File # 18-CRV-0546

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Mason Greenaway, Designated Vice-Chair, Presiding
Teng-teng Amy Go, Board Member
Thomas Kelly, Vice-Chair

Review held on April 4, 2019 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:

M.L.

Applicant

and

A.H.P., MD

Respondent

Appearances:

The Applicant:	M.L.
For the Respondent:	Colin Johnston, Counsel
For the College of Physicians and Surgeons of Ontario:	Lauren David (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 take no further action.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by M.L. (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 A.H.P., MD (the Respondent) during the treatment of the Applicant's husband, Michael Leonetti (the patient). The Committee investigated the complaint and decided to take no further action.

3. The Applicant also sought a review of the Committee decision related to the care provided by another physician. The Board is issuing separate decisions in each matter.

II. BACKGROUND

4. Following a motor vehicle accident on October 26, 2016, the patient was admitted to Etobicoke General Hospital where he was diagnosed as having a myocardial infarction (heart attack) and heart failure requiring non- invasive ventilation (BiPAP) to maintain his oxygen levels.

5. Later the same day he was transferred to Brampton Civic Hospital (BCH) for urgent coronary angiography to evaluate and treat blockages to his coronary arteries.

6. During the patient's stay at BCH, the Respondent provided an intensive care consult for the further care of the patient.

7. On October 27, 2016, the patient was transferred to Toronto General Hospital (TGH) due to poorly controlled type II diabetes, infection, kidney failure, fever and a large blood clot in his heart.

8. The patient was transferred back to BCH on November 17, 2016 at which time, the Respondent resumed care of him as the Most Responsible Physician in the Intensive Care Unit at BCH.

9. On November 18, 2016, the Respondent requested and attended a meeting with the Applicant and some of her family members to discuss the ongoing care of the patient.

10. Sadly, the patient died on November 19, 2016, of cardiac arrest at a time when the Respondent was not on duty.

The Complaint and the Response

11. The Applicant complained that the Respondent behaved in an unprofessional manner towards the Applicant, who was the substitute decision maker for the patient, on November 18, 2016, at Brampton Civic Hospital. For example, the Respondent:

- used an angry tone of voice with the Applicant when she refused to have the patient removed from ventilation; and
- asked the Applicant's mother-in-law if she would remove the patient from his ventilator when the Applicant refused.

12. In his response of February 5, 2018, the Respondent outlined the very serious condition of the patient, as well as the events leading up to, the purpose of, and his recollection of his meeting with the Applicant and her family on November 18, 2016.

13. On March 5, 2018, the Committee investigator received the Applicant's comments on the Respondent's response and on March 26, 2018, the Respondent provided additional comments.

The Committee's Decision

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

III. REQUEST FOR REVIEW

15. In a letter dated September 2018, the Applicant requested that the Board review the Committee's decision, stating that she was filing her request for a review on behalf of her late husband who, "was 57 years old when he died at Brampton Civic hospital. I want my side of the story told. My husband was mistreated by the Ontario hospital system. He was also mistreated by [the Respondent and one other doctor]."

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. Both the Applicant and the Respondent's Counsel made oral submissions at the Review.

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

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

22. In this regard, the Committee is to act in relation to the College's objectives under section 3 of the *Code*, for example, to maintain standards of practice to assure the quality of the practice of the profession, to maintain standards and promote continuing improvement among the members and to serve and protect the public interest.

23. The Committee's mandate is that of a screening committee with regard to 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 members practice, directing remedial measures intended to improve an aspect of a member's practice or referring specified allegations of professional misconduct to the Discipline Committee.

Adequacy of the Investigation

24. 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.

25. The Committee obtained the following documents:

- the Applicant's letter of complaint;

- a memorandum detailing the Applicant's interview with the Committee investigator;
- the Respondent's letter of response to the complaint;
- medical records for the patient from BCH including a note detailing "a very complicated course out of Toronto General Hospital";
- information from another physician involved in the care of the patient;
- the Applicant's comments on the Respondent's letter of response; and
- additional comments from the Respondent.

26. The Applicant, other than stating at the Review that she did not feel the Committee, "gave an adequate review", did not point to any document or information that might reasonably be expected to have affected the decision, should the Committee have acquired it.

27. The Respondent submitted that the Committee's investigation was adequate.

28. The Board notes that the Committee had before it each parties' versions of the November 18, 2016, meeting, which is the focus of the Applicant's complaint, and that each of the parties received and commented on the other party's information. The parties thus had full opportunity to present their recollections of that meeting.

29. The Board finds that the Committee's investigation covered the events in question and yielded the essential relevant information to allow it to assess the complaint regarding the Respondent's conduct and actions.

30. There is no indication of any other information that might reasonably be expected to have affected the Committee's decision should the Committee have acquired it.

31. Accordingly, the Board finds the Committee's investigation was adequate.

Reasonableness of the Decision

32. 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.

33. After considering the parties' submissions, examining the Record and reviewing the Committee's decision, the Board concludes for the following reasons that the Committee's decision to take no further action is reasonable.

34. In this case, the concerns raised by the Applicant in her complaint centred on the Respondent's conduct during the meeting of November 18, 2016 with the Applicant, who was the Substitute Decision Maker for the patient, and other family members.

35. The Board notes that the Committee received divergent accounts from the parties as to what happened at the meeting.

36. The Applicant provided information to the Committee that:

- the Respondent asked her, "to take my husband off of a ventilator;"
- when she did not agree to do so, the Respondent, "got angry at me and turned to [the patient's] mother and asked for her permission to take her son off of the ventilator."

37. The Respondent indicated to the Committee that the purpose of the meeting was not to discuss withdrawal of life support but rather to discuss the code status, that is, whether to do CPR and defibrillation in the event of a cardiac arrest and, that while the Respondent was recommending a " do not resuscitate" order, "(t)his is very different from a

withdrawal of life support which the family was clearly not ready to discuss at this first meeting."

38. Further, the Respondent advised the Committee that he allowed the family time to consider making a decision on code status, but no decision was finalized during this meeting and, as the Record indicates, the patient remained on "full code", that is, the patient remained on resuscitative drugs and a ventilator, and when, in fact, the patient did suffer a cardiac arrest, he received CPR.

39. The Respondent also stated that, as a professional, he would never become angry at the family, especially at this vulnerable and stressful time.

40. In arriving at its decision to take no further action, the Committee considered the accounts of the parties as well as the following information available to it in the Record:

- the patient had suffered a heart attack on October 26, 2016 and was transferred from Etobicoke General Hospital to BCH for urgent cardiac catheterization;
- he required BiPAP and ultimately intubation;
- he had an intra-aortic balloon pump;
- he was transferred to TGH on October 27 for consideration of management of cardiogenic shock;
- his stay at TGH was complicated by infections including C-difficile colitis, toxic megacolon, Streptococcus and sepsis;
- he was seen by a general surgeon at TGH but, because of his poorly controlled diabetes, infections, fever and large blood clot in the heart, was not considered as a surgical candidate or for any advanced rescue techniques;
- he developed thrombocytopoenia resulting in a very low platelet count and a serious bleeding problem;

- he had a tracheostomy at TGH but other than that was considered unfit for any surgical procedures there;
- upon his return to BCH, his cardiac function was quite poor, his platelet count was dangerously low, and his C-difficile continued to be active;
- the Respondent, as the Most Responsible Physician in charge of the patient's care, was concerned that the large blood clot in the left chamber of his heart could break loose and cause a stroke or other complication;
- there was a serious risk of another heart attack as the patient had severe blockages to the heart which were not amenable to any treatment.
- A consultation report from another physician at BCH indicated there had been multiple conversations at TGH with the patient's family regarding CPR and defibrillation and that they wanted "all aggressive treatments." In the opinion of that physician, "this will be an ongoing discussion with the family";
- the BCH Critical Care Record contained a note that after the meeting of November 18, the family was to decide on "code status".

41. The Board can find no independent information in the Record that the purpose of the November 18 meeting was to discuss end of life procedures such as the withdrawal of life support, as opposed to code status, or that there was, in fact, any such discussion.

42. The Board is of the opinion that there is a line of reasoning between the information in the Record and the Committee's decision that the Respondent undertook the appropriate discussion in the circumstances given the patient's serious condition and that the Respondent acted compassionately by giving the family time to process the information and make a decision.

43. Regarding the complaint about the Respondent using an angry tone when speaking to the Applicant during the meeting, the Board notes as indicated above, that upon receiving a complaint, the Committee's function is to screen the complaint to decide what action, if any, should be taken. In circumstances such as this, involving communications where

there is no independent corroboration of one version of events, the Committee is unable to prefer one version of events to another.

44. Consequently, the Board finds the decision of the Committee to take no further action regarding the Applicant's complaint to be reasonable.

VI. DECISION

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

ISSUED May 29, 2019

Mason Greenaway

Mason Greenaway

Teng-teng Amy Go

Teng-teng Amy Go

Thomas Kelly

Thomas Kelly