File # 18-CRV-0721

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Rob Steele, Designated Vice-Chair, Presiding
Maria Capulong, Board Member
Gerard Tillmann, Board Member

Review held on July 23, 2019 at London, 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:

J. D.

Applicant

and

B. R., MD

Respondent

Appearances:

The Applicant:	J. D.
Support for the Applicant:	M. W.
For the Respondent:	Cale R. Sutherland, Counsel
For the College of Physicians and Surgeons of Ontario:	Kimberly Kennedy-Blackhall, Representative (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 accept a remedial agreement from Dr. R. dated August 30, 2018 to undertake education in the areas of appropriate investigation of a patient in a long-term care facility with multiple medical issues, medical record-keeping, communicating with a patient's family members and substitute decision maker, including regarding DNR orders and Advanced Health Care Directives and to take the necessary steps to improve his practice.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by J. D. (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 B. R., MD (the Respondent). The Committee investigated the complaint and decided to accept a remedial agreement as noted above.

II. BACKGROUND

3. The Applicant's brother (the patient) suffered from disabilities and resided at Lady Isabelle Nursing Home (LINH) from December 2015 until August 2017. When the nursing home closed in August 2017, the patient was transferred to Woodingford Lodge (Woodingford).

4. The Respondent (General Practice) assumed care of the patient upon his transfer to Woodingford.

5. On October 12, 2017, the patient was transferred from Woodingford to the Emergency Room at Alexandra Hospital (Alexandra) due to decreased level of consciousness and physical decline. The patient was assessed for suspected stroke (cerebrovascular accident or CVA). A CT scan was ordered and the patient was referred to the transient ischemic attack (TIA) clinic in London. The patient was discharged back to Woodingford.

6. On October 16, 2017, the patient was assessed at the TIA clinic in London. Stroke was ruled out, but due to elevated ammonia levels, Woodingford was advised, and the patient was referred back to Alexandra.

7. On October 17, 2017 the patient was transferred to Alexandra due to high ammonia levels where he was assessed, IV fluids were ordered and he was discharged back to Woodingford on October 18.

8. On October 26, 2017, the patient was sent to Alexandra for lethargy and high ammonia levels. He was discharged back to Woodingford the following day.

9. On October 28, 2017, the patient was sent to Alexandra for vomiting and deceased level of consciousness. The patient was transferred to the intensive care unit (ICU) at Woodstock Hospital where an abdominal CT scan was ordered. The CT scan revealed diffuse metastatic cancer involving the liver, peritoneum and lymph nodes.

10. Sadly, the patient passed away on November 1, 2017.

The Complaint and the Response

11. The Applicant complained that the Respondent failed to provide appropriate care to the patient from August to October 2017 at the Woodingford Lodge. Specifically, the Respondent:

- did not appropriately monitor, assess, and investigate the patient's symptoms and health deterioration; and
- did not explore other differential diagnoses other than seizure or psychiatric issues.

12. The Applicant is also concerned that the Respondent behaved in an unprofessional manner towards the patient and the Applicant from August to October 2017. Specifically, the Respondent:

- signed a "do not resuscitate" (DNR) form without appropriate consent from the patient's attorney with power over health care decisions (the Applicant), when the patient was incapable of making decisions and executing legal documents; and
- spoke in a disrespectful manner towards the Applicant during a telephone discussion on October 27, 2017.

13. In his letter of response to the complaint, the Respondent reviewed the patient's history and the sequence of events of his care. In responding to the specific complaint concerns, he indicated that:

- Regarding the care provided, during his 82 days at Woodingford, the patient was seen more frequently than other residents. He was referred as appropriate to Psychiatry, Neurology, Internal Medicine and also saw Emergency Physicians on each visit to Alexandra Hospital. He was uncertain how to reply to the complaint, as he based his investigations on presenting symptoms as did the consultants.

- With respect to the patient's DNR status, he was assessed by a very capable nurse who, within her scope of practice, determines competency and plan of treatment. The nurse noted that the patient advised that he wanted God to decide when it was his time to go. The Respondent signed the plan of care as provided by the nurse. He noted that this was a daily occurrence in hospitals and Long-Term Care Facilities across the province.

- He apologized if the Applicant felt he was disrespectful but contended that she was accusatory towards him.

The Committee's Decision

14. The Committee investigated the complaint and decided to accept a remedial agreement as noted above.

III. REQUEST FOR REVIEW

15. In a letter dated October 23, 2018, 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. At the Review, the Board was assisted in its deliberations by oral submissions from the Applicant and Counsel for the Respondent, and by information provided by the College Representative in response to questions from the Board.

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 letter of complaint, and confirmation of complaint;
- a letter of response from the Respondent;
- medical records from Lady Isabelle Nursing Home;
- medical records from Woodingford Lodge;
- medical records from the Alexandra hospital;
- a Coroner's report;
- a report from the Chief of Staff at Alexandra hospital; and
- information from four of the patient's other treating physicians.

23. At the Review, neither party challenged the adequacy of the investigation.

24. The Board notes that the Committee provided the parties with multiple opportunities to provide information to the investigation, and that the Applicant did so.

25. 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. There is no indication of additional information that, if obtained, might reasonably be expected to have affected the Committee's decision.

26. Accordingly, the Board finds the Committee's investigation to be adequate.

Reasonableness of the Decision

27. 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.

28. At the Review, the Applicant expressed the view that while the Committee had done "a much better job" in its deliberation, it had still erred in several aspects. She directed the Board's attention to the patient's elevated ferritin levels, which indicated liver damage, and his continuing pattern of falls and confusion that were not diagnosed by the Respondent. She submitted that the Respondent should have recognized that the patient lacked competence to accept a DNR order, due to his mental health issues and disabilities.

29. The Applicant took particular issue with the Committee's decision to accept a remedial agreement, arguing that the disposition was "disgusting" and "not serious", representing only a "slap on the wrist" when a patient had died.

30. Counsel for the Respondent submitted that the Committee had been severely critical of the Respondent's care and documentation, as well as his approach to the patient's DNR status. Counsel submitted that the Committee had, in fact, agreed with each of the Applicant's complaint issues, excepting only the concern regarding the tone of their personal interactions, where it was not in a position to reach a conclusion. He asserted that the Committee had recognized deficiencies in the Respondent's practice and taken the appropriate remedial action.

31. In response to a question from the Board, the College Representative advised that the Respondent had completed the remedial agreement. Counsel provided further details, advising that the Respondent had also directed a review of selected processes at Woodingford, updated the record keeping systems to electronic ones, and made changes to Woodingford's approach to DNR communications. Counsel argued that the Respondent's willingness to accept and complete a voluntary remedial agreement was indicative of his desire to improve his practice.

32. In reaching its decision to accept a remedial agreement from the Respondent, the Committee indicated that:

Re: did not appropriately monitor, assess, and investigate Mr. W.'s symptoms and health deterioration; and, did not explore other differential diagnoses other than seizure or psychiatric issues

- It took the view that the Respondent should have taken a more active role in coordinating the patient's care, particularly during the last three months of his life, when the patient gradually, but significantly deteriorated, from being able to go outside for a cigarette and feed himself, to having increasing falls and confusion, to full blown hepatic encephalopathy. The Respondent did not adequately monitor the patient's laboratory results or take appropriate action, such as when the patient's August 10, 2017, ferritin levels were abnormally high. Although there were consultations with specialists regarding the patient, most of those referrals were due to ER visits rather than made by the Respondent.

- It found the Respondent's record-keeping to be deficient in that it was overly brief. The nurses noted on multiple occasions that the patient had fallen, was sleepy, had difficulty swallowing etc., yet there was very little documentation of assessments or diagnoses by the Respondent after these incidents, or conversations with the Applicant regarding the patient's medical condition. The Committee only noted two occasions where the Respondent documented a visit with the patient on September 29, and October 13, 2017. Both visit notes were extremely brief. At the October 13 visit, the patient was quite ill, having been seen in the ER the day before, and only the following was noted: "Seen in ER yesterday; Arrangements to be seen re ? stroke; More alert today." The cumulative patient profile (CPP) for the patient was essentially blank.

Re: signed a "do not resuscitate" (DNR) form without appropriate consent from the patient's attorney with power over health care decisions (the Applicant), when the patient was incapable of making decisions and executing legal documents

- It took the view that the Respondent overly relied on the nurse practitioner's assessment of the patient's competency when completing his DNR status form, although the patient apparently stated that he wanted God to decide when it was his time to go. Considering the context of the patient's developmental delay, and diagnosis of schizophrenia, and the seriousness and consequences of a DNR order, the Respondent should have discussed the patient's DNR status with his substitute decision maker, in this case the Applicant.

Re: spoke in a disrespectful manner towards The Applicant during a telephone discussion on October 27, 2017

- It noted that it is limited to a documentary review of information and was unable to know exactly what the Respondent and the Applicant discussed over the telephone, or the manner the Respondent used. The Committee observed that it is important for physicians to communicate in an empathetic and sensitive manner when speaking with a concerned family member.

33. With respect to the care provided, the quality of the Respondent's record keeping and his handling of the patient's DNR status, the Board is of the opinion that these aspects of this complaint required the Committee to rely on its medical knowledge and expertise in assessing the Respondent's conduct and actions. The Board observes that the Committee included four professional members who were in a position to evaluate the Respondent's adherence to the standards of practice as part of its decision.

34. There is nothing before the Board to indicate the Committee misconstrued the Record or did not apply its knowledge of the standards expected of a physician in these circumstances, nor is there anything in the Record, or advanced at the Review which could lead the Board to conclude that the Committee's determinations on this aspect of the complaint were unreasonable.

35. Regarding the complaint concerns where the recollections of the parties varied, the Board concludes that the Committee's decision to take no further action with regard to this aspect of the complaint is reasonable. The Committee addressed two competing perspectives of the interactions between the Applicant and the Respondent. There was nothing in the Record or any other information advanced that might assist the Committee in preferring one account to other. As there was insufficient information to determine which version of events was more factual, it was reasonable for the Committee to take no further action in regard to this aspect of the complaint.

36. With respect to the Applicant's submission that the disposition was not sufficient, the Board observes that the Committee process is not intended to determine liability or "punish" physicians. Rather, the Committee considers the investigative information available to determine what action, if any, is warranted. The Committee's role is designed to protect the public by determining whether remedial action is necessary and, if so, what action would best enhance the quality of medical care of the particular physician, and the general quality of medical care in Ontario, by reinforcing the standards of practice.

37. Moreover, in assessing the appropriate disposition in a complaint, a Committee will consider many factors, including the seriousness of the deficiency, whether there is a single concern or a number of concerns about the care at issue, the content of a physician's response, his or her insight as to areas for improvement, and the physician's complaints or discipline history.

38. The Committee exercised its judgement to determine that a remedial agreement was sufficient to address its concerns. The Committee's decision requires the Respondent to demonstrate improvement in the areas of concern raised by the Applicant. The monitoring of the Respondent's education by the College injects a level of accountability designed to protect the public interest and improve the Respondent's practice. The Board acknowledges that the Respondent, through his Counsel, has indicated that he accepts the Committee's concerns, has completed the remedial agreement, and made changes to his practice. In these circumstances, the Board finds the Committee's disposition to be reasonable as it has made the Respondent aware of the Committee's specific concerns and serves to protect the public interest by guiding the Respondent's practice in the future.

39. The Board recognizes that the Applicant remains profoundly distressed that her family member could be seen by multiple physicians over an extended period of time, and still not be accurately diagnosed until shortly before his death. Nonetheless, the information in the Record provides support for the Committee's conclusions and the Board finds the Committee's decision to be reasonable.

40. The Board wishes to express its condolences to the Applicant and her family on the loss of her brother.

VI. DECISION

41. Pursuant to section 35(1) of the *Code*, the Board confirms the decision of the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario to accept a remedial agreement from the Respondent dated August 30, 2018 to undertake education in the areas of appropriate investigation of a patient in a long-term care facility with multiple medical issues, medical record-keeping, communicating with a patient's family members and substitute decision maker, including regarding DNR orders and Advanced Health Care Directives and to take the necessary steps to improve his practice.

ISSUED August 27, 2019

Rob Steele

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Rob Steele

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