File # 22-CRV-0321

**HEALTH PROFESSIONS APPEAL AND REVIEW BOARD**

2024 CanLII 5409 (ON HPARB)

PRESENT:

Timothy P. D. Bates, Designated Vice-Chair, Presiding
Cathy Loik, Board Member
Mitchell Toker, Vice-Chair

Review held on June 22, 2023 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:**

**ALBINA EVANS**

Applicant

and

**BRIAN HUGH CUTHBERTSON, MD**

Respondent

Appearances:

For the Respondent: Sarah Kushner, 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 issue advice to Brian Hugh Cuthbertson, MD regarding the importance of clear and transparent communication with patients and/or their SDMs regarding resuscitation

wishes and clear documentation regarding those discussions, and to state its expectation that physicians ensure professional communications with patients and their SDMs and family members at all times.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Albina Evans (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 Brian Hugh Cuthbertson, MD (the Respondent). The Committee investigated the complaint and decided to issue advice to the Respondent and to state its expectation as indicated above.

## II. BACKGROUND

3. The Respondent is an attending physician in the Department of Critical Care Medicine at Sunnybrook Health Sciences Centre (Sunnybrook).

4. The Applicant's mother (the patient) was admitted to Sunnybrook on May 17, 2021, for the investigation of anemia, as well as multiple co-morbidities including rheumatic heart disease, atrial fibrillation, COPD, and previous cerebral infarcts. Her course in hospital involved an epileptic seizure secondary to newly diagnosed meningioma, coma, and respiratory failure from aspiration pneumonia.

5. The Respondent provided care to the patient as most responsible physician (MRP) from May 27 to June 2, 2021.

6. On May 28, 2021, the Respondent noted on the patient's chart "not for CPR".

7. The Applicant states that she did not agree to the "No CPR order" made by the Respondent.

8. The patient died in hospital on June 17, 2021.



2024 CanLII 5409 (ON HPARB)

## The Complaint and the Response

### *The Complaint*

9. The Applicant complained that the Respondent:

i) Failed to provide appropriate care to the patient at Sunnybrook from May 27 to June 2, 2021, in that he:

- failed to prescribe appropriate treatment for infection, seizures, and excessive fluid retention, and instead over-sedated the patient;
- insisted that the patient's ventilator be shut off, despite the patient's wishes and those explicitly stated by the Applicant, who was the patient's substitute decision maker (SDM); and
- wrote a Do Not Resuscitate (DNR) order when the patient expressed the wish to be resuscitated and the Applicant explicitly advised, as the patient's SDM, that the patient was to be resuscitated;

ii) Behaved in an inappropriate and unprofessional manner, in that he:

- refused to arrange for the patient's transfer to North York General Hospital (NYGH) at the patient's and the Applicant's request; and
- yelled at and scolded the Applicant in front of the patient for calling the hospital frequently.

### *The Response*

10. The Respondent provided to the Committee a chronological summary of his interactions with the Applicant focusing on discussions concerning life support and DNR followed by a response to each of the Applicant's confirmed concerns.

*Failed to provide appropriate care to the patient at Sunnybrook from May 27 to June 2, 2021 in that he failed to prescribe appropriate treatment for infection, seizures, and excessive fluid retention, and instead over-sedated the patient;*



2024 CanLII 5409 (ON HPARB)

11. The Respondent recounted to the Committee that the hospital records indicate that all possible infections were treated during the patient's ICU stay. However, the patient was not infected and therefore did not require antibiotics during the period in which he cared for the patient.

12. Regarding seizure treatment the Respondent stated that he did indeed treat the seizures that occurred before ICU admission and the status epilepticus that occurred in ICU.

13. Regarding diuretics and fluid retention the Respondent directed the Committee to the medical chart notes detailing the explanations provided to the Applicant as to why diuretic medications were not provided to the patient, primarily given her high vasopressor requirements.

*Insisted that the patient's ventilator be shut off, despite the patient's wishes and those explicitly stated by the Applicant, who was the patient's substitute decision maker (SDM)*

14. The Respondent stated that the hospital record and his notes made it clear that both the patient and the Applicant did not want mechanical ventilation as part of her care plan.

*Wrote a Do Not Resuscitate (DNR) order when the patient expressed the wish to be resuscitated and the Applicant explicitly advised, as the patient's SDM, that the patient was to be resuscitated*

15. The Respondent stated to the Committee that the "not for CPR" order was discussed and agreed with the Applicant on multiple occasions during the patient's care and was documented in the medical chart on multiple entries that the Applicant read.

16. In addition the Respondent stated the order was maintained in place by multiple physicians who cared for the patient after his care ended.

*Behaved in an inappropriate and unprofessional manner, in that he: refused to arrange for the patient's transfer to North York General Hospital at the patient's and the Applicant's request; and yelled at and scolded the Applicant in front of the patient for calling the hospital frequently*



2024 CanLII 5409 (ON HPARB)

17. The Respondent stated to the Committee that the patient transfer allegation is not the case.

18. The Respondent explained that at one point the Applicant raised the issue of transferring her mother's care to North York General Hospital and the Respondent told the Applicant he would do so if she felt that was appropriate but warned her that such transfers are very difficult to achieve during the COVID pandemic. The Respondent assured her that he was willing to try to meet her request while she considered her decision.

19. Subsequently, the Respondent offered to transfer the patient's care immediately to the other Critical Care Attending Physician who was working beside him on Critical Care that week. The Applicant declined this offer and became upset stating, "I had to be in charge of [my] mother's care". The Respondent therefore did not progress further with any transfer of care at the time and the Applicant did not raise the issue of a hospital transfer again.

20. Regarding the concern raised about yelling and scolding the Applicant the Respondent recounted to the Committee that during the weekend of May 29 and 30, 2021, the Applicant had started to try to gain his attention on an extremely regular basis as he went about his work on the unit caring for other patients, and indeed when he was at other patient's bedsides. This behaviour become very disruptive to the care he was offering other patients and families, as well as to the work of the unit.

21. On discussing with his nursing colleagues later that day, the Respondent found that the Applicant "phoned the ICU 7 times that afternoon" and asked to speak to the nurses about minor patient care issues.

22. The Respondent spoke to the Applicant that afternoon and asked that she try to reduce the number of calls to the unit to allow the nursing team to care for her mother, reminding her that when nurses were on the phone they weren't directly caring for her mother. The



2024 CanLII 5409 (ON HPARB)

Applicant accepted this but was tearful during this conversation.

23. The Respondent further stated to the Committee that later that evening he was called back into the hospital for an emergency at around 8 p.m. and passed the patient's bedside. The Applicant jumped into his path and attempted to ask him non-urgent questions about the patient's care and the Respondent had to be quite firm with her about the fact that he was attending a clinical emergency and she needed to let him pass so he could offer care to another patient.

24. The Respondent returned to the bedside after delivering the necessary care to the emergency patient and spoke to the Applicant. She was quite upset and said the Respondent had intimidated her by his size.

25. The Respondent stated to the Committee that he unreservedly apologized directly to the Applicant the next day as noted in the medical chart.

**The Committee's Decision**

26. The Committee investigated the complaint and decided to issue advice to the Respondent and to state its expectation as indicated above.

## III. REQUEST FOR REVIEW

27. In a letter dated February 4, 2022, the Applicant requested that the Board review the Committee's decision.

## IV. POWERS OF THE BOARD

28. 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;



2024 CanLII 5409 (ON HPARB)

b) make recommendations to the Committee;

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

29. 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 Ontario Physicians and Surgeons Discipline Tribunal that would not, if proved, constitute either professional misconduct or incompetence.

## V. ANALYSIS AND REASONS

30. 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.

31. 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

32. 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.

33. The Committee obtained the following documents:

- the Applicant's letter of complaint;
- the Respondent's response;
- memos of telephone conversations with the Applicant and the Respondent;

2024 CanLII 5409 (ON HPARB)

- email correspondence from the Applicant;
- the patient's medical records – Sunnybrook Health Sciences Centre; and
- the Respondent's College profile and prior decisions.

2024 CanLII 5409 (ON HPARB)

34. At the Review, Counsel submitted that the Committee's investigation was adequate citing the over 2000-page Record containing the medical chart maintained by Sunnybrook which included the progress notes for the patient and the Respondent's eight page response.

35. The Board finds that 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. There is no indication of additional information that, if obtained, might reasonably be expected to have affected the decision. Accordingly, the Board finds that the Committee's investigation was adequate.

**Reasonableness of the Decision**

36. 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.

37. At the Review, Counsel for the Respondent submitted that the Committee's decision to issue advice to the Respondent and to state its expectation (as noted above) and to take no further action was reasonable for the following reasons.

38. Counsel noted that the Committee included six professional members in order to thoroughly address the principal and important issue of consent to the DNR order.

39. Counsel submitted that with respect to the Applicant's concerns about infection treatment and a care plan to wean the patient off the ventilator, the Committee saw the extensive progress notes which supported the Respondent's treatment of the patient's infection and the ventilator care plan.

40. Counsel submitted that there was ample information in the medical record to indicate that the Applicant provided implied consent to the DNR order while noting the Committee's concern and advice that the medical record could have been clearer concerning consent to that order.

41. Counsel submitted that the Committee's decision to take no action concerning the Respondent's actions about a transfer was well documented and explained.

42. Finally, concerning the Respondent's communications with the Applicant, Counsel submitted that the advice to the Respondent was based on the Record, and that the Respondent accepted the Committee's findings.

43. The Applicant did not attend the Review. The Board notes that there is no legislative requirement that parties attend the Review, and the Board draws no inference from the Applicant's non-attendance.

**The Committee's Analysis**

*Failed to provide appropriate care to the patient at Sunnybrook from May 27 to June 2, 2021 in that he failed to prescribe appropriate treatment for infection, seizures, and excessive fluid retention, and instead over-sedated the patient*

44. The Committee relying on the medical record was satisfied that the Respondent provided acceptable and attentive care for all of these conditions/concerns and for



2024 CanLII 5409 (ON HPARB)

this reason, the Committee determined it would take no action on this aspect of the complaint.

*Insisted that the patient's ventilator be shut off, despite the patient's wishes and those explicitly stated by the Applicant, who was the patient's substitute decision maker (SDM)*

45. From reviewing the medical record, the Committee found that the documentation outlined the plan to wean the patient from the ventilator with no reintubation and that the Applicant was in agreement with this plan and accordingly determined that it would take no action on this concern.

*Wrote a Do Not Resuscitate (DNR) order when the patient expressed the wish to be resuscitated and the Applicant explicitly advised, as the patient's SDM, that the patient was to be resuscitated*

46. The Committee determined that the Respondent could have been more specific in his discussion with the Applicant, and more thorough in his documentation of that discussion, in regard to life support intervention decisions for the patient, including CPR. The Committee observed there was no clear information in the medical record to indicate that the Applicant explicitly agreed to a No CPR order, although her agreement seemed implied.

47. The Committee noted that consideration of the No CPR order happened over a few days, and the Respondent had the opportunity to check back with the Applicant and confirm her wishes, which did not happen.

48. The Committee noted the importance of the need for significant clarity when documenting a No CPR order, which was somewhat lacking.

49. For these reasons and taking into consideration that the Respondent has been the subject of other complaints related to end-of-life discussions resulting in advice, the Committee determined to issue advice to the Respondent that he ensure there is clear and transparent

2024 CanLII 5409 (ON HPARB)

communication with patients and/or their SDMs regarding resuscitation wishes, and that he ensure clear documentation in the record regarding such discussions.

*Refused to arrange for the patient's transfer to North York General Hospital*

50. The Committee noted that the patient's condition was poor and that NYGH would not be offering the patient anything different than what Sunnybrook could provide.

51. The Committee found that transferring the patient was neither practical nor safe. Instead, the patient was transferred to the care of another physician at Sunnybrook.

52. The Committee determined that the Respondent's actions were reasonable.

*Yelled at and scolded the Applicant in front of the patient for calling the hospital frequently*

53. The Committee noted that there were differing accounts of the interaction between the Applicant and the Respondent and that the record suggested that the Applicant created some challenges for staff as she struggled with the patient's condition.

54. The Committee concluded that the Respondent made reasonable efforts to be compassionate and communicate respectfully with the Applicant.

55. The Committee determined it would take no action but expressed its expectation that the Respondent, as all physicians, would ensure professional communications with patients, their SDMs, and family members.

**The Board's Analysis**

56. Regarding the care issues of "failed to prescribe appropriate treatment for infection, seizures, and excessive fluid retention and insisted that the patient's ventilator be shut

2024 CanLII 5409 (ON HPARB)

off' the Board will deal with these issues together as they both involve the Committee's review of the medical record.

57. The Board finds the Committee's decision to take no action regarding these aspects of the complaint to be reasonable.

58. The Board notes that, in the circumstances of the complaint, the six professional member panel of the Committee relied on its medical knowledge and expertise related to the expected standards of the profession in assessing the Respondent's conduct and actions.

59. The Committee reviewed the medical record and was satisfied that the documentation in that record, in particular the progress notes, indicated that the Respondent provided acceptable and attentive care and provided an agreed upon plan to wean the patient off the ventilator.

60. The Board will address the issue of the Do Not Resuscitate (DNR) order, which the Board considers to be the principal issue considered by the Committee. The Committee describes the DNR order to be the main aspect of the complaint.

61. The Board finds the Committee's decision to take no action but to issue advice to the Respondent as indicated above to be reasonable for the following reasons.

62. The Committee noted the importance of the need for significant clarity when documenting a No CPR order.

63. The Board notes that, in the circumstances of this case where the Committee noted that the Applicant had a difficult time supporting orders to limit resuscitation but did agree to the DNR order by implication, the Committee applied its medical knowledge and expertise to the difficult issue of implied consent to the DNR order.

2024 CanLII 5409 (ON HPARB)

64. In coming to its decision to take no action, the Committee had the benefit of a fulsome medical record and the Respondent's succinct response that "not for CPR" order was discussed and agreed upon and documented in the medical chart in multiple entries that the Applicant read and was maintained in place by multiple physicians who cared for the patient afterwards.

65. The Committee however found that the need for significant clarity when documenting a No CPR order was somewhat lacking which was the foundation for the advice provided to the Respondent. In addition, the Committee considered that the Respondent has been the subject of other complaints related to end-of-life discussions resulting in advice.

66. Finally, the Board will consider together the concern that the Respondent refused to arrange for the patient's transfer to North York General Hospital and the concern that the Respondent yelled at and scolded the Applicant in front of the patient for calling the hospital frequently as these concerns relate to what the Committee described as the professional behaviour of the Respondent.

67. The Board finds the Committee's decision to take no action with respect to both concerns, other than to state its expectation, to be reasonable.

68. The Board notes that the Committee applied its medical knowledge and expertise to its consideration of the Applicant's concern about the requested transfer noting the circumstances of the pandemic and noting that NYGH would not be offering the patient anything different than Sunnybrook could provide, concluding that transferring the patient was neither practical nor safe.

69. Regarding the concern that the Respondent yelled at and scolded the Applicant for calling the hospital frequently, the Committee had before it differing accounts of the interaction between the Applicant and the Respondent.

2024 CanLII 5409 (ON HPARB)

70. The Board observes that the Committee generally conducts a documentary review and cannot make credibility findings *per se*.

71. That said, the Committee noted from the medical record that the Applicant was struggling considerably with the patient's condition, and that it created some challenges for staff. The Committee further noted that the Respondent made reasonable efforts to be compassionate and communicate respectfully with the Applicant, but with difficulty at times.

72. The Committee decided to state its expectation that the Respondent, as all physicians, would ensure professional communications with patients, their SDMs, and family members. The Board finds the Committee's statement of expectation in this regard to be reasonable.

73. The Board acknowledges, based on the Applicant's request for review, that the Applicant is dissatisfied with the Committee's decision. However having considered the information in the Record and the Committee's decision, the Board finds 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.

2024 CanLII 5409 (ON HPARB)

## VI. DECISION

74. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to issue advice to the Respondent regarding the importance of clear and transparent communication with patients and/or their SDMs regarding resuscitation wishes and clear documentation regarding those discussions, and to state its expectation that physicians ensure professional communications with patients and their SDMs and family members at all times.

ISSUED January 30, 2024

Timothy P. D. Bates

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Timothy P. D. Bates

Cathy Loik

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Cathy Loik

Mitchell Toker

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Mitchell Toker

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2024 CanLII 5409 (ON HPARB)