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 his response, the Respondent indicates that:
    - The general medical team asked him to see the Patient on her second day of admission. He spoke with the most responsible team and reviewed the Patient's condition. The Patient had multiple severe co-morbidities at baseline.
    - He spoke directly with the surgeon on call to ask that they review the Patient for possible surgical candidacy. Their assessment, similar to his own and that of the general medical team, was that the Patient was dying and even if she had a condition that was amenable to surgery, the Patient would not tolerate any potential operation as there was an unacceptably high likelihood that she would die in the operating room.
    - He informed the Complainant that the Patient was dying and that further resuscitative efforts would not be warranted due to excess harm without benefit and therefore would not be attempted. The Complainant acknowledged this and did not dispute his recommendation that resuscitative efforts would not be attempted. This was reiterated to the Complainant by the other medical and surgical teams as well.
    - The decision whether or not to offer administration of life support is made by the physician, who has a duty to offer or recommend only those treatments that may pose some potential benefit for the patient.
- 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 Emergency Department 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 benefit, 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. The Committee notes that it "appears" from the record 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 he cannot comment on the events that occurred before he was consulted to see the Patient. When he was first involved in the Patient's care, a CT scan had been ordered and the Patient was near the end of life. A transport to the CT scanner was unsafe as there was a serious risk that the Patient would die in transport. The Respondent recommended that the general medical team carefully weigh the risks versus benefits of proceeding with the pending CT scan. The internal medicine team agreed.
- The Committee notes that the Respondent did not order the CT scan, and as previously stated, multiple health teams, including the Respondent, assessed the Patient and unanimously felt the risk of further invasive measures, including transport to the CT scanner and surgery, would not change the outcome and could potentially prolong the Patient's suffering. As such, it was reasonable for

The first 3 paragraphs of this page are the only truths spoken in these 6 pages and of lies obfuscations!

the Respondent to determine that a CT scan transport would be unsafe for the Patient.

1. 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 noted that there would 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.