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to take no further action.

ISSUED February 24, 2017

"Taivi Lobu"

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Taivi Lobu

"Sheldon Cohen"

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Sheldon Cohen

"Norma Grant"

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Norma Grant