File # 16-CRV-0061

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Marla Burstyn, Designated Vice-Chair, Presiding
Thomas Kelly, Vice-Chair
Yasmeen Siddiqui, Board Member

Review held on November 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:

K.D.

Applicant

and

B.C., MD

Respondent

Appearances:

The Applicant:	K.D.
Support for the Applicant:	H.D.
For the Respondent:	Marc Flisfeder
For the College of Physicians and Surgeons of Ontario:	Nadia Raja (by telephone)

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. This decision arises from a request made to the

Health Professions Appeal and Review Board (the Board) by K.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 by the Applicant regarding the conduct and actions of B.C., MD (the Respondent) in relation to the care provided to the Applicant's husband.

2. The Committee investigated the complaint and decided to advise the Respondent regarding documentation of the ICU physician's involvement in a decision to transfer care.

II. BACKGROUND

3. The Respondent is an attending critical care physician at Sunnybrook Health Sciences Centre, and has been in this position since September 2009. He is also the Chief of the Department of Critical Care Medicine at Sunnybrook.

4. The Applicant complained to the College about the care provided to her husband by the Respondent and four other physicians, while her husband was a patient at Sunnybrook. The Committee addressed the concerns regarding the four other physicians in separate decisions.

5. The following is a short summary of the background information giving rise to the Applicant's complaint.

6. On September 22, 2013, in the early morning, the Applicant's husband (the patient) was admitted to the emergency department at Sunnybrook with a brain stem stroke (vertebral artery occlusion).

7. Neurology assessed the patient and treated him with tPA, a "clot buster" drug.

8. The Respondent admitted the patient to the ICU where he was under the Respondent's care.

9. On September 23, 2013, at 9:00 a.m., the Respondent transferred the patient's care to another ICU physician.

10. Later that day, the patient was transferred out of the ICU to the stroke unit.

11. A speech-language pathologist assessed the patient for swallowing and recommended the placement of a nasogastric tube (NG tube) and regular suctioning.

12. On September 23, 2103, at 2:20 p.m., the NG tube was inserted. At 3:33 p.m., a chest x-ray was performed to check the NG tube placement. The radiologist's report stated in part: "The tip of NG tube is seen projected over the left upper quadrant though the side hole is only just at the level of the hemidiaphragm and should be advanced."

13. On September 23, 2013, at 7:20 p.m., the internal medicine fellow ordered that the NG tube could be used for feeding, and the feeding was then started as ordered. The target feeding rate of 55 ml/h was reached by 1:30 a.m. on September 24, 2013.

14. On September 24, 2013, at 10:35 pm., nursing noted that the patient was unresponsive and called a Code Blue. He was readmitted to the ICU after his cardiac arrest. The patient did not make a good neurological recovery after his arrest, and he remained in a vegetative state.

15. The Respondent next became involved in the patient's care as his most responsible physician from October 7, 2013 to October 9, 2013, and was involved again in his care from October 21 to 28, 2013. By the time the Respondent became involved in October 2013, the patient had sustained a severe and diffuse brain injury following four cardiac arrests. He was later diagnosed as being in a persistent vegetative state.

16. Later in October 2013, the patient was transferred from the ICU to a Level 2 unit.

17. In January 2014, the patient was transferred to a long-term care facility. Sadly, he died on June 26, 2014.

18. The Board extends its sympathies to the Applicant and her family on the death of her husband.

The Complaint and the Response

The Complaint

19. The Applicant complained to the College in March 2014 about the care her husband received at Sunnybrook. She provided a lengthy letter with details of the care provided and her concerns. She is concerned that the Respondent discharged the patient from the ICU and is further concerned that he tried to influence her to make the patient's status "do not resuscitate" (DNR).

The Response

20. The Respondent provided a written response to the complaint, which included the following information. Regarding the concern that he discharged the patient from the ICU, he wrote that it was not his decision to discharge the patient, as he handed over the care to another physician at 9:00 a.m. on the morning of his transfer. However, he stated it was the consensus between the neurology team and the ICU team (including himself) and the ICU nursing team, that the patient was ready to be transferred to the ward at that time. The Respondent relied on two notes from neurology residents in the medical record in support of this, and stated that he was not responsible for the supervision of neurology residents. He stated that there are no specific discharge policies from ICU because every case is different, but as a rule the discharge has to be agreed upon by an Attending Intensivist, the ICU nursing /allied professional team and the receiving medical service. Further, it is standard practice for stroke patients to be transferred to the medical / stroke teams' care after ICU care is completed, and not to transfer such patients to an ICU step down unit.

21. The Respondent denied attempts to influence the Applicant to consent to a DNR order. The Respondent explained what was discussed on October 9, 2013, when he met with family members and the attending neurologist. He stated that he did not make any recommendations for limitation of management, but listened to the family's discussion and gave some advice on the Applicant's role as substitute decision-maker, and his own role. The Respondent stated that on October 22, 2013, when the patient had a sudden deterioration, the Applicant and her son were clear that they felt the patient would have wanted ongoing treatment and agreed to continue resuscitation at this stage. He explained to the Applicant that he was obliged to ask questions because she was required to give or refuse consent to treatment decisions and to ensure that she had full information to make decisions.

22. The Applicant provided several letters in reply to the Respondent's response to the complaint in which she disagreed with various aspects of the response and raised further

issues. In addition, she provided her note of the meetings with the Respondent and others on October 9 and 22, 2013. Among other concerns, she raised questions about the Respondent's June 2014 grand rounds lecture entitled "Reflections on the Rasouli Case".

23. The Respondent provided a response to these new communications provided by the Applicant in which he addressed new concerns raised by the Applicant.

Independent Opinion

24. As part of its investigation, the Committee obtained a report dated May 12, 2015 and addendum report dated August 7, 2015 from an independent opinion provider (IOP). The IOP is a stroke neurologist at Kingston General Hospital. He provided an opinion on whether each of the five physicians complained about met the standard of the profession in the care of the patient.

25. Regarding the Respondent, the IOP held the opinion that the Respondent met the standard of care of the profession.

The Committee's Decision

26. Following its investigation of the complaint, the Committee rendered a decision.

27. The Committee concluded that the documentation regarding the decision to discharge was poor and could have been improved by a note on the chart from the Respondent, indicating transfer of care. The Committee decided to advise the Respondent on this point.

28. The Committee decided to take no action regarding the Applicant's concern that the Respondent attempted to influence her to consent to a DNR order.

III. REQUEST FOR REVIEW

29. In December 2015, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

30. 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.

31. 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. POSITION OF THE PARTIES

32. The Applicant filed written submissions and made oral submissions at the Review, all of which have been considered by the Board. This serves to highlight some of her submissions.

33. The Applicant submitted that the Committee's decision to educate the Respondent on documentation during hand-off implies that the Respondent did, in fact, hand-off the care

of the patient to an attending intensivist. She noted that the Respondent handed off her husband's care to an unidentified person, and she has not been told who the attending intensivist was on September 23, 2013 between 9:00 a.m. and 5:40 p.m., despite making numerous written requests of the College for that information. She submitted that the Committee will not address issues which have potential system-wide implications and serious repercussions for physicians.

34. The Applicant submitted that the Committee's decision is unreasonable. She stated that the Board should require the Committee to issue a written caution to the Respondent regarding hand-off and transfer procedures and the need to ensure that ICU patients are always under the care of an attending intensivist, in view of the serious consequences of the Respondent's poor hand-off and transfer practices.

35. Counsel for the Respondent submitted that the investigation was adequate and the decision was reasonable and requested that the decision be confirmed. Among his submissions, counsel submitted that the decision is based on the expertise of the Committee and is supported by the IOP report and the medical record.

VI. ANALYSIS AND REASONS

36. 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.

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

38. In conducting this complaint Review, it is important to note the role of the Committee. The Board observes that the Committee's mandate is that of a screening committee with regard to complaints received about its members. The Committee considers the information it obtains in order 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. The Committee does not conduct a hearing or make findings of misconduct.

Adequacy of the Investigation

39. 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.

40. The Committee obtained the Applicant's communications about the complaint. The Record indicates that the College investigator and her colleague attended the Applicant's home to provide information about the complaints process and to clarify and identify the subject physicians and the Applicant's exact concerns.

41. The Committee obtained information from four of the physicians involved in the patient's care including the Respondent, and records from Sunnybrook. The Applicant was provided an opportunity to respond to the information obtained from the physicians.

42. The Committee obtained a report from an IOP providing an opinion on the care provided by five physicians about whom the Applicant complained, including the Respondent.

43. Four physicians complained about, including the Respondent, were provided a copy of the IOP's report for comment. The Respondent decided to provide no comments in response to the IOP report. One of the physicians complained about provided comments in response to the IOP's report. Further, in response to the IOP report which was critical of that physician's care, that physician provided an opinion dated June 11, 2015 from an internal medicine and respiratory medicine physician regarding the care he provided to the patient and the concerns raised by the Applicant. The IOP provided an addendum to his report, after reviewing that physician's response.

44. The Board acknowledges the Applicant's concern that the name of the physician to whom the Respondent handed off care at 9:00 a.m. on September 23, 2013 in the ICU, has not been identified. She wrote that her husband's condition deteriorated over the course of the day on September 23, 2013, up to and prior to the time of the transfer to the ward, and she does not know who was responsible for the patient's care while in the ICU after 9:00 a.m. Further, the Applicant wrote that in the absence of documentation or the name of the attending intensivist to whom the Respondent handed over care at shift change, the patient was managed by postgraduate trainees who cannot practice independently.

45. The Board finds that the absence of the name of and/or information from the attending physician who took over from the Respondent in the ICU on the morning of September 23, 2013, does not render the Committee's investigation inadequate based on the following.

46. The Applicant's concern related to the Respondent's decision to discharge the patient from the ICU.

47. The Committee obtained the medical records to consider the contemporaneous information regarding the decision to transfer from the ICU to the ward. The Respondent provided general information to the Committee about the organization of critical care services at Sunnybrook. The general information is that there is an attending physician who is responsible for the unit for a specific period of time, usually one week. When the specific period of time ends, the attending physician hands care over to the new attending physician (the MRP), at which time all clinical responsibility and decisions are delegated to the new MRP.

48. The Respondent also provided specific information about the discharge in this case. He wrote that he handed over care at 9:00 a.m. on September 23, 2013 to the new attending physician, before the patient was discharged from ICU and transferred to the ward. Further, the Respondent provided information in the Record about the decision to discharge - that it was the consensus between the neurology team and the ICU team (including himself) and the ICU nursing team, that the patient was ready to be transferred to the ward at that time.

49. The Board notes that there is no information in the Record that would suggest that there was no Attending Physician in place at the time that the Respondent handed over care at 9:00 a.m. Rather, only that the name of the physician has not been identified.

50. Given that the Respondent addressed the issue of how the decision to discharge was made in this case, the Board finds that the investigation of the name of the attending physician who took over from the Respondent in the ICU on the morning of September 23, 2013 would not likely affect the outcome of the decision regarding the Respondent.

51. The Board understands the Applicant's desire to know who the MRP was while her husband was in the ICU on September 23, 2013 after 9:00 a.m. It is not clear to the Board why she has not been able to find this out. Nevertheless, the Board finds that this does not render the investigation of the Respondent care inadequate as it relates to this complaint.

52. The Board concludes that the Committee collected and considered the essential information to assess the complaint. 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

53. 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.

Decision to Discharge from the ICU

54. The Committee determined that the appropriate disposition in this matter was to advise the Respondent regarding documentation of the ICU physician's involvement in a decision to transfer care.

55. The Board finds this decision to be reasonable for the following reasons.

56. The Committee relied on the information in the Record from the Respondent that he was not the physician who discharged the patient from the ICU because he handed over care at 9:00 a.m. on September 23, 2013. The Committee was critical of the documentation of the decision to discharge from the ICU, describing it as "poor". Further, the Committee explained how the Respondent could have improved the documentation, by a note on the chart from him (the ICU consultant), indicating transfer of care.

57. The Committee relied on information in the medical record that neurology felt that the patient was stable to be discharged, and that the ICU fellow was involved in the discharge decision.

58. The Board notes that the Committee noted no concern with the decision itself to discharge the patient. Although the Committee did not reference the opinion of the IOP in its decision on this issue, the Board notes that it was the opinion of the IOP that the decision to transfer the patient was reasonable, noting that there was no indication that he was too hemodynamically unstable for the transfer and further noting that dysphagia issues are common in stroke patients and can be cared for by the interdisciplinary team on an acute stroke unit. He wrote that there is no information that this is not in keeping with the usual practice in Sunnybrook, or that the decision was made without the involvement of the interdisciplinary team.

59. The Board finds that the Committee's decision to advise the Respondent about his documentation falls within the range of possible, acceptable decisions. It is an educational disposition which addressed the Committee's concern and provides guidance to the Respondent in his future practice.

Decision to Influence DNR status

60. The Committee decided to take no action regarding the Applicant's concern that the Respondent attempted to influence her to consent to a DNR order.

61. The Committee noted the parties' differing version of the discussions that took place regarding the patient's DNR status, and stated that it is unable to reconcile the differing accounts. The Committee noted that it reviewed the medical chart regarding the discussions about the DNR order. There was no indication in the chart that would support the Applicant's allegation that the Respondent tried to influence her.

62. The Board observes that as a screening committee limited to conducting a review of the documents and information obtained as a result of its investigation, it is sometimes difficult for the Committee to determine what transpired between parties. In the circumstances, the Board finds it to be reasonable for the Committee to take no further action.

63. Regarding the Rasouli case, the Committee noted that the circumstances were different since the patient was not on mechanical life support, and found nothing to support the Applicant's concern that the lecture included reference to the patient's care.

64. In conclusion, the Board finds that it was reasonable for the Committee to take no further action regarding this aspect of the complaint.

VI. DECISION

65. Pursuant to section 35(1) of the *Code*, the Board confirms the decision of the Committee to advise the Respondent regarding documentation of the ICU physician's involvement in a decision to transfer care.

ISSUED March 24, 2017

Marla Burstyn
Marla Burstyn

Thomas Kelly
Thomas Kelly

Yasmeen Siddiqui
Yasmeen Siddiqui