File # 13-CRV-0305

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Bonnie Goldberg, Designated Vice-Chair, Presiding
Timothy P.D. Bates, Board Member
Celia Denov, Board Member

Review held on May 26, 2014 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:

DANIEL CHET-TI WONG, MD, KEVIN SANDERS, MD AND DONNA McRITCHIE, MD

Applicants

and

SARA COSTANTINI

Respondents

Appearances:

The Applicants:	Daniel Chet-Ti Wong, MD Kevin Sanders, MD Donna McRitchie, MD
For the Applicants:	Jennifer Hunter
The Respondent:	Sara Costantini
For the Respondent:	Alecs Mladenovic, Counsel

For the College of Physicians and Surgeons of Ontario: Margaret Obermeyer (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:

> Require Dr. Wong to attend the College to be cautioned in person with respect to:
>
> - considering all sources of information (including nursing and family concerns) in assessing similar patients in the future, particularly when the case fails to resolve in the manner or time frame predicted by the pathology;
> - ensuring repeated, documented neurological assessments in such a situation to alert the clinician to pathological change; and
> - discussing the patient's condition more frequently with the consultant neurosurgeon to keep him/her informed of the change (or lack thereof) in the patient's status.
>
> Issue a written caution to Dr. Sanders with respect to the need to interpret physiological instability in the context of a patient's presenting pathology and to be open to consideration of potential intracranial causation, and to ensure these considerations are documented in the record.
>
> Issue a written caution to Dr. McRitchie with respect to documenting progress notes of neurological findings supporting one's conclusions, in this case regarding a patient's stability; the importance of a thorough review of a patient's course from the time of admission when taking over care late in the hospitalization; plus the need for attentiveness to the findings of nurses and concerns of a patient's family.
>
> Advise Dr. McRitchie to ensure compassionate communications with patients and/or their families in stressful situations such as this.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by Daniel Chet-Ti Wong, MD, Kevin Sanders, MD, and Donna McRitchie, MD (the Applicants) 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 filed by Sara Costantini (the Respondent) regarding the conduct of five physicians, including the three Applicants, in providing medical care to the Respondent's late husband, Vincenzo Costantini (the patient). The Committee investigated the complaint and decided as noted above.

II. BACKGROUND

3. The patient fell and struck his head at work on September 2, 2009. He was taken to North York General Hospital (NYGH) by ambulance. Two CT scans were taken of the patient's head shortly after his arrival. Dr. King, the emergency room physician, assessed the patient when he arrived and contacted Dr. Wallace, a neurosurgeon at Toronto Western Hospital (TWH), for an opinion. Dr. Wallace felt that the patient was not yet a candidate for surgery, and recommended observation, repeat CT scans, and consultation with the Neurology Department. Dr. Wallace provided his contact details and said he was available on call 24 hours if the patient's condition changed.

4. Dr. Wong (a neurologist) began his care of the patient on September 3, 2009. He assessed the patient and recommended a transfer to the ICU. Dr. Wong contacted a neurosurgeon (Dr. Spears at Toronto's St. Michael's Hospital) to revisit the possibility of surgical decompression and was told that surgery was not indicated at that time, but to contact him if there was a material change. Dr. Wong remained the patient's neurologist from September 3-13, 2009.

5. Dr. Sanders (a respirologist/internist) treated the patient while he was at NYGH, from September 4-11, 2009.

6. Dr. McRitchie (a general surgeon) provided care to the patient from September 11-13, 2009, prior to his transfer to TWH for surgery.

7. The patient's condition deteriorated significantly. On September 13, 2009, a transfer was arranged to TWH for emergency surgery. Two physicians working under the supervision of Dr. Wallace performed a craniotomy. A complication ensued during surgery and the patient suffered cardiac arrest. Tragically, the patient died.

The Complaint and the Response

8. The Respondent expressed concern that the family observed that the patient was significantly deteriorating prior to September 13, and that investigations such as a repeat CT scan on September 9, 2009 confirmed this. She identified the many ways in which the patient's condition changed materially while he was in hospital, including the development of a headache, elevated blood pressure, incontinence, confusion, and drowsiness. She raised these concerns with the treating physicians to no avail. The Respondent's specific concerns respecting each Applicant were as follows:

9. The Respondent complained that Dr. Wong:

- failed to transfer her husband to a trauma centre in a timely manner;
- failed to contact a neurosurgeon in a timely manner; and
- failed to document his discussions with Dr. Wallace.

10. The Respondent complained that Dr. Sanders:

- failed to provide appropriate and timely care to the patient; and
- failed to transfer the patient to a trauma centre in a timely manner.

11. The Respondent complained that Dr. McRitchie failed to:

- provide appropriate and timely care to the patient;
- transfer the patient to a trauma centre in a timely manner;
- request a consultation with Dr. Wong when requested by the Respondent;
- be caring and compassionate towards the Respondent, and to answer the questions [she refused to stay and talk to the family].

12. The Respondent also complained about the conduct of two physicians at Toronto Western Hospital. Neither physician requested a review of the Committee's decision nor did the Respondent seek a review of the Committee's decision respecting those two physicians.

13. In a response to the Committee, Dr. Wong explained that he did not have authority to transfer a patient without the agreement of a physician from another facility. He explained that he consulted neurosurgery three times during the patient's admission: on September 3, he spoke to Dr. Spears who felt that the patient did not require surgery at that time and advised him to contact neurosurgery again if there was a material change; on September 13, as soon as he was aware of the patient's deterioration, he contacted CritiCall and spoke to Dr. Da Costa, neurosurgeon at Sunnybrook Hospital, where no beds were available; and then he spoke to Dr. Wallace at TWH. Dr. Wong explained that he immediately sent CT scans via taxi for Dr. Wallace to review, and arrangements were made to transfer the patient after Dr. Wallace accepted him as a patient. Dr. Wong stated that he documented his discussion with Dr. Wallace in the discharge summary on September 14, 2009.

14. In his response, Dr. Sanders explained that his initial assessment of the patient indicated that the patient was stable. He noted that he assessed the patient twice a day and the neurology department also assessed the patient "regularly." He stated that the patient's condition was monitored frequently, including his vital signs, neurovital signs, cardiac condition and blood pressure via an arterial line. Dr. Sanders explained that on September 9, the patient developed a headache and was more confused; he ordered a CT scan which showed some worsening of the edema and a possible increased size of bleeding. He reviewed the films with Dr. Wong, who disagreed with the radiologist's interpretation and did not feel that there was a substantial change from the patient's previous scan. He stated that he generally concurred with Dr. Wong that the patient's clinical presentation did not suggest any material decline in his condition. He stated that by September 10, the patient's condition had improved in that he was less confused, able to tolerate soft foods and his intravenous did not need to be increased. His blood pressured was controlled. Dr. Sanders stated that the patient could be managed in a non-ICU setting. He explained that he did not feel that there was a need to a transfer the patient to a different ICU.

15. In her response, Dr. McRitchie explained that the patient was in her opinion, neurologically stable. She noted that he could follow commands, his blood work was fine,

and his blood pressure controlled. Other than concerns about swallowing, she opined that he was recovering well and could soon be transferred to the floor. She noted that on September 12, he was much "brighter" and she met with the family to inform them that the patient would be transferred. She recalled that the family was concerned but she explained to them that the patient's condition had improved and that he no longer required specialized ICU care. She wrote orders for him to be transferred. She recalled that the patient was eventually transferred at 2:00 a.m. on September 13. At about 10:15 a.m., a nurse with the Critical Care Response Team assessed the patient, recognized his deterioration and paged her. She responded, assessed him, and also noted a dramatic deterioration, including decreased consciousness and labored breathing. The patient had an urgent CT scan, which revealed edema and an increasing midline shift. She paged Dr. Wong who assessed the patient and arranged the transfer to neurosurgery at TWH after consultation. She disagreed that she failed to be caring or compassionate towards the patient or his family.

The Committee's Decision

16. The Committee investigated the complaint and decided to require Dr. Wong to attend for an oral caution; and to issue written cautions to Drs. Sanders and McRitchie. Additionally, the Committee issued advice to Dr. McRitchie.

III. REQUEST FOR REVIEW

17. Dissatisfied with the decision of the Committee, in a letter from counsel dated May 23, 2013, the Applicants requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

18. 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.

19. 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 a discipline hearing that would not, if proved, constitute either professional misconduct or incompetence.

V. ANALYSIS AND REASONS

20. 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.

21. 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

22. In reviewing the adequacy of the Committee's investigation, the function of the Board is to examine the information and documentation obtained during the course of the investigation, and considered by the Committee. An investigation need not be exhaustive, but in order to be considered adequate, information that is sufficient and relevant so as to allow the Committee to fulfill its statutory function must be obtained. If it is clear that there is other information that, if obtained, could have changed the outcome of the Committee's decision, then the investigation might not be considered adequate.

23. In the course of its investigation, the Committee obtained the Respondent's letter of complaint and subsequent correspondence; responses from the five physicians named in

the complaint; and the entirety of the patient's medical record from both TWH and NYGH.

24. The Committee also obtained an independent opinion from a neurologist, Dr. Young, regarding Dr. Wong's care in this case. Dr. Young opined that Dr. Wong's treatment was appropriate and met the standard. In his view, Dr. Wong's care did not demonstrate a lack of knowledge, skill or judgment. He stated that Dr. Wong's practice, behaviour and conduct did not expose, nor is likely to expose his patients to harm or injury. He stated that it was not uncommon for neurosurgeons to recommend that patients with traumatic brain injury be managed in peripheral hospitals. If all patients were transferred to a trauma centre, the trauma centres would be overwhelmed. He stated that it appeared that Dr. Wong was in "frequent contact" with neurosurgeons about the patient's condition and that there was no need for neurosurgical intervention until September 13 or 14. He opined that the patient was closely monitored and while the September 5, 2009 and September 9, 2009 CT scans showed some worsening, there was not always a strong relationship to his clinical status. Further, in his opinion, given the patient's level of consciousness, he did not feel that Dr. Wong should have placed an intracranial pressure monitor or begun decompressive craniectomy. Moreover, the patient died from a recognized complication of neurosurgery (the opening of the venous sinus) rather than the timing of the surgery.

25. The Committee also had before it an opinion from Dr. Daniel H. Selchen, a neurologist, who was asked by Dr. Wong's legal counsel to provide an opinion about Dr. Wong's care. Dr. Selchen opined that Dr. Wong managed the case appropriately. He noted that Dr. Wong followed the patient daily, ordered additional CT scans on September 5 and 9, and although the September 9 scan showed some worsening, as the patient was clinically stable this change was not significant. Further, the medical notes suggested that the patient's condition fluctuated intermittently, but was relatively stable. Additionally, the September 12, 2009 notes indicated that Drs. Wong and McRitchie observed some improvement in the patient, although nursing notes later that day observed slight deterioration. The patient's transfer was not medically indicated until September 13, at which time it was promptly arranged.

26. The Committee also had before it an opinion from a neurosurgeon, Dr. Smyth, who commented on the care provided by Dr. Wallace - the neurosurgeon who accepted the patient's transfer for emergency surgery at TWH.

27. Additionally, the Surgical Panel of the Committee considered this matter. This particular panel of the Committee included an anesthesiologist, a paediatric neurosurgeon, and an orthopaedic surgeon.

28. The Board finds that the Committee's investigation covered the events in question and yielded relevant documentation to assess the complaint regarding the Respondent's conduct.

29. Counsel for the Applicants submitted that the Committee failed to obtain the appropriate expertise to consider the Respondent's complaint. She argued that the surgical panel could assess the patient's surgery but was not sufficiently knowledgeable to assess the medical care provided by the three Applicants. She argued that the Committee's lack of a neurologist on the panel rendered its investigation inadequate.

30. The Board considered that the Committee had the benefit of its own expertise, which comprised expertise from three physicians, all of whom had specialized knowledge. In addition, the Committee had the benefit of opinions from two neurologists and a neurosurgeon who opined on various aspects of the care. The Board finds that the investigation was not inadequate because of a lack of medical expertise.

31. Furthermore, counsel for the Applicants argued that the Committee failed to share with Dr. Wong the opinion of the neurosurgeon, Dr. Smyth, who considered Dr. Wallace's care. Counsel argues that the Committee should have provided this opinion to Dr. Wong given her view that the Committee relied on the neurosurgeon's opinion to caution Dr. Wong.

32. The Board considered Dr. Smyth's opinion and the information on which he relied. The Board finds that Dr. Smyth had sufficient information on which to assess the chronology of events that led to the patient requiring emergency surgery, including the Criticall records, six CT scans, and the radiographic reports of the CT scans. Furthermore, as is discussed below, Dr. Smyth was not asked to opine on Dr. Wong's care nor did he offer his opinion on Dr. Wong's management of the case. Thus, the Board is not persuaded that the fact that Dr. Wong did not have an opportunity to respond to Dr. Smyth's opinion would render this investigation inadequate. The Board observes that Dr. Wong had an opportunity to review Dr. Young's opinion, and submit an opinion from Dr. Selchen in response.

33. As such, the Board finds that there is no indication of further information that might reasonably be expected to have affected the decision, should the Committee have acquired it. Accordingly, the Board finds that the Committee's investigation was adequate.

Reasonableness of the Decision

34. 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.

Submissions

35. Counsel for the Applicants submitted that the decision respecting Dr. Wong is unreasonable because the Committee lacked the expertise to assess the Respondent's complaint; inappropriately relied on the opinion of a physician from a different specialty; and did not provide Dr. Smyth with the entirety of the patient record. She argued that the

Board should remove the caution directed toward Dr. Wong or in the alternative, direct the Committee to reconsider its approach to using expert opinions, noting it should not be able to rely on the opinion of an independent opinion provider who lacked essential information and had a different medical specialty.

36. Counsel for the Applicants submitted that the decision respecting Drs. Sanders and McRitchie is unreasonable because the Committee lacked essential information to consider the complaint, given the Committee's lack of specialized expertise. For example, the Committee did not seek an independent opinion from a specialist who practises in Drs. Sanders' and McRitchie's field of specialization. As well, Dr. Smyth did not have the entirety of the record, and the Committee ignored the opinion of Dr. Selchen and the explanation of the treating physicians in favour of the nursing notes and the family's observations.

37. In addition, Counsel for the Applicants argued that the decision to advise Dr. McRitchie regarding communication skills was unreasonable as it was inappropriately based on the Committee's interpretation of her conduct history.

38. Counsel for the Respondent argued that the Committee's decision was reasonable in all respects. In particular, he highlighted that many of the Committee's concerns are directed at general medical skills; he argued that these are skills which any committee of physicians could assess without an expert opinion. Furthermore, he emphasized that the Committee's conclusions were based on the medical record and thus did not require specialized expertise. He reviewed the patient's clinical picture as revealed in the medical records and contrasted this to the Applicants care and their assessment of the patient. He argued that the nursing notes, coupled with the family's observations, were a reliable indicator of the patient's evolving condition at the relevant times. He submitted that the Committee was entitled to disagree with the opinions of Drs. Selchen and Young and articulated its reasons for doing so. He argued that the Committee did not solely rely on Dr. Smyth's opinion to arrive at its conclusions regarding Dr. Wong's care. Regarding

Dr. McRitchie's communication skills, counsel argued that there was sufficient other information in the Record to support the Committee's conclusions.

Analysis

39. Having considered the information in the Record, the Board concludes that the Committee's decision was reasonable, as it was based on the available relevant and adequate information and the Committee's own expertise. The reasons for this conclusion follow.

The Committee's conclusions regarding Dr. Wong's care

40. Respecting Dr. Wong, the Committee stated that it disagreed with the opinions of Drs. Young and Selchen and concluded that Dr. Wong's management of the case was not appropriate. In arriving at this conclusion, the Committee noted in particular that Dr. Wong did not have "frequent," "appropriate" or "regular" contact with neurosurgery during the patient's admission, observing that he contacted neurosurgery only on September 3 and 13, 2009.

41. The Committee expressed concern that both Dr. Wallace and Dr. Spears recommended that they be re-contacted if there was a material change in the patient's condition. The Committee expressed concern that none of the physicians at NYGH contacted Dr. Wallace between September 3 and 13, despite his availability.

42. The Committee concluded that there was a material change in the patient's condition at several points during his admission and well prior to September 13 when neurosurgery was ultimately contacted again. The Committee considered that Dr. Wong should have contacted neurosurgery sooner but at least after the September 9, 2009 CT scan, which the radiologist reported as showing a worsening and which was ordered by Dr. Sanders because the patient had developed a headache and was more confused. The Committee

observed that Dr. Wong's "very brief" notes stated only that he "disagreed" with the radiologist's opinion because this did not match the patient's clinical condition.

43. The Committee also found that Dr. Wong's documentation of his neurological assessments and qualitative observations of the patient inadequate. The Committee questioned Dr. Wong's assessment that the patient's condition was stable or improving, especially from September 9 to 12, given the nursing notes and the descriptions provided by the family. The Committee highlighted several specific instances in the nursing notes and the family's contemporaneous written observations that demonstrated its view that the patient was unable to recognize family members by September 7; became incontinent of urine the next day; became progressively drowsier and more confused; had difficulty swallowing; and by the evening of September 11, was experiencing irregular respirations and unstable blood pressure with hypertensive spikes.

44. The Committee stated that the fluctuations that the nurses and family observed in the patient's blood pressure, level of consciousness, and general function clearly were significant in retrospect, and should have been considered significant prospectively as well. The Committee opined that the failure to appreciate the significance of these findings had grievous consequences in this case. Given these findings, the Committee opined that Dr. Wong failed to provide adequate documentation as to why he disagreed with these observations, and supporting his perspective that the patient's condition was stable. Further, the Committee was concerned that Dr. Wong also failed to adequately document the logic and reasoning behind his disagreement with the radiologist's review of the patient's September 9 CT scan, which the Committee noted documented an "overall worsening" as well as a previously unidentified fracture. The Committee noted that Dr. Wong illogically relied on the patient's "clinical stability" to justify his disagreement with the radiologist. The Committee considered this inadequate, especially in light of Dr. Sanders' decision to order the scan because of the patient's headache and increased confusion. The Committee expressed concerns with Dr. Wong's approach to record keeping.

45. The Board finds that these conclusions are reasonable given that are soundly rooted in the medical record. Even if one discounts the family's written and subjective observations of the patient's deteriorating mental condition (which accorded with the nursing notes in any event), the Committee was entitled to rely on the contemporaneous and very detailed nursing notes as an accurate reflection of what was occurring between September 3 and 13. Notably, the Committee highlighted that Dr. Sanders ordered the September 9 CT scan given concerns about the patient's deteriorating condition.

46. The Board finds that the Committee was entitled to rely on its expertise to consider the nursing notes and consider what they signified from a clinical perspective. It was fully reasonable for the Committee to use its expertise to assess whether the professional care provided was in accordance with professional standards. As noted earlier in this decision, the panel of the Committee in this case, included medical specialists well-positioned to assess the care issues in this case.

47. The Board is not persuaded that the Committee lacked the necessary expertise to assess the patient's care in the context of the complaint. The Committee collectively possessed the necessary medical expertise to review CT scans (the imaging was part of the medical record), to assess progress notes, and to consider opinions from consulting neurosurgeons and radiologists.

48. Moreover, it was open to the Committee to reject the opinions of Dr. Selchen and Dr. Young. The Committee articulated clear and compelling reasons for not relying on these opinions. The Board distinguishes the case before it for this very reason from the case submitted by Applicants' counsel. In *J.O.A.M. v J.V.* [2011 CanLII 82481 (ON HPARB)], the Board returned the matter for reconsideration given that the Committee had not articulated its reasons for rejecting an independent opinion. That is not the case here. The Committee in this case provided specific reasons for rejecting the expert opinions.

49. In *F.A.A. v. A.C.* [2012 CanLII 40877 (ON HPARB)], the Board considered an investigation inadequate because it was revealed that the Committee consulted "informally" with an ophthalmologist who opined on the case before it. This case is distinguished from the present matter in that in the present matter, the Record reflects that there was no comparable "informal" consultation of an expert.

50. Much was made at the Review of the following statement in the Committee's reasons:

> We also note that the IO [independent opinion] provider who reviewed Dr. Wallace's care also reviewed the records from NYGH and identified several points at which the patient's condition was such that an additional consultation with neurosurgery was warranted prior to Dr. Wong's contacting Dr. Wallace again on September 13.

51. Dr. Smyth in his report stated the following:

> While this patient was not referred a second time to Dr. Wallace for a neurosurgical opinion until September 13, 2009, the 11th day following his injury, it is my opinion that the record clearly shows that the clinical crisis in this case actually occurred between days 4 and 6 post injury, during which days it has always been my classical teaching that definitive decision-making is necessary as, by this time, the patient's clinical course will clearly be one of resolution or deterioration. That determination was entirely in the hands of the staff of the North York General Hospital.

52. With respect to Dr. Wong, Dr. Smyth referenced him by name once, and only factually, stating:

> Apparently at this point Dr. Wong, the original consulting neurologist, was summoned once again and, as we switch back finally to the Criticall record, there is evidence that Dr. Christopher Wallace was contacted on this date, for the first time since the patient's admission to North York General Hospital, this time by Dr. Wong.

53. Counsel for Dr. Wong has argued that the Committee inappropriately relied on Dr. Smyth's opinion to caution Dr. Wong. She argued, as discussed above, that Dr. Wong did

not have an opportunity to respond to this comment, and that Dr. Smyth did not have the entirety of the record as the Committee believed.

54. The Board agrees that the Committee mistakenly stated that Dr. Smyth had the entirety of the Record. However, the Board observes that Dr. Smyth was not asked to opine on Dr. Wong's care and did not so opine. As discussed above, Dr. Smyth had copious material on which to form his opinions on the trajectory of the patient's care.

55. However, the Board disagrees that the Committee relied on Dr. Smyth's opinion to arrive at its conclusions. As discussed above, the Committee's analysis is based on the information contained in the patient's medical record, coupled with the family's observations, and informed by its own expertise. That the Committee mentioned this comment is interpreted by the Board as the Committee's statement that in its view, Dr. Smyth agreed with its analysis of the care provided and not that it based its opinion on this statement.

56. The Board considers the Committee's decision to require Dr. Wong to attend for an oral caution to be reasonable. The Committee noted that of all the physicians involved in the patient's care, Dr. Wong observed him over the entire period and had "the most responsibility as the consulting neurologist."

57. In assessing the appropriate disposition in a complaint, a Committee will consider many factors, including the seriousness of the deficiency, whether there is a single concern or a number of concerns about the care at issue, the content of a physician's response, his or her insight as to areas for improvement, and the physician's complaints or discipline history.

58. In the matter before us, the Committee identified a significant deficiency in Dr. Wong's care. Given the nature of its concerns, it was reasonable for the Committee to determine it would require him to attend in person to be cautioned for his approach in this situation. A caution is a remedial disposition and is intended to protect the public interest.

59. The Board finds that the Committee's decision falls within a range of possible, acceptable outcomes, based on the information before it and is one of the outcomes available to a complaints committee. The decision to require Dr. Wong to attend in person for an oral caution is specifically targeted to the areas of concern identified by the Committee and reflects the College's public interest mandate.

60. Accordingly, the Board finds that the Committee's decision respecting Dr. Wong is supported by information in the Record and is reasonable.

The Committee's conclusions regarding Dr. Sanders' care

61. The Committee concluded that Dr. Sanders consulted neurology appropriately and recognized that Dr. Sanders relied on Dr. Wong's advice in this regard. However, the Committee expressed concern about Dr. Sander's lack of documentation. The Committee noted that Dr. Sanders failed to appreciate or consider that the patient's labile blood pressure may have been a sign of increasing intracranial pressure and failed to document in the record that this could have been an issue. Further, the Committee expressed concern about the inconsistency between the fact that Dr. Sanders requested a cranial CT scan on September 9, because the patient "developed headache, more confused," but Dr. Sanders responded in his letter that he concurred with Dr. Wong that the patient's "clinical presentation did not suggest any material decline in his condition." The Committee was of the view that the patient's condition had changed and that this prompted the CT scan, which in turn confirmed the clinical change. The Committee observed that Dr. Sanders did not document why he disagreed with the radiologist's finding on the September 9 CT scan. The Committee felt that the increased confusion coupled with a headache, combined with the CT scan results which showed a worsening, would be considered a material decline in the patient's condition, and that another consultation with a neurosurgeon was warranted at this point. Further, the Committee expressed concern that aside from giving the patient Mannitol on admission, nothing else appears to have been done to treat intracranial pressure, even though the patient had obvious cerebral edema.

62. In the result, the Committee decided to caution Dr. Sanders as described above.

63. The Board finds the Committee's conclusions reasonable. The Committee considered the medical record which recorded the patient's deteriorating condition, and in particular the September 9, 2009 CT scan, which a radiologist read as demonstrating a worsening condition. The Committee had before it the medical record identifying that Dr. Sanders ordered the September 9 CT scan in response to concerns raised by those observing the patient that he was confused and had developed a headache. The Board's review of the patient's record, in addition to Dr. Sander's response, and that of the other physicians who provided care, supports the Committee's concerns.

64. While Counsel for the Applicants has expressed concern about the Committee's reliance on the nursing notes and family observations, the Board finds that this is a reasonable approach to assessing care that occurred four years prior, and afforded the Committee a reliable and contemporaneous reflection of the patient's treatment at critical times.

65. The Board disagrees that the Committee required a specialist opinion in order to assess Dr. Sanders' care. The Board finds that the Committee, which as described above was both comprised primarily of physicians, and physicians with specific expertise, had sufficient medical knowledge to assess Dr. Sanders' medical judgment and record-keeping in this case.

66. As outlined above, the Committee's decision to caution Dr. Sanders is one of the available dispositions available to the Committee. In the circumstances, the Board finds the Committee's approach to be reasonable as it addresses the Committee's specific concerns and addresses the public interest in relation to the concerns identified respecting Dr. Sander's practice.

67. Accordingly, the Board finds that the Committee's decision respecting Dr. Sanders is supported by information in the Record and is reasonable.

The Committee's conclusions regarding Dr. McRitchie's care

68. The Committee expressed a number of concerns about Dr. McRitchie's care. The Committee observed that on September 11, Dr. McRitchie had concerns about the patients swallowing and responsiveness. However, when Dr. Ritchie then considered the patient to be "brighter" and "much improved" on September 12, she did not document a neurological assessment to substantiate this change. The Committee opined that Dr. McRitchie failed to recognize the patient's fluctuating status, which would have been evident from the nursing notes and a discussion with the family. As an example, the Committee referenced a nursing note that recorded the patient's breathing difficulty which as the Committee noted "in the context of head trauma should be considered a sign of possible brainstem compression." The Committee opined that Dr. McRitchie's view of the patient's improved condition contrasted with the nursing notes and the family's observations. Also, the Committee noted that Dr. Wong assessed the patient at 1:30 p.m. that day and noted that the patient could not recognize his family. The Committee concluded that given these discrepancies, more details and an explanation as to why Dr. McRitchie felt that the patient had improved should have been included in the record.

69. The Committee was concerned that Dr. McRitchie did not record that she paged Dr. Wong and expressed concern that had Dr. Wong been difficult to reach, Dr. McRitchie could have contacted a neurosurgery department herself. The Committee was of the view that Dr. McRitchie failed to appreciate the degree of deterioration in the patient's cognitive state and relied on her colleagues' reassurance that he was stable, "rather than reviewing the record and conducting a thorough assessment herself."

70. Similar to its analysis of the care provided by Drs. Wong and Sanders, the Committee assessed the care provided by Dr. McRitchie in the context of its own expertise and more importantly, the documentation provided by the nurses, other treating specialists and the family. In light of the documented concerns respecting the patient's deteriorating condition, the Board finds that it was reasonable for the Committee to express concerns

about Dr. McRitchie's approach to this patient's care, including her decision that he had improved to such an extent that he could be transferred from the ICU to a ward.

71. Similarly, it is not apparent to the Board that the Committee required the expertise of a specialist to assess Dr. McRitchie's care given its identified concerns respecting medical record keeping and her assessment of the patient.

72. As discussed elsewhere in this decision, the Committee appropriately chose a caution as a disposition in this matter. The caution highlights the Committee's concerns with Dr. McRitchie's approach and is designed to guide Dr. McRitchie.

73. The Committee noted that the Respondent had complained about what she perceived as difficult interactions with Dr. McRitchie. The Committee identified that it was limited to a documentary review of the Record. However, it also referenced that Dr. McRitchie had a prior complaint with respect to communication and in the result, concluded that Dr. McRitchie would "benefit from some advice regarding her communication with patients and their families."

74. Counsel for Dr. McRitchie argued that the Committee inappropriately relied on a prior decision in which the Committee decided to take no further action. The Board appreciates that the information in the Record pertaining to this prior decision is sparse and was provided to the Board in only summary form. Nonetheless, the Board observes that the Committee is entitled to rely on a physician's complaint history, along with the information pertaining to the current complaint before it, to assess a complaint. Moreover, the Committee's disposition is neither a sanction or punitive. The Committee has crafted an educative disposition to reflect its concern that Dr. McRitchie could improve her communication with patients. The Board sees this advice as a reasonable outcome that addresses the information in the Record and is in the public interest.

75. Accordingly, the Board finds that the Committee's decision respecting Dr. McRitchie is supported by information in the Record and is reasonable.

Conclusion

76. The Board wishes to extend its sincere sympathy to the Respondent and her family on the death of the patient.

77. In conclusion, the Board finds that the Committee's decision and its dispositions are reasonable in light of the information contained in the Record.

VI. DECISION

78. Pursuant to section 35(1) of the *Code*, the Board confirms the decision of the Committee to:

> Require Dr. Wong to attend the College to be cautioned in person with respect to:
>
> - considering all sources of information (including nursing and family concerns) in assessing similar patients in the future, particularly when the case fails to resolve in the manner or time frame predicted by the pathology;
> - ensuring repeated, documented neurological assessments in such a situation to alert the clinician to pathological change; and
> - discussing the patient's condition more frequently with the consultant neurosurgeon to keep him/her informed of the change (or lack thereof) in the patient's status.
>
> Issue a written caution to Dr. Sanders with respect to the need to interpret physiological instability in the context of a patient's presenting pathology and to be open to consideration of potential intracranial causation, and to ensure these considerations are documented in the record.
>
> Issue a written caution to Dr. McRitchie with respect to documenting progress notes of neurological findings supporting one's conclusions, in this case regarding a patient's stability; the importance of a thorough review of a patient's course from the time of admission when taking over care late in the hospitalization; plus the need for attentiveness to the findings of nurses and concerns of a patient's family.

Advise Dr. McRitchie to ensure compassionate communications with patients and/or their families in stressful situations such as this.

ISSUED July 24, 2014

Bonnie Goldberg

Timothy P. D. Bates

Celia Denov