ANALYSIS

The Committee considered the following points in reaching its decision:

The Respondent failed to inform the Complainant that a do-not-resuscitate (DNR) order had been written for the Patient, against the Complainant's wishes and without his consent

- In her response, the Respondent indicates that:
    - On July 22, 2023, she initially examined the Patient in the Emergency Department (ED). She was concerned that the Patient had a bowel obstruction. She ordered x-ray imaging of the Patient's abdomen. She informed the Complainant that the Patient was very unwell, and that she would not withhold any care from the Patient because of her age, but if the Patient were to become sicker, she may not be eligible or safe to receive some testing and care.
    - She consulted the Critical Care Response Team (CCRT) and ordered an urgent CT scan. She reassessed the Patient later that day and reviewed the Patient's blood work, which indicated that the Patient was in probable multiorgan failure.
    - She participated in a case conference with the CCRT physician, and they agreed that the Patient was too unstable to transfer to the CT scanner. She spoke to the Complainant and informed him that the Patient was dying and that any efforts to save her would not prolong her life and would likely cause her more suffering. She asked the Complainant if she could consult palliative care and he agreed.
- The medical records indicate that the care plan was based on the clinical presentation of the Patient, who had multiple co-morbidities and was at end-of-life. The Patient presented to the ED with nausea, vomiting, hypotension, and hypovolemia. She had a bowel obstruction and acute kidney injury. She received treatment with volume replacement, supplemental oxygen, a nasogastric tube and antibiotics. Multiple health teams assessed the Patient and unanimously felt the risk of further invasive measures, including transport to a CT scanner and surgery, would not change the outcome and could potentially prolong the Patient's suffering. It is documented that this was

communicated to the Complainant, and that he understood and agreed with this plan.

- As such, the records support that the Respondent informed the Complainant that the Patient was at end-of-life and further invasive measures would cause more harm than benefits, and the Complainant agreed. In the absence of convincing evidence to the contrary, the Committee is satisfied that the contemporaneous medical record is a reliable source of information as to what occurred.

The Respondent did not communicate information regarding the Patient's condition or prognosis

- The records satisfy the Committee that the Respondent and the Patient's healthcare team shared information regarding the Patient's condition and prognosis with the Complainant on multiple occasions. There are several documented discussions with the Complainant. There is extensive documentation that the Respondent communicated the Patient's condition, prognosis, care plan and rationale behind the care plan to the Complainant. The Committee notes that it appears that the Complainant received information regarding the Patient and was involved in the Patient's care.

The Respondent delayed ordering a CT scan to rule out a bowel obstruction until the Patient was too sick to have it done; the Patient was admitted to hospital for vomiting, abdominal distention and an x-ray identified blockage

- The Respondent indicates that she cannot comment as to whether the CT scan could have been ordered earlier given that the Patient was initially under the care of the ED team. She explained that she ordered the CT scan immediately after her first assessment of the Patient; she spoke to radiology to get the CT scan done urgently; she called CCRT to see the Patient more urgently. The scan had to be put on hold because of the Patient's clinical instability.
- The Committee notes, as previously stated, that multiple health teams, including the Respondent, assessed the Patient and unanimously felt the risk of further invasive measures, including transport to a CT scanner and surgery, would not change the outcome and could potentially prolong suffering. As such, it was reasonable for the Respondent to determine that a CT scan transport would be unsafe for the Patient.

The first 3 paragraphs of this page are the only truths spoken in these half-dozen pages of lies and obfuscations!

- Overall, the Committee is of the view that the Respondent provided reasonable and appropriate care for the Patient and will take no further action on this complaint.

Non-disclosure of Committee Members' Names

- In reviewing the investigative file, the Committee observes that the Complainant has repeatedly made inflammatory and threatening remarks towards the Respondent and hospital staff. This includes the dissemination of photographs of the Respondent on public online platforms. The Complainant informed the College that he plans to "blacken the doctors' reputations", and that the physicians "will wish they were dead".

- Furthermore, the Complainant left an exceptionally high volume of inflammatory and threatening voicemail messages for the College. The Complainant shares his intention to post the Committee's decision publicly and notes that there will be a "rude awakening" if the College takes no action.

- The Committee is concerned by the Complainant's statements and believes, in the interests of safety, that it would be reasonable in this case not to disclose the identities of individual panel members. This is an infrequent occurrence, although nothing in the Code requires that the names of panel members be disclosed. In the circumstances, the Committee believes it is reasonable for panel members to remain anonymous. This matter was considered by a panel of the Committee consisting of three physicians and one public member.