File # 15-CRV-0488

**HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**



PRESENT:

Lorne Sossin, Designated Vice-Chair, Presiding
Beth Downing, Board Member
Douglas Kearns, Board Member

Review held on May 17, 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:**

**E.W.**

Applicant

and

**M.G.C., MD AND D.J.L., MD**

Respondents

Appearances:

| | |
|---|---|
| The Applicant: | E.W. |
| Counsel for the Respondent: | Erica Baron and Christine Wadsworth |
| For the College of Physicians and Surgeons of Ontario: | Pearl Wood and Lisa Brown (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 issue a written caution to M.G.C., MD and D.J.L., MD on their failing to ensure proper communication with the patient's SDM when a

"Full Code" status was being changed to a DNR order, and to require that they provide the Committee with a written report, including statements about what they have learned, whether/how the relevant policies at their hospital have been reviewed in light of this case, and reflecting on how their own practices will change in the future.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by E.G.J.W. (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 M.G.C., MD and D.J.L., MD, (the Respondents) in their care of the Applicant's father, D.G. (the patient). The Committee investigated the complaint and decided to issue a written caution to both Respondents as indicated above and to require a written report.

## II. BACKGROUND

3. This is the Applicant's request for a third review of decisions of the Committee, involving a DNR order made by the Respondents which the Applicant did not know about and to which she would not have agreed.

4. The patient had a past medical history significant for end-stage kidney disease, coronary artery disease, atrial fibrillation, type II diabetes, peripheral vascular disease, bilateral toe gangrene and had been on maintenance dialysis since 2006.

5. The Applicant is a registered nurse and was the patient's daughter and Substitute Decision Maker (SDM).

6. On July 29, 2008, the patient was transferred to Sunnybrook Health Sciences Centre (SHSC) for comprehensive care due to his increased vascular needs and dialysis requirements.

7. On August 28, 2008, a "Do Not Resuscitate" order ("DNR") was completed at a family meeting.

8. On September 17, 2008, the patient's legs were amputated above the knee and he was placed in the Intensive Care Unit (ICU) post-operatively. Prior to surgery, his status was changed to "Full Code" at the Applicant's request, because of her concern that her father's intra-operative and post-operative care in relation to the upcoming surgery might be compromised by his DNR.

9. On September 22, 2008, Dr. C., the critical care staff physician member of the Rapid Response team assessed the patient, and along with Dr. L. co-signed the following orders in the chart: "do not attempt resuscitation in the event of cardiorespiratory event. No transfer to ICU".

10. The change in code status was made without input from the Applicant. Dr. C. called the Applicant and left a message that did not allude to the change in her father's status.

11. On September 22, 2008, the Applicant came to the hospital to visit her father where she witnessed him in respiratory distress. According to the chart records, no medical interventions were made to save the patient, despite the Applicant's pleading for help and her own efforts of placing an "ampubag" on the patient. She requested an urgent dialysis which was not done. Her father passed away later that day.

**The Complaint and the Response**

12. The Applicant initially complained about four physician Respondents, but only requested that the Board review the Committee's decision in relation to Drs. C. and L. She expressed many concerns about the patient care received from the Respondents following his surgery on September 17, 2008.

13. More specifically, with respect to Dr. C., the Applicant was concerned that he:

- did not inform the Applicant that her father was deteriorating;
- wrote a DNR order on the patient's chart without the Applicant's consultation or permission; and
- refused the patient resuscitative treatment on September 22, 2008.

14. The Applicant complained that Dr. L.:

- co-signed an unauthorized DNR order and failed to follow SHSC policies regarding DNR orders;
- denied treatment, knowing that it would cause the patient's death;
- allowed an inexperienced junior resident to care for the patient without proper supervision;
- failed to adequately document a complete assessment, medical history, preoperative surgical assessment, and daily progress notes;
- failed to advocate for the patient or develop and communicate a pre/post-operative care plan that included arrangements for care and medications;
- failed to adequately manage the patient's dialysis treatment;
- failed to arrange for an ICU bed for the patient in a timely manner;
- failed to order IV infusion to be controlled by an infusion pump;
- failed to advise and make arrangements for the use of an epidural analgesic and a central line of post-operative pain control; and
- failed to adequately communicate with the Applicant.

15. In January 2010, after an investigation of the Respondents' actions (and two other physicians involved in the patient's care), the Committee concluded no further action was needed and that the Respondents had acted in a clinically appropriate way in the circumstances.

16. The Applicant sought a review of this decision before HPARB. On review, in a decision released in January, 2012, the HPARB panel concluded the Committee's decision was

unreasonable. The Board based its finding on the fact that the Committee had not considered whether the Respondents met the required standard of practice when they changed the standing order for the patient from "Full Code" to DNR without the consent of his SDM, who was the Applicant. The Board also noted that the Committee appeared not to apply the relevant sections of the *Health Care Consent Act* (*HCCA*), and the College's own policy on Decision-Making for the End of Life, together with the Hospital's policies.

17. The matter was thus returned to the Committee for further consideration. In September, 2012, the Committee issued a new decision, once again reaching the conclusion that no further action was needed in relation to the complaint against the Respondents and that the Respondents had acted in compliance with the Hospital's policies.

18. Once again, the Applicant sought a review of the decision of the Committee before HPARB. In a decision dated August 28, 2014, once again, HPARB concluded the Committee's decision was unreasonable. The Board noted that the Committee had given too little consideration to the *HCCA*, its requirements of consent, and its dispute resolution mechanisms.

**The Committee's Decision**

19. With the matter returned once again to the College, the Committee, in its decision of May 21, 2015, reached a different conclusion.

20. While the Committee concluded that the actions of the Respondents met the standard of practice with respect to their clinical judgment, the Respondents failed to discharge their responsibility to communicate with the Applicant as the SDM for the patient about the proposed change to the standing order from "Full Code" to DNR.

21. The Committee observed that while the legal position surrounding these circumstances, as it existed in 2008, was presented as "black and white," it appeared to them more as

"grey." The Respondent's obligation to communicate with the Applicant prior to initiating any change in treatment, however, was clear from the College's own policy regarding decision-making for the end of life.

22. In its decision, the Committee noted that the facts are not in dispute, and well-documented. The Committee referred to the following additional factors:

- As is noted by Drs. C. and L.'s counsel, before referring a specified allegation to the Discipline Committee, this Committee is to consider whether it is appropriate to employ other remedial action in relation to concerns raised in order to adequately protect the public's interest.

- In *Reyhanian v. Health Professions Appeal and Review Board* [2013] OJ. No. 1292, the Divisional Court stated that the Committee is entitled to take a critical look at the evidence before it, to determine whether a referral to the Discipline Committee is warranted. The Committee is not required to refer a matter simply because it raises serious or important issues. In *Re Matheson and College of Nurses of Ontario* 27 O.R. (2D) 632, the Court of Appeal stated that the Committee's power to refer an individual to the Discipline Committee should be used sparingly.

- We recognize that the issues being addressed in this case are very serious, and we are by no means trivializing them by concluding that a referral to the Discipline Committee is not warranted on the facts of this case.

- While HPARB has indicated that the Committee should consider whether a referral to the Discipline Committee is warranted here, HPARB has not directed that such a referral be made. The Committee has fully considered (but rejected) referral.

- In our view it would not be reasonable to apply a present day lens to decisions that Drs. C. and L. made in good faith, in 2008, interpreting policy that was in place at that time.

- Counsel for Drs. C. and L. has indicated that if the physicians were non-compliant with the HCCA (and College policy) in writing the DNR order on [the patient's] chart, this was because of a good-faith misunderstanding of the requirements of the HCCA, which were, at best, unclear in 2008.

- HPARB acknowledged that a good-faith misunderstanding as to the nature of a legal duty is an important factor to consider in determining the appropriate

action to take in this matter.

- Drs. C. and L. have no relevant history with the College.

23. The Committee noted that while the case raised "a very important issue with a compelling public interest," they concluded it was appropriate to do so through a review and update of the College's end of life policy, and not appropriate to do so through a discipline proceeding against the Respondents. Its conclusion is influenced, in part, by the Committee's view that the Respondents had "reflected deeply" about the issues and focused their attention on the importance of further education about end of life issues should similar circumstances arise in the future.

24. In light of these factors, the Committee issued a written caution:

> "on failing to ensure proper communication with the patient's SDM when a "Full Code" status was being changed to a DNR order, in the particular circumstances of this case (i.e. where there had been numerous discussions between the SDM and her father's health care providers, a "Full Code" status was clearly documented on the chart, a conversation had taken place the day before where the SDM confirmed her desire for "Full Code" and she understood that this status was continuing, there had been no satisfactory attempt to discuss the change from "Full Code" to DNR with the SDM, which resulted in her attending her father's bedside and witnessing his difficult final moments as they unfolded.)"

25. The Committee further ordered that the Respondents submit 2-4 pages of "written homework" based on a careful review of the *HCCA*, "including statements about what they have learned, whether/how the relevant policies at SHSC have been reviewed in light of this case, and reflecting on how their own practices will change in the future."

## III. REQUEST FOR REVIEW

26. In a letter dated July 13, 2015, the Applicant requested that the Board review the Committee's decision.

## IV. POWERS OF THE BOARD

27. 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.

28. 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

29. 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.

30. The Board has considered the submissions of the parties, examined the Record of Investigation (the Record), the previous decisions of the Committee and the Board, and reviewed this most recent Committee's decision.

### Adequacy of the Investigation

31. 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. In this case, the adequacy of the

investigation has been confirmed twice by the Committee and twice this Board has confirmed that aspect of the Committees' decision.

32. The Applicant indicated that the adequacy of the investigation was now her "main concern," as new disclosures of the patient's medical records have brought to light new concerns. For example, the Applicant notes that her father was not in need of resuscitation as suggested by the Committee. Rather, the standard of practice considered by the Committee in relation to the complaint should have involved suction and oxygenation where a patient is in respiratory distress. Further, the Applicant believes that the Committee "cherry picked" from the documentary record and focused on the Code status rather than the appropriateness of the response of the Respondents to the medical condition of the patient.

33. The Respondents assert that it is not appropriate to raise new questions about the investigation and its adequacy at the third Board review of this matter, where such concerns were not raised earlier. Additionally, the Respondents note that the treatment issues mentioned by the Applicant in her submissions were not part of the summary of concerns circulated at the time of the original complaint.

34. While the Applicant provided detailed information from the Record to support her concerns, those concerns in the view of the Board do not relate to the investigation of the Committee, but rather to the interpretation of the Record by the Committee. In other words, the Applicant is not suggesting the Committee lacked the necessary information before it to consider the complaint, but that the Committee should have found greater concern in that Record, and should not have "cherry picked" from the information it had obtained.

35. As the Applicant did not point to new information not originally before the Committee which could might have reasonably affected the Committee's decision and led to a different outcome, the Board concludes that the investigation of the Committee was adequate.

**Reasonableness of the Decision**

36. 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.

37. The Applicant submits that the failure of the Committee to refer the Respondents to the disciplinary process of the College is unreasonable.

38. The Applicant also believes that the Committee's decision to issue written caution, together with the requirement of a brief report, was "dismissive" of the seriousness of the complaint and what the Applicant believes to be the misconduct at issue.

39. The Respondents submits that the choice of remedy for a deficiency in a physician's practice is a matter squarely within the expertise of the Committee and that the Board should defer to that expertise in these circumstances.

40. While the Applicant provided a detailed account of why she disagrees with the conclusions of the Committee, the task of the Board is not to choose between possible outcomes which the Record supports. Rather, the Board must consider the outcome chosen by the Committee and determine whether it was a possible outcome, rooted in the Record and supported by an intelligible and transparent rationale. That standard, in our view, was met in these circumstances.

41. The Committee's decision is closely rooted in the Record and reflects a clear and thoughtful consideration of the arguments and issues before the Committee. In particular, the Committee's explanation for why an educative remedy was chosen, rather than referral to discipline, is justified by several considerations, including the lack of clarity

around the previous legal and policy standards for end of life decision-making and the ongoing review of the College's end of life policy. The Committee also relied on the previous decisions of the Board in these same circumstances.

42. In light of the analysis above, the Board finds that the Committee's decision and its disposition were reasonable.

## VI. DECISION

43. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to issue a written caution on their failing to ensure proper communication with the patient's SDM when a "Full Code" status was being changed to a DNR order, and to request that they provide the Committee with a written report, including statements about what they have learned, whether/how the relevant policies at their hospital have been reviewed in light of this case, and reflecting on how their own practices will change in the future.

ISSUED October 3, 2016

*"Lorne Sossin"*

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Lorne Sossin

*"Beth Downing"*

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Beth Downing

*"Douglas Kearns"*

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