SUMMARY

DR. DANIEL HENRI MOQUIN (CPSO# 64177)

1. Disposition

On June 1, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") required family physician Dr. Moquin to appear before a panel of the Committee to be cautioned with respect to the importance of: advocating for more intensive investigation in the management of a very ill patient and reviewing a decision to discharge a patient with elevated bilirubin.

2. Introduction

A family member of Patient A complained to the College about Dr. Moquin's management of Patient A (who is now deceased), and queried why Patient A had not been transferred immediately from Parry Sound to Toronto for specialty care and instead was treated by hospitalists (including Dr. Moquin). After being discharged from hospital in Parry Sound, Patient A returned to Toronto and the next day was hospitalized for liver failure resulting from alcoholic hepatitis. Patient A died in hospital a few weeks later.

Dr. Moquin responded that he assumed care as Patient A's most responsible physician ("MRP") mid-way through Patient A's admission to hospital in Parry Sound. He indicated that, in the few days he provided care, overall, Patient A's laboratory results were improving (with the exception of bilirubin which remained elevated), and Patient A was walking about and alert. Dr. Moquin noted that he consulted with an internist who recommended discharge and this plan was discussed with Patient A and Patient A's family. He pointed out that the plan was for Patient A to follow up in Toronto with Patient A's family doctor with referral to a hepatic specialist pending. He noted that on the day of discharge, Patient A was in stable condition and fit to travel.

3. Committee Process

A panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which

reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee noted that the usual indication for discharge for patients with liver failure includes a bilirubin level below 170 μmol/L, yet Patient A's bilirubin remained very elevated at over 500. The Committee noted that Patient A also had evidence of renal failure and disagreed with Dr. Moquin that Patient A's laboratory values were improving.

Overall, the Committee did not conclude that discharge was appropriate considering Patient A's clinical status and was of the view that, furthermore, Patient A ought to have been transferred from Parry Sound to a higher level hospital given his critically ill status. Although Dr. Moquin pointed to the fact that an internist also agreed with the decision to discharge Patient A, the Committee concluded that Dr. Moquin had the experience to recognize for himself when a patient requires transfer to a higher level hospital or should not be discharged. The Committee also noted that Dr. Moquin's follow-up plan of care for Patient A was lacking and that he should have made greater efforts to ensure timely follow-up with the appropriate specialist, rather than leaving this to Patient A's family physician to arrange.