

**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. Ruth Elizabeth Levis (CPSO #97837)  
(the Respondent)**

## **INTRODUCTION**

The Respondent is a paediatrician at a hospital. She was on call when she took over the care of the Patient who had been admitted to the hospital with symptoms of persistent vomiting and intermittent fever with no known cause.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

## **COMPLAINANT'S CONCERNS**

**The Complainant is concerned that the Respondent failed to provide adequate care and treatment to the Patient in July 2019 when he was admitted to the hospital. In particular, the Respondent:**

- **failed to perform her job to the fullest;**
- **failed to perform an adequate examination of the Patient;**
- **failed to check the Patient's weight when ordering fluids and medication (he weighed 33 pounds not kilograms).**
- **behaved in an unprofessional manner;**
- **called the Complainant a "Google mom";**
- **failed to communicate effectively; and was incompetent and arrogant, causing the Patient unnecessary suffering for 24 hours.**

## **COMMITTEE'S DECISION**

A Surgical Panel of the Committee considered this matter at its meeting of February 5, 2021. The Committee required the Respondent to appear before the Committee to be cautioned in this matter with respect to the ongoing assessment of a child with abdominal pain, recognition of when the child's condition is deteriorating and the course of action to be taken at that time.

The Committee also accepted an undertaking from the Respondent.

## **COMMITTEE'S ANALYSIS**

*Concern that the Respondent failed to perform her job to the fullest*

-AND-

*Concern that the Respondent failed to perform an adequate examination of the Patient*

After reviewing the medical record, it is unclear which parts of the Patient's physical examination was conducted by the Respondent or how many times the Patient was examined, as there were no direct notes from the Respondent.

The nursing notes indicated that the Patient, who was a child, had severe abdominal pain, increasing abdominal distension and persistent vomiting with no cause determined after more than five days of symptoms.

The Committee noted that the Respondent failed to recognize that this Patient's symptoms were not typical for the working diagnosis of gastroenteritis and further blood work and imaging should have been ordered to investigate other possible diagnoses. An abdominal x-ray was not ordered until almost 30 hours after the Patient's admission and revealed a bowel perforation, by that time the Patient was already in septic shock. The Committee's view is that the Respondent did not appreciate the evolution of the Patient's symptoms throughout the day and night of her care and that there was an unacceptable delay in recognizing the Patient's acute abdomen where he became septic from the perforation.

The Committee regarded this as a serious lapse in judgement and decided to caution the Respondent, as set out above.

*Concern that the Respondent failed to check the Patient's weight when ordering fluids and medication (he weighed 33 pounds not kilograms)*

Prior to the Respondent taking over care, the Patient's weight was incorrectly recorded in the medical record in kilograms, rather than pounds, when he was weighed prior to the Respondent taking over his care. As a result, the Patient was provided with fluids and medication doses based on an incorrect weight that was nearly double the Patient's actual weight.

The Respondent stated that at the hospital, patients are only weighed upon admission to the floor so she did not verify his weight during her shift as she did not order any new fluids or medications or make any changes to the previous orders.

The Committee is concerned that the Respondent failed to recognize that the recorded weight was far above the average weight of a normal child of the Patient's age. Part of a

proper assessment involves verifying a child's weight and being mindful that the weight makes sense for a child of that age.

As a result of this investigation, the Committee had concerns about the Respondent's ongoing assessment of a child with abdominal pain, recognition of when the child's condition is deteriorating and the course of action to be taken at that time. In addition to cautioning the Respondent on this issue, the Committee accepted an undertaking from the Respondent, with terms to include professional education in the area of management of acute abdomen in children.

The Committee took no further action on the concerns respecting the Respondent's behaviour, demeanour and communication.