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. Jamie Spiegelman (CPSO# 83030)
(the Respondent)

INTRODUCTION

The College received information raising concerns about the involvement of the Respondent (Critical Care and Internal Medicine) in the case of a patient (the Patient) where withdrawal of life support measures had been used, and organ donation was planned. Specifically, there was concern about the Respondent's use of a paralyzing agent during the withdrawal of life support.

Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a review of the Respondent's practice.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of September 20, 2021. The Committee required the Respondent to appear before the Committee to be cautioned with respect to the use of paralytic agents for patients undergoing withdrawal of life support for the purpose of organ donation after circulatory death.

COMMITTEE'S ANALYSIS

As part of this investigation, the Registrar appointed an independent Assessor to review the Patient's chart and other documents relevant to the matter, interview the Respondent, and submit a written report to the Committee.

The Assessor opined that the Respondent did not meet the standard of practice, and lacked knowledge, skill and judgment in the care provided to the Patient. The Assessor stated that instead of a paralytic, the Respondent should have used either other sedative or anti-epileptic drugs. The Respondent should also have explained to the family that myoclonus (involuntary muscle jerks, which the Patient was experiencing) was not harming or causing discomfort to the Patient.

However, the Assessor was not of the view that the Respondent exposed or was likely to expose patients to harm or injury, as he had insight into his mistake and had pursued appropriate education to inform future practice.

The Committee accepted the Assessor's conclusions, and was satisfied there were no ongoing patient safety concerns arising from this matter and that the Respondent (who

admitted he had made an error in judgment in this case) had completed relevant education and made the appropriate changes to his practice and helped change processes in the hospital. Nonetheless, this was a sufficiently serious mistake that the Committee decided to require that the Respondent appear before the Committee, as outlined above.