File # 22-CRV-0499

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

2023 CanLII 109216 (ON HPARB)

PRESENT:

Bonita Thornton, Designated Vice-Chair, Presiding
Mark Gordon, Board Member
Michelle Mann-Rempel, Board Member

Review held on July 27, 2023 in Ontario (by teleconference)

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:

JG

Applicant

and

JAYANTHINI NADARAJAH, MD

Respondent

Appearances:

The Applicant: JG
For the Respondent: John Petralla, Counsel

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 issue advice to Jayanthini Nadarajah, MD on the importance of following the College's policy on end-of-life care and, specifically, ensuring compassionate communication with patients and their families, considering involvement of the palliative care team to support patients and their families; and ensuring clear documentation of conversations with patients.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by JG (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 medical care provided by Jayanthini Nadarajah, MD (the Respondent). The Committee investigated the complaint and decided to issue advice to the Respondent.

3. The Board issued a publication ban in this matter. This decision is subject to that order.

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II. BACKGROUND

4. The Applicant is the late patient's daughter. In February 2021, the patient was admitted to Royal Victoria Regional Health Centre (the Hospital), Barrie, with shortness of breath. The patient was later diagnosed with query lung cancer and respiratory illness/pneumonia.

5. During the patient's admission to hospital, the Respondent was her most responsible physician (MRP).

6. Sadly, the patient died in hospital on March 2, 2021.

The Complaint and the Response

The Complaint

7. The Applicant complained that between February 21 and March 2, 2021, the Respondent told the patient that she had Stage 4 lung cancer, without any confirmation of the diagnosis, did not consult oncology, repeatedly pressured the patient to agree to a Do Not Resuscitate (DNR) status/palliative care, and was unprofessional and combative in her approach to the family. Specifically, the Applicant was concerned that:

- the Respondent failed to provide quality care, including failing to provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns;
- despite requests from the family, the Respondent failed to request a consultation with either of the patient's existing respirologist(s) or a staff respirologist;

- the Respondent intentionally prescribed a superfluous amount of medication/narcotics with the knowledge that the dose would hasten or induce the patient's death; and
- the Respondent pressured the patient and her family for DNR palliative care status.

The Response

8. The Respondent provided two letters in response to the Applicant's complaint. The Respondent provided an overview of her care of the patient following her admission to the Hospital Emergency Room (ER) with progressing dyspnea and a working diagnosis of chronic obstructive pulmonary disease (COPD). The Respondent reviewed the details of the patient's condition and discussed the steps taken to care for the patient, including that the patient was started on antibiotics, and a CT scan and biopsy were performed, however, the Respondent noted that the patient was declining clinically. Additional details of the Respondent's response to the Applicant's complaint concerns will be discussed in the reasonableness section of this decision.

The Committee's Decision

9. The Committee investigated the complaint and decided to issue advice to the Respondent, as noted above.

10. The Committee stated that a review of the complaint and the Record indicated to the Committee that much of the Applicant's concern stems from an under-appreciation of the patient's frail pulmonary status. While the Applicant described the patient as having stable and non-deteriorating respiratory disease, this contrasted with the patient's history of a very recent hospitalization a week prior to her final admission, and a CT scan showing severe findings, including lung nodules indicative of metastases.

Concern that the Respondent failed to provide quality care, including failing to provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns

11. The Committee determined that based on its review of the medical record, it was satisfied that the Respondent's medical care of the patient was appropriate. The Committee determined that the treatment for COPD/pneumonia was standard, Infection Disease (ID)

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service was involved to ensure appropriate antimicrobial coverage, and the pulmonary nodules were biopsied. The Committee stated that the patient had deterioration from a respiratory standpoint (hypoxia and dyspnea) which did not respond to treatment (unless the care progressed to invasive respiratory support). The Committee indicated that referral to oncology would not normally be done until a tissue diagnosis is available, as this is needed to determine therapy. With the severe underlying lung disease and multiple presumed metastatic nodules increasing on two scans, it was reasonable for the Respondent to present this information to the patient as being a situation with an expected poor prognosis.

12. The Committee decided that given that the Respondent's care of the patient was acceptable and appropriate, it would take no action on this area of concern.

Concern that despite requests from the family, the Respondent failed to request a consultation with either of the patient's existing respirologist(s) or a staff respirologist

13. The Committee stated that there was no mention of the request to consult with the outside respirologist in the Respondent's chart notes; the chart documented that the Applicant had a discussion with the outside respirologist to discuss the patient's Code status, but there was no follow up commentary; and there was a handwritten note from the ID service asking for notes from this outside respirologist about the aspergillus culture.

14. The Committee found it could not tell from the medical record if the Respondent and the Applicant discussed consulting a respirologist, but it did not appear to the Committee that an additional consultation was necessary.

15. The Committee decided to take no further action on this issue.

Concern the Respondent intentionally prescribed a superfluous amount of medication/narcotics with the knowledge that the dose would hasten or induce the patient's death

16. The Committee stated that the medications ordered were standard medications to be used in palliative care, to relieve secretions, pain, and agitation, and that they were ordered with standard dosages and intervals appropriate to the clinical situation of end-of-life care.

17. The Committee decided to take no further action on this aspect of the complaint.

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Concern that the Respondent pressured the patient and her family for DNR/palliative care status

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18. The Committee indicated that it was difficult to fully discern from the medical chart whether there was any pressure from the Respondent, but that it was clear that the patient and the Applicant had differing ideas about the phase of illness the patient was in.

19. The Committee noted from the chart that the patient was competent and participating in these care discussions, and there were comments made by the Respondent about recommending that the Applicant read about a court ruling on the physician's role in code status.

20. The Committee found that the Respondent's comment was a potentially inflammatory remark to make in this circumstance.

21. The Committee further noted in the chart that the patient experienced some increased anxiety after the code status discussions, which seemed to take place daily. The Committee found that it was difficult to determine the content of these discussions with the patient as the notes were brief.

22. The Committee determined there were clear notes from the Respondent, the nurse, the unit manager, and the team leader indicating that the Applicant was not supportive of limiting care for the patient and did not agree with the diagnosis and prognosis for her mother.

23. The Committee decided, given the complexities of the situation and the brevity of the Respondent's chart entries with respect to discussions, that the Respondent would benefit from advice on following the College's policy on end-of-life care, and specifically on ensuring compassionate communication with patients and their families, considering involvement of the palliative care team to support patients and their families, and ensuring clear documentation of their conversations with patients.

III. REQUEST FOR REVIEW

24. In a letter dated July 27, 2022, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

25. 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.

26. 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 specified allegations to the Discipline Committee that would not, if proved, constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

27. 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.

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

29. In this regard, the Committee is to act in relation to the College's objectives under section 3 of the *Code*, which include, in part, to maintain programs and standards of practice to assure the quality of the practice of the profession, to maintain standards of knowledge and skill and programs to promote continuing improvement among the members, and to serve and protect the public interest.

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30. The Committee's mandate is to screen 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 member's practice, issuing a caution or directing other remedial measures intended to improve an aspect of a member's practice, or referring specified allegations of professional misconduct or incompetence to the Ontario Physicians and Surgeons Discipline Tribunal (OPSDT) if the allegations are related to the complaint.

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The Parties Submissions

31. The Applicant submitted that the investigation was not adequate. The Applicant submitted that the matter required further investigation, and that there was not a stage 4 diagnosis for the patient until after the patient passed away.

32. The Applicant restated some of her original complaint and submitted that the Committee's decision was not reasonable because the quality of care provided by the Respondent was not adequate and the Committee's decision focused on the Respondent's opinion. The Applicant submissions included the following;

- her objections were around the unethical treatment the patient received from the Respondent;
- the Respondent diagnosed the patient with terminal cancer, but the Applicant submitted there was no information at the time that the patient had stage 4 cancer; however, the Respondent told her the patient's condition was terminal from the first day, no matter what the Applicant requested;
- the Applicant did not see a pathology report that confirmed stage 4 cancer;
- the Applicant felt the patient was bullied into acquiescing to terminal care, and submitted that the Respondent said she told her mother that if her heart stops, she will not resuscitate her;
- there had been no consultation with the palliative care department;

- there were clear notations in the medical records that the family and patient disagreed with palliative care, and thinks that the families wishes were not honoured;
- there were no "do not resuscitate" forms in the record; and
- palliative care does not give a doctor the right to withdraw care, and the Applicant was not certain why the patient was not given treatment options for that – in terms of palliative care.

33. Counsel for the Respondent submitted that the investigation was adequate, and that the materials gathered by the Committee were entirely adequate and were not missing any crucial information

34. Counsel for the Respondent submitted that the Committee's decision was reasonable. Counsel submitted that the Committee's decision was clear and supported by the medical records. Counsel further submitted that the Committee's decision to issue advice to the Respondent was reasonable and that the Respondent takes it seriously.

35. 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

36. 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.

37. The Board finds that the investigation was adequate for the reasons that follow.

38. The Committee obtained the following documents:

- the Applicant's letter of complaint and additional correspondence;
- a memorandum of a conversation between the Applicant and the Committee investigator, confirming the Applicant's complaint;
- an email from the Applicant providing additional concerns;
- a subsequent memorandum from the Committee investigator to the Applicant, outlining the revised concerns;
- the letter of response from the Respondent and a subsequent response providing additional information;

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- the patient’s medical records from the Royal Victoria Reginal Heath Centre,
- the College’s policy: *Planning for and Providing Quality End-of-Life Care*; and
- the Respondent’s College profile and prior decisions.

39. The Applicant submitted that the investigation required further investigation.

40. The Board notes that the Committee’s investigation included obtaining the patient’s hospital records from 2010, including the patient’s prior admission and covering the entirety of the Respondent’s care of the patient. These records included results from a biopsy and CT scans, references to resuscitation orders and discharge information.

41. The Board observes that the parties were offered opportunities to submit information to the Committee. The Applicant clarified and confirmed her concerns in writing, and the Applicant continued to correspond with the Committee investigator, adding additional concerns. The Respondent provided her response and her additional response, as well as medical records in relation to her care of the patient. In addition, the Committee obtained the Respondent’s College Physician Profile and prior decisions.

42. The Board finds the Committee’s investigation covered the events in question, and that it obtained the essential information relevant to making an informed decision regarding the issues raised in 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.

43. Accordingly, the Board finds that the Committee’s investigation was adequate.

Reasonableness of the Decision

44. In determining 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. Rather, the Board considers the outcome of the Committee’s decision in light of the underlying rationale for the decision, to ensure that the decision as a whole is transparent, intelligible and justified. That is, in considering whether a decision is reasonable, the Board is concerned with both the outcome of the decision and the reasoning process that led to that outcome. It considers whether the Committee based its decision on a chain of analysis that is coherent and rational and is justified in relation to the relevant facts and the laws applicable to the decision-making process.

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45. The Board notes that the circumstances of this complaint required the Internal Medicine Panel, which included four professional members, to rely on its medical knowledge and expertise related to the expected standards of the profession in assessing the Respondent's conduct and actions.

46. The Board further notes that the Committee made specific reference to and relied on the contemporaneous health records in support of its conclusions. For example, the Committee specifically noted the following information from the medical records in its decision:

- The patient had a medical history of COPD, bronchiectasis, pulmonary fibrosis, coronary artery disease (CAD), and hypertension. She was on home oxygen, and had been recently discharged from hospital for an admission from February 5 to 14, 2021, for COPD/pneumonia. A CT scan during this admission showed extensive lung disease, including a new finding of multiple nodules concerning for metastases.
- On February 21, 2021, the patient was taken to the ER via EMS with worsening shortness of breath, wheezing, and low-grade fever. In the ER, a chest x-ray showed extensive airspace disease, needing high amounts of oxygen. The patient was readmitted to RVRHC with an admitting diagnosis of "COPD/pneumonia" under the Respondent's care. The patient was deemed competent and her resuscitation status was documented as Full Code on admission.
- The Respondent stated that she would not escalate care to include cardiopulmonary resuscitation (CPR) for the patient at this point. The chart documents that the patient was grateful for the call.

47. Health records are legal documents which all health professionals are required to make. They provide a contemporaneous record of the interactions with the patient, made by health professionals prior to the commencement of any complaint or legal process. As such, in the absence of compelling information to the contrary, health records are a reliable source of information as to what occurred during patient encounters.

48. The Board has considered the Committee's decision under the same issues identified by the Committee.

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Concern the Respondent failed to provide quality care, including failing to provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns

49. The Board finds that the Committee's decision to take no further action with respect to the Applicant's concern that the Respondent failed to provide quality care is reasonable.

50. The Board notes that in reaching its determination the Committee referred to the information in the Record. The Committee specifically noted the following information from the medical record:

- Under the Respondent's care, ID service consulted in the patient's care on February 22 due to aspergillus on sputum from the patient's prior admission. The ID consultant recommended repeat CT scan and prescribed an anti-fungal medication (voriconazole). Repeat CT scan showed pneumonia, bronchiectasis with necrotic areas of lung, and multiple nodules in the lungs suggestive of malignancy. The patient received ongoing treatment with bronchodilators, diuretics (Lasix), antibiotics, and oxygen.
- On February 24, there is documentation in the chart by the Respondent, the unit manager, and the service leader after several telephone calls from the Applicant. The Respondent's chart entry suggested conflict between the patient and the Applicant with respect to expectations, with the patient stating that the Applicant was "unrealistic".
- On February 26, the patient underwent a lung biopsy, which proceeded without complications.
- On February 28, the patient showed signs of clinical deterioration, with worse hypoxia and fatigue; the chart indicates that the patient was aware of the decline in her condition and that she was nearing the end of life. The patient agreed to not escalate care. The patient had a telephone call with the Applicant and a nurse on speakerphone in which the Applicant disagreed with the patient's deteriorating status and requested a repeat CT (which was not indicated). The chart documented that the patient was grateful for the call.
- On March 1, the patient had worsening hypoxia and confusion.

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- On March 2, the patient experienced severe dyspnea; she decided to move to comfort measures only and wanted her loved ones to be contacted. A chest x-ray was unchanged from the previous scan. The patient's care was changed to palliative, and the Respondent placed orders for dilaudid, nozinan, and scopolamine as needed, in doses appropriate for palliative care. The patient died that evening.

51. The Committee also referred to information from the Respondent including:

- The Respondent discussed the CT scan results with the patient and the Applicant, and that she was awaiting the results of the biopsy for the patient.
- The patient wanted to go ahead with a lung biopsy. The Respondent also discussed Code status with the patient.
- On February 25, the Respondent had a telephone call with the patient and the Applicant in which she again reviewed the results of the CT scan, discussed an oncology consultation once tissue diagnosis from the biopsy was available, discussed a referral to speech language pathology for choking/problems swallowing, and explained the rationale for the decision on the patient's Code status.

52. The Board notes that the Committee applied its knowledge and expertise related to the expected standards of the profession in considering that information and assessing the the Respondent's conduct and actions to state the following:

- the Committee was satisfied the Respondent's medical care of the patient was appropriate;
- the treatment for COPD/pneumonia was standard;
- the patient had deteriorated from a respiratory standpoint and a referral to oncology would not normally be done until a tissue diagnosis was available; and
- it was reasonable for the Respondent to present this information as an expected poor prognosis.

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53. The Board acknowledges the Applicant's submissions that she had doubts about the Respondent's diagnosis; however, the Board finds that the information in the Record, including the contemporaneous medical records, provides support for the Respondent's response and the Committee's conclusion on the diagnosis and its decision to take no further action.

54. The Board finds that the Committee's decision to take no further action on this aspect of the complaint is reasonable.

Concern that, despite requests from the family, the Respondent failed to request a consultation with either of the patient's existing respirologist(s) or a staff respirologist

55. The Board finds that the Committee's decision to take no further action with respect to the Applicant's concern that the Respondent failed to request a respirologist consultation is reasonable.

56. The Board observes that in reaching its conclusion the Committee referred to information in the Record. The Committee specifically noted the medical record, which documented that the Applicant spoke with the outside respirologist to discuss the patient's code status, and which documented a handwritten note from the ID service asking for notes from this outside respirologist about the aspergillus culture. The Committee also noted that there was no notation by the Respondent of a request for an outside respirologist.

57. The Board notes that the Committee applied its knowledge and expertise related to the expected standards of the profession in considering that information and deciding that although it could not tell from the medical record if a discussion regarding a respirologist occurred, the Committee found that an additional consultation was not necessary.

58. The Board therefore finds that the Committee's decision to take no further action with respect to this aspect of the complaint is reasonable.

Concern the Respondent intentionally prescribed a superfluous amount of medication/narcotics with the knowledge that the dose would hasten or induce the patient's death

59. The Board finds that the Committee's decision to take no further action with respect to the Applicant's concern that the Respondent intentionally prescribed superfluous medication is reasonable.

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60. The Board notes that the Committee considered the Applicant's concern, and the Committee had the patient's hospital record before it, which contained the information on the medications prescribed by the Respondent. The Board observes that the Committee considered the information before it and applied it knowledge and expertise related to the expected standards for the profession in assessing the Respondent's actions and stating that the medications ordered were standard medications to be used in palliative care.

61. The Board therefore finds that the Committee's decision to take no further action on this aspect of the complaint is reasonable.

Concern that the Respondent pressured the patient and her family for DNR/palliative care status

62. The Board observes that the Committee's decision makes specific references to information in the Record, including the information that the Applicant's calls to the Respondent and others suggested that she felt that the patient was being forced into agreeing to minimally invasive care, that the patient had "white coat syndrome" and as a result was getting sicker while in the hospital setting, and that the Applicant did not agree with the diagnosis and prognosis for the patient.

63. The Committee also referred to information from the medical record, which included the following:

- the patient chart, which indicated that the patient signed a form consenting to minimally invasive measures, that the patient was competent and participating in care discussions, that the patient requested to move to comfort care and did not want to continue fighting in her current state, and that the chart indicated the patient experienced some increased anxiety after Code status discussions;
- notes from the Respondent and other health care professionals indicating that the Applicant had a different view on the care her mother should receive; and
- the Respondent's notes, which included the comment made to the Applicant recommending court rulings and the physician's role in Code status.

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64. The Board notes that the Committee applied its knowledge and expertise related to the expected standards of the profession, and considered the relevant College standard, in assessing the Respondent's conduct and actions and in observing that there was not much detail in the notes with respect to the contents of the Respondent's discussions with the patient and the Applicant, and in deciding to provide advice to the Respondent on following the College's policy on end-of-life care; ensuring compassionate communication with patients and families; involvement of the palliative care team to support patients and families; and ensuring clear documentation.

65. The Board finds that the documentation in the Record supports the Committee's identification of a concern with the Respondent's practice. The Board further finds that the advice the Committee provided to the Respondent fully addresses the concern the Committee identified and is a remedial disposition that can be expected to improve the Respondent's practice. In choosing to provide advice, the Committee considered appropriate factors such as the Respondent's lack of a significant complaints history with the College, and no previous decisions related to the issue identified in this matter. The Board sees no indication in the Record that the Respondent is not capable of remediation in this area.

66. The Board therefore finds that the Committee's decision to issue advice to the Respondent with respect to this aspect of the complaint is reasonable.

Conclusion

67. The Board acknowledges that the Applicant continues to have questions about the care the patient received and is dissatisfied with the Committee's decision. The Board finds however that the Committee conducted an adequate investigation and reached a reasonable decision that is supported by the information in the Record. The Board finds that the Committee's decision demonstrates a coherent and rational connection between the relevant facts, the outcome of the decision and the reasoning process that led it to that outcome, and that its decision as a whole is transparent, intelligible, and justified.

68. The Board notes that the Applicant's complaint and the Committee's disposition in this matter will remain on the Respondent's permanent (although private) record with the College and will be considered should another complaint arise in the future.

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69. For the reasons set out above, the Board finds that the Committee's investigation was adequate and the Committee's decision is reasonable.

70. The Board wishes to extend its condolences to the Applicant for her loss.

VI. DECISION

71. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to issue advice to the Respondent on the importance of following the College's policy on end-of-life care and, specifically; ensuring compassionate communication with patients and their families; considering involvement of the palliative care team to support patients and their families; and ensuring clear documentation of conversations with patients.

ISSUED November 22, 2023

Bonita Thornton

Bonita Thornton

Mark Gordon

Mark Gordon

Michelle Mann-Rempel

Michelle Mann-Rempel

Cette décision est aussi disponible en français. Pour obtenir la version de la décision en français, veuillez contacter hparb@ontario.ca

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