SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee
(the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Richard Goolden Perrin (CPSO #22324)
(the Respondent)

INTRODUCTION

The Patient presented to the Emergency Department (ED) of their local hospital and was admitted for pneumonia. The Complainant, a family member of the Patient, indicates that the family found the Patient unattended after a fall, with a decreased level of consciousness. The Complainant indicates that the family was advised that the Patient had undergone a CT scan, and that the Respondent, who had been consulted at another hospital, felt no further action was necessary and that the Patient's brain bleed was "not very bad." When the local hospital attempted, via the CritiCall services, to secure a neurosurgery consultation at the Respondent's hospital following the Patient's further deterioration and a subsequent CT scan, the Respondent (who took the call) initially refused to accept transfer of the Patient. The Patient was eventually admitted to the other hospital, but sadly passed away following surgery.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent:

- **failed to read the Patient's first CT scan, or failed to read it accurately, as he may not have had the appropriate equipment to read the scan correctly at home**
- **failed to accept the Patient at SMH after reading the second CT scan and recognizing the Patient had a subdural hematoma and had a Glasgow Coma Score (GCS) of 3**
- **failed to recognize that the Patient required emergency surgery, thereby delaying surgical intervention by about seven hours, which caused the Patient's death.**

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of May 17, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his failure to abide by the Criticall policy and inappropriately refusing to accept a patient for care.

COMMITTEE'S ANALYSIS

The Respondent provided an extensive explanation with respect to his version of events, in which he defended his actions and the actions of nursing staff. He emphasized that the Patient's condition deteriorated very rapidly, and indicatedthat approximately only two hours

passed between the time he was first contacted and when the Patient was authorized to be admitted to SMH.

The Committee was of the view that it would have been appropriate for the Respondent to rely on what he was told by the emergency physician during the first consultation, if the CT scan was not readily available for review at that time. As such, they found the Respondent's actions on this first occasion to have been reasonable. Having said that, the Committee commented that in this modern and digital society there are ways to obtain images if required, which physicians can explore.

The Committee was, however, concerned that the Respondent failed to accept the Patient for admission once he was informed of the Patient's deterioration. In the Committee's view, a prudent physician would recognize that refusing acceptance of a deteriorating patient would place that patient at risk. Once informed of the deterioration, it was the Respondent's responsibility to find an available bed for the Patient.

The Committee reviewed transcripts which support the emergency physician's Criticall dictated report, which indicates inadequate communication on the part of the Respondent. When the Respondent was reminded by Criticall of the policy, he hung up. The Committee found this response to be unacceptable and unprofessional. The Committee noted that the Respondent has a history with the College regarding his communication, which reinforced its concerns in this case.

The Committee found no indication of a seven hour delay of surgical intervention in this case. While it acknowledged that even a two hour delay can be crucial in cases of cerebral anoxia, it was not in a position to speak to causation or to determine with any certainty whether the Respondent's actions contributed to the Patient's death.

Overall, the Committee was of the opinion that the Respondent's decisions were reactive rather than proactive, and that he did not appropriately review the available images once they were available. The Committee pointed out that potentially-life-saving care should not be determined based on bed availability. While there are instances where a physician can refuse to admit a patient under the Criticall policy, the Committee noted that this was not one of those cases, and that the Respondent therefore failed in his responsibilities under the Criticall policy.

Based on the above, the Committee felt a caution was warranted in the circumstances, as outlined above.