File # 18-CRV-0545

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

O.H. , MD

Respondent

Appearances:

The Applicant:	M.L.
The Respondent:	O.H. , MD (by teleconference)
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 O.H. , MD (the Respondent) in providing care to the Applicant's late husband (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 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. On October 27, 2016, he 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.

7. The patient was transferred back to BCH on November 17, 2016, and, sadly, he died on November 19, 2016, of cardiac arrest.

8. The Respondent was the ICU doctor on call on November 19, 2016 and was involved in the Code Blue medical teams' response to the patient's cardiac arrest and was also present during a BCH meeting with the Applicant and her son on December 29, 2016

The Complaint and the Response

9. 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 19, 2016 and December 29, 2016, at Brampton Civic Hospital. For example, the Respondent:

- did not discuss with the Applicant/the substitute decision maker the patient's change in cardiac condition, did not request her permission to stop resuscitation during the patient's cardiac arrest, and did not inform her of what occurred when the patient died on November 19, 2016; and
- did not refer to the patient by his given name, and called him a "poor specimen" during a meeting with the Applicant on December 29, 2016 (arranged by Patient Relations).

10. In his response of February 5, 2018, the Respondent outlined the patient's grave condition leading up to his cardiac arrest in the early afternoon of November 19, 2016 and the Respondent's involvement with the patient as a result of a "Code Blue" being called when the Respondent was on duty in the ICU of BCH.

11. The Respondent also discussed his understanding of what occurred at BCH following the passing of the patient and at a meeting with the Applicant on December 29, 2016.

The Committee's Decision

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

III. REQUEST FOR REVIEW

13. 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

14. 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.

15. 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

16. 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.

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

18. 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.

19. 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.

20. 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

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;
- 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; and
- the Applicant's comments on the Respondent's letter of response.

23. The Board notes that the information collected provided the Committee with the respective positions of the parties, as well as additional independent information.

24. Neither party submitted that the investigation was inadequate.

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

26. 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.

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

Reasonableness of the Decision

28. 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.

29. In this case, the Board notes that the Committee's decision was based on a review of the information before it and that there was a line of reasoning between the decision and that information.

Re: not discussing with the Applicant the patient's change in cardiac condition or requesting her permission to stop resuscitation during the cardiac arrest

30. In reaching its decision to take no further action on this aspect of the complaint, the Committee noted that, according to the medical record, at the time of the events in question:

- there were no surgical options or transplant options for the patient's heart failure;
- the patient was increasingly experiencing additional complications, including sepsis, respiratory failure, renal failure, gastrointestinal bleeding, and clotting problems;
- on his way to a CT scan, the patient suffered a cardiac arrest and the medical team's efforts to revive him were unsuccessful.

31. The Committee also had before it the information from the Record that during the medical team's CPR efforts, the patient, whose platelet count was "profoundly low", had large amounts of blood coming out of his breathing tube and the clinical decision to stop CPR was made given that the risks of ongoing bleeding from his airway outweighed any potential benefit of continuing.

32. The Committee noted that, in the circumstances, the medical team's first priority was saving the patient's life and that everything else, including notifying the Applicant regarding his condition, would have been secondary.

33. Further, the Committee expressed its opinion that "it is not reasonable to ask family/decision makers to consent to stop CPR when no electrical activity is present, and that unlike withdrawal of life support, the cessation of CPR is an acute medical decision."

34. The Board finds that this aspect of the Committee's decision is supported by the information in the medical record regarding the specifics of the assessment and treatment of the patient's condition by the Respondent. It is based on the application of the Committee's expertise and knowledge of the standards of the profession regarding appropriate assessment based on the patient's presenting concerns. The Board has no

basis to find that the Committee inappropriately applied its expertise and knowledge of the standards of the practice in regard to this aspect of the complaint.

Re: not informing her of what occurred when the patient died on November 19, 2016

35. On this issue the Committee considered the following information from the parties.

36. The Applicant stated that, upon being advised of her husband's death, she drove to BCH and told the nurse at the desk that she wanted to speak to the Respondent. The nurse told her the Respondent was not available to talk to her.

37. The Respondent advised that at no point was he told that the Applicant was in the hospital or that she wanted to talk to him. Had this been brought to his attention, he said, he would have gladly taken the opportunity to update the Applicant on the day's unfortunate events.

38. While the Committee stated it could not reconcile, what it called "the divergent accounts", the Board finds it is possible that both accounts are correct. There is nothing in the Record that disputes the Applicant's statement that she requested to speak to the Respondent. Nevertheless, as pointed out by the Committee, there is nothing in the Record that would suggest that the Respondent was made aware of the request and on that basis the Board finds the Committee's decision to take no action was reasonable.

Re: not referring to the patient by his given name and calling him a poor specimen during a meeting with the Applicant on December 29, 2016

39. On this aspect of the complaint the Committee received divergent accounts.

40. The Applicant indicated in her letter of complaint and telephone interview with the Committee investigator, that at the December 29, 2016 meeting with the Respondent, arranged by Patient Relations, the Respondent did not refer to the patient by name and called him a "poor specimen" in front of her and her 19-year-old son.

41. The Respondent explained that he referred to the patient as "your husband" and "your father" rather than "Mr. Leonetti" because, he stated, he found the latter somewhat distant and unnecessarily formal. He said, "… the term 'poor specimen' is not something I have ever used in my everyday work vernacular and is certainly out-of-character for me. I am entirely sure that I never used this term, but if I did I sincerely apologize for whatever stress/anxiety it may have caused."

42. The Board observes, as indicated above, that the Committee's mandate is that of a screening committee with regard to complaints about its members. The Committee considers the information it obtains in order to determine whether, in all 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 factual findings. The Committee does not assess credibility *per se*, but it is permitted to engage in some limited weighing of the facts to assess the complaint.

43. In these circumstances, the Committee took no further action on the complaint and the Board finds this decision to be reasonable.

44. The Board shares the Committee's stated impression that the Respondent was attempting to deal with a complex and deteriorating health situation. The Board, however, also recognizes and sympathizes with the painful position of the Applicant and her son, who, because of circumstances that were beyond their control, were unable to say goodbye to their husband and father, thereby delaying their grieving and extending the trauma they have experienced.

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 Greenway

Mason Greenway

Teng-teng Amy Go

Teng-teng Amy Go

Thomas Kelly

Thomas Kelly