File # 22-CRV-0055

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Anna-Marie Castrodale, Designated Vice-Chair, Presiding
Timothy P. D. Bates, Board Member
Cathy Loik, Board Member

Review held on October 11, 2022 in Ontario (by teleconference)

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:

DH

Applicant

and

RYAN A. D'SA, MD

Respondent

Appearances:

For the Respondent: Jonathan McDaniel, Counsel

DECISION AND REASONS

I. DECISION

1. The Health Professions Appeal and Review Board confirms 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 DH (the Applicant) to review a decision of the Inquiries, Complaints and Reports Committee (the Committee or the ICRC) of the College of Physicians and Surgeons of Ontario (the College). The decision concerned a complaint regarding the conduct and actions of Ryan A. D'Sa, MD (the Respondent). The Committee investigated the complaint and decided to take no further action.

3. The Board issued a publication ban in this matter. This decision is subject to that order.

II. BACKGROUND

4. The Applicant's father (the patient) was admitted to Sunnybrook Health Sciences (Sunnybrook) in April 2021 after becoming infected with COVID-19.

5. The patient was diagnosed with pneumonia and on April 27, 2021 was transferred to the intensive care unit of the Niagara Health System, St Catharines General site (St Catharines General). The Respondent was one of five physicians who provided care to the patient in the intensive care unit (ICU).

6. Sadly, the patient passed away on May 23, 2021. The post-mortem examination revealed the cause of death to be fatal acute intracranial hemorrhage and underlying cerebrovascular disease, focal acute subdural hematoma and severe COVID-19 lung changes.

The Complaint and the Response

The Complaint

7. The Applicant is concerned that the Respondent failed to provide appropriate care to the patient during the patient's ICU admission at St Catharines General in 2021. Specifically, the Applicant complained that the Respondent:

- told the family he would not resuscitate the patient if required;
- over-sedated the patient;
- refused to permit the family to visit;
- refused to perform a tracheostomy; and
- was unprofessional in his approach toward the family.

8. The Applicant added context to her complaint including the following:

- "The Respondent said my father is like a fish out of water?, like a dog on a highway, won't make it, won't survive"; and

- "Nobody in 3 weeks ever mentioned he had blood clots. They came out of nowhere. I believe my father was targeted because he was 80. I need justice. My family was treated with disrespect. They never even did a tracheostomy surgery on him to try and save him, they kept delaying it. They never did their best to save him. They let him suffer and die needlessly. They kept having an excuse that the specialist was not available for days. I believe they are hiding something. I need his medical records obtained and these doctors should not be allowed to do this to family. They caused me mental, physical and emotional pain."

The Response

9. The Respondent provided a written response to the complaint. He offered his condolences on the passing of the patient whom he described as a lovely gentleman. He provided a summary of his education and professional experience and his current practice.

10. The Respondent set out the patient's history, noting that he was an 80 year-old man who had COVID-19 pneumonia, and information regarding his admission at Sunnybrook and his transfer to St Catharines General.

11. The Respondent summarized the care provided to the patient at St Catharines General, making specific references to the medical records, including the information which follows.

    - On admission on April 27, 2021, the patient was intubated, fully ventilated and not breathing above the ventilator.
    - The patient experienced a very short-lived period of improvement and then began decompensating. On April 30, 2021 the Respondent was on service in the ICU and phoned the Applicant to discuss the patient's decompensation and the potential therapy options. The Applicant would not consider palliation and was unable to understand why the patient was decompensating. The Respondent attempted to explain using an analogy of a battle.

- On May 7, 2021, a leg doppler revealed occlusive thrombosis. The patient was given anticoagulant medication to treat the deep vein thrombosis (DVT) beginning on May 8, 2021.
- On May 10, 2021, a tracheotomy was considered. The otolaryngology (ENT) consult noted that the patient was a good candidate for a bedside tracheotomy and recommended waiting to discuss the timing of proceeding with the ICU team.
- The viability of a tracheostomy was dependent on the patient's oxygen requirements, his location in the "extended" ICU in the post-anaesthetic recovery room (PARR), where they could not facilitate a bedside tracheostomy due to the aerosol generating nature of the procedure, and his prone positioning.
- Between May 9 and 16, 2021 the patient was assessed by two other ICU physicians BT, MD (Dr BT) and JT, MD (Dr JT). Over this time, the patient did not improve. They spoke with the Applicant and the patient's family.
- For example, Dr BT called the Applicant with the patient's grave prognosis and recommended no cardiopulmonary resuscitation (CPR), ongoing medical treatment, and review if the patient deteriorated further. The Applicant communicated that the family would like to continue full code and that they felt overwhelmed. The family accused the ICU team of stopping therapy without consent and transferring the patient from ICU to ICU.
- The Respondent's ICU colleagues concluded that the patient was unlikely to survive. They attempted to relay this information to the Applicant on multiple occasions but were met with disbelief and resistance.
- On May 17, 2021, the Respondent rotated back onto service. The patient continued to decompensate and despite a ventilator, he was gasping for oxygen. The Respondent relayed to the Applicant that the patient would feel like a "fish out of water" so that she might be able to understand the extent of the patient's clinical condition and his struggle to breathe.
- On May 18, 2021, a CT scan showed a brain hemorrhage. The neurological consultation revealed that the hemorrhage was catastrophic and suggested palliation and withdrawal of life sustaining therapies.

- The patient was actively dying and at this point, there were no therapies that would prevent his death.
- The Respondent subsequently changed the status of the patient to Do Not Resuscitate (DNR).
- Immediately after this consultation the Respondent phoned the Applicant to relay the sad news. The Respondent said that the tracheostomy was suspended as it would be of no benefit and suggested withdrawal of life sustaining therapies.
- The Applicant was initially fixated on why the Respondent had cancelled the tracheostomy, and then asked the Respondent what he injected into the patient to "kill him".
- As the ICU team did not have consent to withdraw life sustaining therapies, all active therapies continued.
- On May 19 and 20,2021, the ICU attempted to contact the family through a Skype meeting, which the family did not attend and phone calls that went to voicemail. The Respondent left a message that the patient was dying and that they could facilitate the family visiting to support him in his last stages of life.
- Later on May 20, 2021, the Applicant and her sister phoned. The Respondent relayed that the patient was dying and that they could facilitate a visit. Instead, the Applicant and her sister remained fixated on the patient's stroke and how they perceived that the Respondent had induced it and asked for the medical records. The Respondent offered a face to face meeting.
- By May 21, 2021, the patient's overall prognosis was extremely guarded, and comfort care measures were recommended.
- The ICU team scheduled a family meeting by phone with the patient's son. It was explained that that the patient's chance of survival was zero and that he could pass overnight. An offer to come in and say goodbyes was extended. The patient's son stated that he "was hoping for a miracle" and did not want the ventilator discontinued. He said he would update his sisters.
- Between May 21 to 23, 2021, the ICU team continued to provide care to patient and did not withdraw any care up until the time of his death.

12. The Respondent denied each of the complaint concerns and included the information which follows.

- He had described the sensation of High Flow Nasal Cannulae (HFNC) to the Applicant as the air hitting one's face akin to driving down the highway with the windows rolled down. He in no way meant to compare the patient to a dog and believes this was a misunderstanding. He relayed to the Applicant that the patient would feel like a fish out of water so she could understand how much the patient was struggling to breathe. He wanted to provide the family with an accurate view of the patient's prognosis so that they could make informed decisions regarding his care.
- The patient was diagnosed with a DVT on May 7, 2021. The appropriate treatment is to prescribe a full dose of an anticoagulant. Once the brain hemorrhage was found, they held the patient's anticoagulation medication. There was no indication that this should have been done sooner.
- He denies any prejudice against the patient due to his age. The patient's age played a role in his ability to recover but in no way impacted the Respondent's treatment of him.
- A tracheostomy was considered but ultimately ruled out due to the logistics of the patient being in the PARR, the need for prone positioning, and later, a catastrophic brain hemorrhage. Further, the patient's oxygen demands were not ideal for a tracheostomy.
- The patient's chart is well-documented and records the actions that the Respondent and the ICU team took to care for this patient. This was an incredibly difficult case, which the Respondent will continue to reflect on and consider whether his practice, including family relations, can be improved upon in any way. The Respondent is confident that his care was reasonable and that he has been and always will be, forthcoming and transparent.

13. The Respondent concluded that he will carefully consider no longer using analogies to describe his patients' conditions. He will continue to ensure that his communications with patients and their families are tactful, transparent, and fulsome at all times.

Additional Information from the parties

14. Counsel for the Respondent also submitted a report by Mark Crowther, MD, a hematologist and internal medicine specialist, and a Professor and Chair of the Department of Medicine at McMaster University. Dr Crowther described his principal research and clinical interests as benign hematologic diseases including thromboembolism. He noted the records he reviewed, including the patient's medical records from St Catharines General. He opined as follows:

> In summary, [the patient] suffered acute venous thromboembolism despite the use of appropriate preventative strategies, was treated with an appropriate dose of anticoagulation for his acute venous thromboembolism and suffered a rare and unpredictable complication of this treatment. The treatment this patient received was completely consistent with my understanding of the standard of care.

15. The Applicant sent a series of brief emails to the College. They included the following information.

- "They gave my father [the patient] albumin, blood thinners, diuretics ... i don't even know what these are and if he needed them."
- "My mother told me to remind you that my late father told her they stopped giving him feeding tube and his mouth was so dry filled with bacteria"
- "Even [the Respondent] that always wanted my dad dead never worked late at night but that week was with my dad for 5 full nights just so he won't save him and ended up killing him Saturday night. they even moved him to palliative care without telling us and hide it"
- "They even made him have difficulty swallowing by messing with his brain."
- "I have obtained autopsy results of my father and believe he was medically abused. the coroner agreed the medications given might have led to his brain stroke" they gave my father fentaNYL and medications physcotic for example (to treat schizophrenia) they made my father's blood pressure so high that he died of brain bleeding …. i believe he died of drug abuse and medical negligence."

- "I also noticed in the records they stopped the blood thinner which led to his death. Why would they stop it?"
- "They also poison him with extra oxygen because he was talking to us fine and was ready to be discharged then they started increasing his oxygen demand which caused further damage to his lungs."

16. The Respondent provided an additional response. He noted that invasive sedation is the standard of care for hypoxaemia. He addressed the ICU team's use of narcotics and anti-psychotics, noting their goal was minimum sedation and that anti-psychotics are used with a view to withdrawing patients from narcotics. He noted that the ICU team recognized and addressed the patient's low blood pressure. Finally, he explained that albumin was used as it serves in resuscitating the patient.

The Committee's Decision

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

III. REQUEST FOR REVIEW

18. In a letter dated February 2, 2022, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

19. 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.

20. 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 specified allegations to the Discipline Committee that would not, if proved, constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

21. 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.

22. In conducting this complaint review, the Board assesses the adequacy of an investigation and the reasonableness of a Committee decision in reference to its role and dispositions available to it when investigating and then assessing a complaint filed about a member's conduct and actions.

23. In this regard, the Committee is to act in relation to the College's objectives under section 3 of the *Code*, which include, in part, to maintain programs and standards of practice to assure the quality of the practice of the profession, to maintain standards of knowledge and skill and programs to promote continuing improvement among the members, and to serve and protect the public interest.

24. The Committee's mandate is to screen complaints about its members. The Committee considers the information it obtains to determine whether, in all of the circumstances, a referral of specified allegations of professional misconduct to the College's Discipline Committee is warranted or if some other remedial action should be taken. Dispositions available to the Committee upon considering a complaint include taking no action with regard to a member's practice, issuing a caution or directing other remedial measures intended to improve an aspect of a member's practice or referring specified allegations of professional misconduct or incompetence to the Discipline Committee, if the allegations are related to the complaint.

25. The Applicant did not attend the Review. There is no legislative requirement for a party to attend a review and the Board draws no inference from the Applicant's non-attendance.

26. In her request for the Review, the Applicant made submissions, which are summarized below.

- The Respondent said that the patient got the DVT from Sunnybrook but the ICRC decision says that he got in on May 7, 2021, while at St. Catharines General. She asked "Why the lie?
- A hospital in Vaughan said they would transfer the patient and do his surgery, yet the Respondent declined. She had been told that if she found a hospital willing to accept transfer, they would allow it. The day she asked for a transfer, the patient suffered a "life ending stroke."
- She queried why they were giving the patient neuro-blocking agents (NBA) so that he could not be weaned off sedation. The goal was for the patient to be weaned off to do a "trach" but they kept chemically paralyzing him."

27. Counsel for the Respondent submitted that the Committee's investigation was adequate and its decision reasonable, directing the Board's attention to information in the Record, previous decisions of this Board including *Kadri v Shahideh*,[1]and the Supreme Court of Canada's decision in *Canada (Minister of Citizenship and Immigration) v Vavilov*[2] in support of his submissions.

28. Counsel addressed the Applicant's request for review. With respect to the allegation that the Respondent told her that the patient got the DVT from Sunnybrook, he noted that this is not borne out by the Record which indicates that the DVT was discovered on May 7, 2021 while the patient was at St Catharines General. Secondly, Counsel submitted that the issue of transferring the patient to another hospital was considered by the Committee, and addressed in the Record including in the Respondent's consult notes where he wrote that the repatriation of COVID-19 patients had been halted by the Ontario Covid-19 Critical Care Command Centre. Finally, he submitted that the issue of sedation was fully considered by the Committee.

[1] 2022 CanLII 55781 (ON HPARB)
[2] 2019 SCC 65 (CanLII), [2019] 4 SCR 653

29. 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

30. 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.

31. The Committee obtained the following documents:

- the Applicant's letter of complaint;
- a memorandum of a telephone call confirming the Applicant's complaint;
- the Respondent' response;
- the report of Dr Crowther;
- the Report of Postmortem examination;
- the patient's medical records from Sunnybrook Health Sciences Centre;
- the patient's medical records from, St Catharines General;
- email correspondence from the Applicant;
- an additional response from the Respondent;
- CPSO Policy *Prescribing Drugs*;
- CPSO Policy *Planning for and Providing Quality End-of-Life Care*; and
- the Respondent's physician profile and prior decisions with the College.

32. The Board notes that the Committee obtained the Applicant's complaint, confirmation of her complaint and subsequent communications to the College, the Respondent's response and additional response, a report from Dr Crowther, the postmortem report and the patient's relevant medical records. The parties were offered an opportunity to provide information to the Committee and both did so.

33. The Board finds the Committee's investigation covered the events in question, and that it obtained relevant information to make an informed decision regarding the issues raised in the complaint.

34. 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 that the Committee's investigation was adequate.

Reasonableness of the Decision

35. In determining 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. Rather, the Board considers the outcome of the Committee's decision in light of the underlying rationale for the decision, to ensure that the decision as a whole is transparent, intelligible and justified. That is, in considering whether a decision is reasonable, the Board is concerned with both the outcome of the decision and the reasoning process that led to that outcome. It considers whether the Committee based its decision on a chain of analysis that is coherent and rational and is justified in relation to the relevant facts and the laws applicable to the decision-making process.

36. The Board notes that the internal medicine panel of the Committee considered this matter.

Concern that the Respondent told the family he would not resuscitate the patient if required

37. The Committee found that it was apparent from the medical record that the physicians involved in the patient's care had many discussions with the family about the patient's poor prognosis, and that the physicians advised the family that the patient's condition was critical and he was unlikely to survive.

38. The Committee noted as follows:

    i) The Respondent changed the patient's status to DNR on May 18, 2021, by which time the patient had experienced a catastrophic brain hemorrhage and it was the Respondent's clinical judgment that it would have been futile to attempt to resuscitate him;

    ii) The Respondent indicated that he telephoned the Applicant to deliver the news about the DNR status, but she was fixated on the fact that he had cancelled the tracheostomy and had injected something into the patient to "kill him";

iii) A Skype meeting was arranged for the following day to discuss the situation with the family, but the family did not attend;

iv) The Respondent stated that telephone calls to the Applicant and her brother on May 20 went straight to voicemail; and

v) The care team tried to convey to the Applicant's brother on May 21 that the patient's chance of survival was zero.

39. The Committee found that there was no way for the Respondent to keep the patient alive once he began to decompensate; nevertheless, and despite the DNR status, the physicians provided active therapies to the patient up to the day of his death because there had been no agreement to withdraw support. Moreover, the Committee noted that the Respondent was not the physician in charge of the patient's care on the last day of his life.

40. The Committee was satisfied by its review of the medical record that the Respondent's care of the patient was appropriate and found that he clearly had difficulties discussing the patient's impending death with the family because they were understandably upset and may have been avoiding the Respondent's calls.

41. The Committee decided to take no action. The Committee commented that it is important for physicians to discuss DNR orders with families when patients are nearing the end of life and that when families are not answering the phone, it is sometimes reasonable to send the police to provide notification.

42. Counsel for the Respondent noted that the Committee summarized the relevant records and observed that the physicians were still giving active life support therapies up to the time of the patient's death despite the DNR order, which he submitted simply means that CPR will not be given. He directed the Board's attention to the CPSO Policy *Planning For and Providing End-of-Life Care* in the Record which distinguishes a no-CPR order from an order to withdraw life-sustaining treatment.

43. The Board has considered the information in the Record and finds support for the Committee's conclusion that there was no information to support this complaint concern.

44. The Board notes that in considering this complaint concern the Committee applied its knowledge and expertise related to the expected standards of practice in assessing the Respondent's conduct and actions.

45. The Board notes that the Committee's decision makes specific and frequent reference to the information in the Record. For example, the Committee referred frequently to the patient's medical records and the Respondent's response regarding the patient's medical status, the active therapies provided to the patient up until the time of his death and the Respondent's efforts to communicate with the Applicant and the patient's family about the patient's impending death. In the Board's view, this contemporaneous documentation is presumptively reliable and supports the Committee's decision to comment on the importance for physicians to discuss DNR orders with families and to take no further action.

Concern that the Respondent over-sedated the patient

46. The Committee noted that sedation is required and appropriate for a ventilated patient and that it had no concerns with the amount of sedation the Respondent ordered for the patient.

47. The Board notes that the Committee applied its knowledge and expertise related to the expected standards of practice in assessing the Respondent's conduct and actions with respect to sedation of the patient, and in determining that it had no concerns. The Board finds the Committee's decision to take no further action regarding this aspect of the complaint to be reasonable.

Concern that the Respondent refused to permit the family to visit

48. The Committee observed that there were strict rules for visitation in place in Ontario acute care hospitals at the time of the patient's hospitalization. Under these rules, which were required because of the COVID-19 pandemic, the family was not permitted to visit the patient in the ICU. When the patient neared the end of his life, the rules were relaxed, and the family was invited to visit. The Committee sees no basis for action on this area of concern.

49. The Board notes that once again in considering this complaint concern, the Committee relied on its knowledge and expertise related to the expected standards of practice in assessing the Respondent's conduct and actions.

50. The Board notes that the Committee referred to specific information in the medical record regarding inviting the patient's family to visit near the end of his life. The Board finds that the information in the Record regarding attempts to contact the patient's family by the Respondent and others to facilitate a visit before his death supports the Committee's determination that there was no basis for action on this complaint concern.

Concern that the Respondent refused to perform a tracheostomy

51. The Committee observed that it was apparent from the medical records for May 13 and 17, 2021 that the care team considered performing a tracheostomy procedure on the patient and ultimately determined that tracheostomy was not appropriate given that the patient was being positioned frequently in the prone position to help improve his breathing. The Committee took no exception to this clinical judgment.

52. The Board notes that the Committee relied on its expertise and knowledge in assessing this complaint concern and referred to specific information in the Record regarding the appropriateness of a tracheostomy for a patient frequently in the prone position. The Board finds that this information supports the Committee's determination that it took no exception to the Respondent's clinical judgment in this instance.

Concern that the Respondent was unprofessional in his approach toward the family

53. The Committee noted that the Applicant expressed concern that the Respondent referred to her father as a fish out of water and a dog on the highway, and had stated that the Respondent was abrupt, unkind and did not see her father as a human being.

54. The Committee further noted that the Respondent explained that the Applicant misunderstood some of the analogies he used to try to convey to her how her father was struggling, and that he emphasized that he did not mean to compare the patient to a dog or a fish and found the patient to be "a lovely man".

55. The Committee noted that it conducts a review of documentation only and has no real way to determine the nature of a physician's communication when the parties have provided differing versions of events, as in this case. With no information to support the Applicant's concern that the Respondent's approach to the family was unprofessional in any way, the Committee was not prepared to take action.

56. The Board notes that the Committee generally conducts a review of documentation. It acts as a screening body and has limited ability to make credibility determinations. The Committee was unable to determine the nature of the Respondent's communications and interaction with the Applicant in the absence of independent information to corroborate what occurred. Where the Committee could not find information to support the allegations of unprofessional behaviour, it decided to take no further action. The Board finds that the Committee's decision is reasonable.

Additional concerns

57. The Committee noted that the Applicant made additional submissions to the College in which she raised further concerns with the College about the Respondent's care. These concerns included that the medications her father received led to a brain stroke, that her father died of a drug overdose and that the Respondent wanted her father dead so he would not have to work nights. The Respondent responded to the Applicant's additional allegations in further correspondence to the College, including reviewing the medications given to the patient and why they were indicated. His initial response addressed the indications for a DNR order and his discussions with the family about discontinuing life sustaining therapies. The Committee had no concerns in this regard.

58. The Board notes that the Committee applied its knowledge and expertise in assessing the Respondent's conduct and actions regarding these additional concerns.

59. The Board notes that as set out above the Committee made frequent reference to information in the patient's medical record and reviewed in detail the care provided by the Respondent to the patient.

60. Additionally, the Board notes that the Committee referred to the opinion of Dr Crowther and quoted his conclusion including, "The treatment this patient received was completely consistent with my understanding of the standard of care."

61. Accordingly, the Board finds it reasonable that the Committee took no action on these additional concerns.

Conclusion

62. In conclusion, the Board notes that the Committee applied its knowledge and expertise related to the expected standards of the profession when assessing the Respondent's care of the patient and his interactions with the Applicant and her family.

63. The Board finds that the Committee's disposition to take no further action is based on the information in the Record. In addition, the Board finds that there is a logical and rational line of analysis from the information contained in the Record to the Committee's disposition and accordingly, that the Committee's decision is reasonable. The Committee's decision demonstrates a coherent and rational connection between the relevant facts, the outcome of the decision and the reasoning process that led it to that outcome, and its decision as a whole is transparent, intelligible and justified.

VI. DECISION

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

ISSUED October 27, 2022

Anna-Marie Castrodale

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Anna-Marie Castrodale

Timothy P. D. Bates

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Timothy P. D. Bates

Cathy Loik

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Cathy Loik

Cette décision est aussi disponible en français. Pour obtenir la version de la décision en français, veuillez contacter hparb@ontario.ca