File # 16-CRV-0413

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

David Scrimshaw, Designated Vice-Chair, Presiding
Michael Bossin, Vice-Chair
Taivi Lobu, Vice-Chair

Review held on January 25, 2017 at Ottawa, 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.M.

Applicant

and

R.P., MD

Respondent

Appearances:

The Applicant:	M.M.
For the Respondent:	Brieanne Brannagan, Counsel
For the College of Physicians and Surgeons of Ontario:	Nadia Rajah (by teleconference)

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 take no further action.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by M.M. (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 R.P., MD (the Respondent). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. The Applicant was the mother of the patient, a young woman who had a medical history of Down syndrome and asthma. The Applicant and a friend both had Power of Attorney (POA) for personal care for the patient.

4. In January 2015, the patient was admitted to hospital with a diagnosis of influenza A and pneumonia. On January 12, 2015, the patient required intubation for respiratory distress and she was admitted to the ICU (Intensive Care Unit). Over the next few days, the patient did well and her condition improved.

5. On January 17, 2015, it was decided to remove the intubation, but after about two hours, the patient developed respiratory difficulty and required reintubation. The reintubation process was complicated. After a number of unsuccessful attempts using several different methods, an emergency tracheostomy was performed. During the tracheostomy, the patient went into cardiac arrest which caused her to lose oxygen to the brain for more than ten minutes. During the tracheostomy, physicians discovered that the patient suffered from a previously undetected condition characterized by soft cartilage in the trachea that was weak and floppy, which can cause the tracheal wall to collapse. A collapsed tracheal wall blocks the airway and causes difficulty breathing. This would have affected the reintubation attempts.

6. The loss of oxygen led to an anoxic brain injury. Assessments by neurologists in the following days concluded that the patient had very little chance ever to breathe on her own or make any kind of meaningful recovery from the devastating brain damage she had sustained.

7. The Respondent physician, an internal medicine specialist, first saw the patient on the morning of January 27, 2015. Later that day, after a meeting with the patient's family that included the POAs, the decision was made to discontinue ventilation and provide palliative care to the patient.

8. On January 29, the patient died.

The Complaint and the Response

9. The Applicant confirmed her complaint as being that she was concerned that the Respondent failed to provide appropriate care to her daughter, the patient, when he assumed her care in that he:

- discontinued her ventilator without consent from the POAs;
- failed to adequately document the decision to remove the patient from the ventilator and leaving the only documentation about same to be from the hospital Chaplain;
- did not give the patient enough time to progress before making the decision to terminate the ventilation; and
- failed to try medication other than propofol to treat the patient's seizures.

10. The Applicant also stated she would like a detailed explanation of the reintubation attempts to see documentation on third party reviews mentioned by a physician involved with her daughter's care.

11. The Respondent had several conversations with a College Investigator about the Applicant's complaint. The Respondent denied discontinuing the patient's ventilator without consent. Regarding this, the investigator noted that the Respondent said:

- The patient's care followed a team approach.
- The team would not have proceeded without consent.
- There was consensus amongst the medical team that there was no reasonable chance of recovery.
- It was his understanding that the Applicant wanted the patient's body to do what it wanted to do and that the Applicant understood that the patient would not survive without the ventilator.
- He was shocked and hurt by the intimation that he proceeded without the full support of the family. That was something he would never do and did not do, and even if he wanted to, the team would not support that and someone would have called the Consent and Capacity Board.

12. The Respondent confirmed that he had not documented the decision to remove the patient from the ventilator. He said that he should have made the record of the conversation, but the ICU was very busy that day and the hospital Chaplain, who also attended the meeting with the POAs, discussed that she would write the note on behalf of both of them. He said he felt comfortable with this because there was no contention about the decision.

13. Regarding the concern that the Respondent did not give the patient enough time to progress before making the decision to terminate the ventilation, the Respondent said that if the family had expressed that there was not enough time or that the family needed more time, he would have given them more time, but this was never expressed to him.

14. The Respondent said that propofol was continued for the patient's seizures because there was nothing better.

15. The Respondent stated that the Applicant had contacted the hospital's Patient Relations department who did a review of the patient's care and offered to meet with the Applicant, but the Applicant did not wish to proceed at that time.

16. The Respondent further said that he and the head of the ICU, who also spoke to the College investigator, would bring some of the Applicant's suggestions to the next department meeting.

The Committee's Decision

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

18. The Committee found that the Respondent's management of the patient – and in particular his discussion with the POAs with respect to consent for withdrawal of ventilation and treatment with palliative care only – was appropriate. The Committee noted that consent was required in order to withdraw life-sustaining treatment and that there is documentation in the chart that indicates the family agreed to withdraw ventilation and initiate palliative care.

19. The Committee found that while it might have been ideal, in retrospect, for the Respondent to have charted the meeting with the family, the Committee accepted his decision to delegate the task to the hospital Chaplain given his understanding at the time that the family, including the Applicant and the other POA, had provided consent and that there was nothing controversial in the outcome of the family meeting. The Committee stated that the important aspect from a documentation perspective is that the chart entry provides evidence of the outcome of the meeting in question in keeping with College policy on medical records.

20. The Committee accepted the Respondent's statement that, had he been aware that the Applicant felt she did not have enough time after making the decision, he would have provided her more time.

21. The Committee also accepted the Respondent's explanation that propofol was the best drug available to provide relief to the patient from the seizures she was experiencing.

22. The Committee found it was not certain if there was a "third party" report related to the care provided to the patient, but that the Respondent had advised that he was aware of an internal hospital review and the Committee suggested that the Applicant might be able to review it if she contacts the hospital's Patient Relations department.

III. POWERS OF THE BOARD

23. 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.

24. 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.

IV. ANALYSIS AND REASONS

25. 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.

26. 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

27. 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.

28. The Committee obtained the following documents:

- the Applicant's initial complaint and subsequent communication including memoranda of conversations between the Applicant and the College investigator;
- memoranda of conversations between the Respondent and the College investigator;
- the patient's medical records;
- a memorandum of a conversation with the hospital Chaplain who attended the meeting with the patient's family on January 27, 2015
- memoranda of conversations with the head of the ICU;
- CPSO Policy #4-12: *Medical Records*; and
- CPSO Policy #4-15: *Planning for and Providing Quality End-of-Life Care*.

29. The Applicant submitted that the investigation was inadequate because the Committee should have interviewed the patient's other POA.

30. Counsel for the Respondent submitted that the investigation was adequate in that the essential information was gathered to assess the complaint and no additional information was needed to determine the standard of care issue. Regarding interviewing the patient's other POA, counsel submitted that the Committee's investigation did not need to be exhaustive and that the Committee cannot determine credibility.

31. Following a question from the Board during the Review, the College representative indicated that during the investigation, the Applicant was asked if the other POA should be interviewed and the Applicant indicated that the other POA did not wish to participate. On this point, the Applicant submitted that while the other POA preferred not to participate, she would have done so if asked.

32. The Board finds the Committee's investigation to have been adequate. The essential records were obtained. The Applicant had the opportunity to provide information from the other POA, and even if this information was provided, there is no indication that it would have substantially differed from information provided by the Applicant herself, which the Committee considered.

Reasonableness of the Decision

33. 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.

Consent

34. The main concern for the Applicant was whether the Respondent had consent to discontinue the patient's ventilation. The Applicant maintained that she and the patient's other POA had not given their consent, while the Respondent stated there was consent.

35. The Committee found that the patient's medical records supported the Respondent's understanding that the Applicant and her joint-POA had provided informed consent to discontinue ventilation. The Committee noted that the documentation from the hospital Chaplain following the meeting on January 27, 2015 stated: "it was decided to let [the

patient] go…" and that the discharge summary stated: "After discussion with the family it was jointly decided that the most appropriate and kind thing was to withdraw care." In addition, the Committee was satisfied that the nursing notes also demonstrate that the Applicant agreed with and consented to the decision to withdraw life support. The Committee noted that the Respondent, the head of the ICU and the hospital Chaplain all pointed out that if the Applicant had made any objections, the Respondent could not have acted unilaterally to withdraw life support as this would go against their professional, ethical and legal obligations.

36. While the Applicant submitted at the Review that she did not consent, the Board notes that the Applicant was present during the relevant discussions and the medical records contain no indication that either she or the other POA objected to the withdrawal of the patient's ventilation at the time.

37. The Board finds the Committee's decision on this concern to be supported by the information in the Record and therefore it is reasonable.

Documentation by the hospital Chaplain

38. Although the Respondent stated that he should have written his own documentation of the family meeting on January 27, 2015, the Committee found it acceptable for the documentation to have been done by the hospital Chaplain who also attended the meeting. The Committee stated that the important aspect from a documentation perspective is that the entry provides evidence of care, or in this case evidence of the outcome of the meeting in question, in keeping with College policy on medical records.

39. The Board notes that the College policy on medical records requires physicians to ensure the accuracy of the entries made into the medical records, but permits entries to be made on behalf of a physician by "a trainee or the recipient of delegation."[1] The Board further notes there is no indication in the Record that the Respondent would have documented the outcome of the meeting any differently than the hospital Chaplain did.

[1] CPSO Policy #4-12: *Medical Records*, page 3.

40. The Board finds the Committee's decision on this concern to be reasonable because the decision is supported by the Record and grounded in the Committee's expertise and College policy.

Enough time

41. The Committee accepted the Respondent's statement that, had he been aware that the Applicant felt she did not have enough time after making the decision, he would have provided her more time and therefore took no action on this aspect of the complaint.

42. The Board notes that both the complaint and the Respondent's response concerned giving the patient more time to progress before the decision was made to take her off the ventilator. That being said, the Committee noted that the head of the ICU had indicated that in a situation like the patient's, 72 hours is the usual time given to see if a patient recovers, but in this case, it was 11 days, without any sign of significant improvement, before the decision was made to discontinue the ventilation. The Board notes there is no indication in the Record that the Applicant or any other family members requested more time before the patient's ventilation was removed. A memorandum of a conversation between the College investigator and the Applicant states that the Applicant indicated, "she did not verbalize that she required more time." There is information in the Record that the patient was continuing to have seizures and these distressed family members.

43. The Board finds it reasonable for the Committee to have taken no action on the concern that the Respondent did not give the patient enough time to progress before making the decision to terminate the ventilation as the Committee's decision is based on information in the Record and the Committee's expertise and there was no persuasive information in the Record or advanced at the Review to demonstrate that the Committee's opinion on this issue was inappropriately applied.

Medication other than propofol

44. The Committee stated that it accepted the Respondent's explanation that propofol was the best drug available to provide relief to the patient from the seizures she was experiencing. The Committee panel that assessed this complaint included two physicians. The Board finds that assessing this aspect of the complaint was within the Committee's expertise and the decision is reasonable as there was no persuasive information in the Record or advanced at the Review to demonstrate that the Committee's opinion on this issue was inappropriately applied.

Third Party Report

45. The Committee could not ascertain the existence of a third party report regarding the care of the patient, however the Respondent did advise that he was aware of an internal hospital review which was initiated after the Applicant contacted the hospital's Patient Relations department after the patient's death and Patient Relations offered to discuss the internal review with the Applicant. The Board finds this conclusion is supported by the Record, and whether the Applicant's concern is with a third party report or an internal hospital review, there is no indication in the Record that the Respondent had any role in whether it was provided to the Applicant.

Conclusion

46. Because the Committee found no issues of concern with the Respondent, it was reasonable for the Committee to take no further action on the complaint.

47. The Board expresses its sincere condolences to the Applicant on the loss of her daughter.

V. DECISION

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

ISSUED March 24, 2017

David Scrimshaw
David Scrimshaw

Michael Bossin
Michael Bossin

Taivi Lobu
Taivi Lobu