File # 17-CRV-0491

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Katherine Ball, Designated Vice-Chair, Presiding
James Beamish, Board Member
Kathleen Ryan Elliott, Board Member

Review held on April 18, 2018 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:

A.D.

Applicant

and

M.O.M., MD

Respondent

Appearances:

The Applicant:	A.D.
For the Respondent:	Marc Flisfeder, Counsel
For the College of Dental Surgeons of Ontario:	Lindsay Turnbull (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 with respect to this matter.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by A.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 regarding the care provided by M.O.M., MD (the Respondent) to the Applicant's late son (the patient). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. On October 1, 2016, the patient was crossing the street when he was hit by a car. The patient was initially taken to Guelph General Hospital where he was assessed at level 3 on the Glasgow Coma Scale, an assessment akin to a deep coma. The patient was then transferred to the Intensive Care Unit (ICU) at Hamilton General Hospital (HGH) for further assessment and early investigations revealed a catastrophic traumatic brain injury.

4. At approximately 12:45 p.m. on October 6, 2016, the patient was declared brain dead. Later the same day, the Applicant requested a family meeting. A meeting was conducted by the HGH Ethicist and a plan of care was agreed upon.

5. The Respondent, an intensivist, was the patient's most responsible physician (MRP) at HGH until October 6, 2016.

6. On October 21, 2016, the patient's mechanical ventilation was discontinued.

The Complaint and the Response

7. In correspondence dated October 11 and 17, 2016, the Applicant complained to the College about the care provided to the patient by the Respondent and three other physicians. Regarding the Respondent, the Applicant complained that she conducted herself in an unprofessional manner and provided an inadequate assessment, care and management of the patient during his admission to HGH. Specifically, the Applicant complained that the Respondent:

- neglected to treat the Applicant and the patient with integrity, respect and compassion;
- failed to perform legitimate and valid clinical investigations on the patient and misdiagnosed him as brain dead; and
- inappropriately counselled the Applicant, on more than one occasion, to cease life-sustaining treatment for the patient, motivated by an unprofessional desire to obtain his organs for donation.

8. In a letter dated November 28, 2016, the Respondent provided her response to the Applicant's complaint and stated that:

- She recalled caring for the patient during the first 6 days of his hospitalization and also reviewed his hospital records. The Respondent set out the circumstances of the patient's accident and his transfer to HGH for management of a multisystem trauma including severe traumatic brain injury, which was his most critical injury.
- An initial brain CT scan showed extensive injury with bleeding, severe swelling and early signs of brain herniation. A CT angiogram revealed severely compromised blood flow through the anterior circulation of the brain. The consulting neurological resident assessed the patient in the Emergency Room as "likely brain dead" and spoke to the patient's family about his critical condition and likely poor prognosis.
- The Respondent expressed regret if her communication style with the Applicant did not convey the respect and compassion that she felt for her and that the Applicant perceived her to have failed to act with integrity. The Respondent stated that she had had responsibility for conveying tragic news to patients for many years and it was rarely easy to communicate such a devastating prognosis. The Respondent went on to describe the efforts she made to convey respect and compassion.

- The Respondent stated that she was pleased to include the Applicant in her beside ICU rounds and to answer her questions, soliciting input from others when necessary. At an early family meeting, they all agreed that barring apparent change in the patient's condition, the Respondent would examine the patient's brain function and order a CT scan after three days and at the ethics meeting they all agreed upon the timing, the people and the methods for assessing brain function.
- The Respondent stated that she respected and acknowledged the Applicant's training as a nurse and the special understanding and experience this entailed. She also respected the tremendously difficult position of the Applicant being both a nurse and the mother of a tragically injured child.
- As a mother of teens herself, the Respondent stated that she could barely imagine the pain that the Applicant endured over the patient's first 6 days in hospital, when she was involved in the patient's care. Out of respect for the Applicant and her wishes, the Respondent delayed a formal assessment of brain function first by 3 days and then by 1 more day. The Respondent's usual practice and the practice of the hospital was to examine a patient for signs of brain function as soon as one suspects brain death.
- The Respondent was comfortable delaying the brain function assessment and ordering an otherwise unnecessary test at the Applicant's request, in light of the Applicant's tremendous suffering.
- The Respondent stated that she consulted with colleagues for second opinions, calling a number of consultants at home in the evening after the meeting with the family and the HGH ethicist. The Respondent also asked the Applicant's friend and family how she might better support the Applicant.
- The Respondent felt caught between her compassion for the Applicant and her respect for the patient. She strongly suspected that the patient had already died but nevertheless chose to perform an invasive procedure (chest tube insertion) in order to prevent a possible cardiac arrest on the day that the patient developed a complication of chest trauma. Out of respect for the patient, the Respondent explained to the Applicant that she would only delay the brain

death assessment if the Applicant would agree that in the event of possible cardiac arrest, cardiopulmonary resuscitation (CPR) would not be performed. The Applicant agreed. Nursing staff respectfully continued to care for the patient and attend to his privacy long after they suspected that he had died and even after they confirmed that he had died.

- In the Respondent's formal assessment for brain death, the Respondent followed the highest standards of neurological death determination, as described in the national guidelines, provincial protocols and the Hamilton Health Sciences standards. Each step was conducted by two authorized intensive care physicians, in accordance with the guidelines.
- The Respondent conducted the assessment with one of her ICU colleagues and they arrived at the same determination of death. This determination was accepted by the coroner who recorded the official time of death as 12:45 p.m. on October 6, 2016.
- The Applicant did raise concerns about the validity of the assessment for neurologic death in circumstances where there was a brain edema and a chest tube in pace and at the ethics meeting the Respondent noted the validity of the testing in the patient's case and addressed the Applicant's concerns by having another authorized physician carry out the test with her, consulting with the on-call neurologist to address the concerns and allowing the Applicant to arrange for an independent expert consultation from an expert of her choice. The Respondent stated that all three of the consulting physicians agreed with the validity of the clinical testing and diagnosis.
- The Respondent denied counselling the Applicant to cease life-sustaining treatments for the patient. Her usual approach was not to discuss withdrawal of life support until such time as (i) a family accepts a very grim prognosis for a meaningful recovery or (ii) death by neurologic criteria has been determined or (iii) the family asks clear questions about withdrawal of life support.
- The Respondent stated that she would never discuss organ donation unless (i) a decision was made to withdraw life support or (ii) there was a neurologic

determination of death or (iii) unless specifically asked about organ donation by a family member. This is the approach that she teaches and practices.

- The Respondent did answer questions about organ donation from the Applicant at their first meeting during the patient's first morning in the ICU. The Respondent was told by the patient's nurse that the Applicant wished to speak to her about organ donation "as soon as possible".
- When the Respondent met with the Applicant, she indicated that she wanted the patient to be an organ donor and the Respondent informed her that she had yet to do a full neurological assessment and that they should focus on his comfort his potential for recovery and consideration of appropriate goals for care for the time being.
- The Respondent stated that she answered questions about withdrawal of life support at a family meeting on the second day when the patient's brothers asked how things would proceed if the patient was determined to be brain dead. The Respondent described that on that day they knew that the patient was not brain dead because he was still initiating breaths. She described the procedures for the withdrawal of life support and about the hypothetical possibility of organ donation in such situations, as the Applicant had previously raised the issue.
- At the meeting with the ethicist and in response to a direct question from the ethicist about steps after a formal neurologic determination of death, the Respondent stated that she explained as gently as possible that they typically allow time for family and friends to visit and then, at an agreed upon time, they remove the life support treatments.
- The Respondent stated that she did not recall other discussions with the Applicant about withdrawal of life support or organ donation.
- The Respondent expressed appreciation for the feedback received, even in the form of a complaint to the College and that she would keep the concerns in mind as she faced similar discussions in the future.

9. In a letter dated December 23, 2016, the Applicant provided her comments upon the Respondent's letter of response to her complaint. The Applicant disagreed with many aspects of the Respondent's response and repeated her complaint that the Respondent denied care to the patient as she wished to obtain his organs.

The Committee's Decision

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

III. REQUEST FOR REVIEW

11. By letter dated August 13, 2017, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

12. 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.

13. 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

14. 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.

15. 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

16. 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 issue raised in the complaint.

17. In her submissions to the Board, the Applicant stated that she felt the investigation was inadequate as she had questions that were not answered. The Applicant submitted that there was nothing in the investigation that addressed what she called the "bullying" and unprofessional conduct of the doctors and she did not feel that the responses from the doctors to her complaints were appropriate.

18. In respect of the Respondent, the Applicant repeated her concern that she addressed the Applicant in a threatening and intimidating manner saying that when she sought to speak to the radiologist, "they called security".

19. The Applicant told the Board that her biggest concern was that the patient started breathing on his own 2-3 days after the accident and then suddenly he was not breathing. It was never explained to her why the patient was sometimes breathing and sometimes not. The Applicant repeated her concerns regarding organ donation.

20. Counsel for the Respondent submitted that the investigation into the Applicant's complaint was adequate and it garnered the essential and relevant information for the

Committee to make an informed decision regarding the conduct of and the care provided by the Respondent.

21. In the course of the investigation, the Committee obtained the following documents:

- the Applicant's letters of complaint, dated October 11 and 17, 2016 and subsequent correspondence;
- the Respondent's letter of response, dated November 28, 2016 and the Applicant's comments on the Respondent's letter;
- information from the other physicians involved in the patient's end of life care: an anaethesiologist, an intensivist and a general surgeon;
- patient records from Guelph General Hospital;
- patient records from HGH;
- a Report and Recommendations of the Canadian Council for Donation and Transplantation on Severe Brain Injury to Neurological Determination of Death;
- orders of the Consent and Capacity Board (CCB) regarding the patient;
- College Practice Guide;
- the patient medical chart; and
- College Policy #6-16: *Planning for and Providing Quality End of Life Care*.

22. The Board has reviewed the information in the Record and notes that it includes the full patient chart for the period of the Respondent's care and for the rest of his admission at HGH. The chart includes the Respondent's contemporaneous notes on the patient record and her assessments of the patient that led to the declaration of neurological death on October 6, 2016. The Record also includes the Respondent's notes of the consultation with the ethicist and family meetings and her consultations with physicians from various specialties.

23. The Board further notes that the Committee had before it the applicable College policy, namely the policy for end-of-life care and the report and recommendations of the

Canadian Council for Donation and Transplantation on Severe Brain Injury to Neurological Determination of Death, which provide the recommended clinical criteria for determining neurological death. The Committee's investigation also included the CCB decision following the Applicant's application for directions as Substitute Decision Maker (SDM).

24. The Board finds that there is no further information that has been identified that might reasonably be expected to have affected the Committee's decision had it been before the Committee when it considered the Applicant's complaint regarding the Respondent's care and professional conduct.

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

Reasonableness of the Decision

26. 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.

27. In its decision, the Committee set out its findings in respect of each of the Applicant's specific concerns in the complaint. Regarding the concern that the Respondent had not treated the Applicant and the patient with integrity, respect and compassion, the Committee found that there was no information before it to support the Applicant's concern. The Committee stated that it "commends" the Respondent on how she handled what it described as a "difficult and sensitive situation and the compassionate care that she provided." The Committee noted that the Respondent delayed the formal assessment of the patient's brain function by four days to give the Applicant tie to adjust and accept the reality of the situation.

28. The Committee also noted in its decision that the Respondent made many efforts to help the Applicant and the patient's family understand the situation and she appropriately involved the hospital ethicist and other staff.

29. The Board has reviewed the information in the Record and notes that the patient chart includes lengthy handwritten chart entries made by the Respondent outlining the discussions and meetings that she held with the Applicant and others in the patient's family. The Respondent's notes provide the most contemporaneous record of the care she provided and the steps taken to answer the Applicant's questions and address her concerns. The Board finds that the Committee's conclusions regarding the Respondent's treatment of the Applicant and the patient are based upon the information in the medical chart and the Respondent's recollection of treating the patient, set out in her response to the complaint. The Board determines that the Committee's decision regarding this aspect of the complaint is reasonable.

30. Regarding the Applicant's concern that the Respondent misdiagnosed the patient as brain dead, in its decision, the Committee found that the Respondent was one of two authorized ICU physicians who completed an assessment of the patient's brain function and that the notes of the assessments were "excellent".

31. The Committee found that the Respondent appropriately consulted with other specialties; a neurologist and a general surgeon practicing in general surgery, critical care and trauma. The Committee noted that all four physicians reached the conclusion that the patient was brain dead. The Committee stated that it was satisfied that appropriate assessments, guidelines and protocols were followed prior to the Respondent declaring the patient brain dead.

32. The Board notes that within the patient's chart is the consultation note from the meeting with the ethicist, where it is recorded that the Respondent agreed to postpone testing of brain function until October 5, being 5 days after the accident, which "the team felt that

this delay was more than reasonable." The consultation note also shows that both the medical team and the family had concerns but that until a definitive diagnosis of brain death was made, the patient would continue to receive medical management and this in fact continued beyond the assessment of brain function that indicated the patient was brain dead.

33. The patient notes also include the Respondent's handwritten notes from consultations with physicians from other specialties. The Board observes that within the information in the Record is the decision of the CCB following the Applicant's application for directions. In its order of October 20, 2016, the CCB stated that it accepted the uncontradicted evidence that the patient has experienced neurological death. The Board notes that there was no evidence before the CCB to suggest that the assessment of brain death was a misdiagnosis.

34. The Board finds that the Committee's decision that appropriate assessments, guidelines and protocols were followed, prior to the Respondent determining that the patient was brain dead, is supported by the information in the Record and is therefore reasonable.

35. Regarding the Applicant's concern that the Respondent inappropriately counselled her to cease life-sustaining treatment for the patient, motivated by an unprofessional desire to obtain his organs for donation, in its decision, the Committee relied upon the information in the patient medical record. The Committee observed that the patient chart showed that the Respondent had recorded the Applicant raising the issue of organ donation and it decided to take no further action on this aspect of the complaint. In its decision, the Committee noted that the difficult discussions regarding code status, withdrawal of life support and organ donation were appropriate in the circumstances.

36. The Board is cognizant that the Committee's review of the Respondent's conduct was limited to a documentary review and so it cannot determine with certainty who raised the issue of organ donation. However, as the Committee noted, the patient's medical record

is presumptively reliable and more accurately reflects the physician's management of a patient's care than "unaided human memory."

37. The Board finds that the Committee's decision regarding this aspect of the complaint is based upon the medical chart, written by the Respondent at the time that she was caring for the patient, and is therefore reasonable.

38. In conclusion, the Board finds that the Committee conducted an adequate investigation and its decision to take no further action is reasonable and supported by the information in the Record.

39. The Board extends its condolences to the Applicant for the sad loss of her son.

VI. DECISION

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

ISSUED September 19, 2018

"Katherine Ball"
Katherine Ball

"James Beamish"
James Beamish

"Kathleen Ryan Elliott"
Kathleen Ryan Elliott