SUMMARY

DR. LJUDMILLA JEFREMOVA (CPSO# 78482)

1. Disposition

On November 15, 2017, the Inquiries, Complaints and Reports Committee (the Committee) ordered family physician Dr. Jefremova to appear before a panel of the Committee to be cautioned with respect to the timely attendance and examination of patients in the emergency room (ER), and the care and management of burn patients.

The Committee also ordered Dr. Jefremova to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Jefremova to:

- complete the next available Advanced Cardiovascular Life Support (ACLS) course and Advanced Trauma Life Support (ATLS) course or provide proof of completion of these two courses within the last two years;
- complete a continuing professional development program in burn care, such as, Advanced Burn Life Support (ABLS) Now offered by the American Burn Association or an equivalent acceptable to the College at the next available date;
- provide proof of successful completion of these three courses;
- review Clinical Practice Guideline(s) on burn management. The review, to be submitted to the College, will include a written summary of the document(s), self-reflection on how each document is applicable to Dr. Jefremova's situation, as well as how Dr. Jefremova would respond to a similar circumstance were it to arise again.

2. Introduction

A family member complained about the care that Dr. Jefremova provided in the ER to two elderly patients who had escaped a fire. Specifically, Dr. Jefremova failed to attend the ER in a timely manner to assess the patients and the need for transfer to a burn unit; prescribed medication and dressings without assessing the burns; did not complete an appropriate

assessment (in that she did not remove the dressings to assess the burns) when she eventually attended the hospital; failed to demonstrate compassion to the patients following their escape from a burning home; and told them that they would be going home that day because their injuries were minor.

Dr. Jefremova responded that her attendance at the hospital was delayed due to a death in the family. There was no back up and she did not know of a physician to call to attend on her behalf. Nurses informed her of the patients' statuses and she gave orders over the phone, and asked that they call with any changes. When she assessed the patients, she was able to see and document the burns without removing the dressings. She noted in one case the bandages were dry. She did not want to damage the skin by removing them. She expected the next ER physician on shift to remove them and that a transfer would be arranged to a burn unit. She endeavoured to provide compassionate care and did not tell the patients that their injuries were minor.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who specializes in family and emergency medicine. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

A General 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 IO provider opined that Dr. Jefremova did not meet the standard of care in treating these two burn patients, and that Dr. Jefremova's clinical practice, behaviour and conduct exposes, or is likely to expose, her patients to harm. In particular, the IO provider noted:

- Dr. Jefremova should have attended in person to assess these patients who were elderly and arriving to the ER with significant burns after escaping a house fire. Dr. Jefremova should have recognized the urgency of the situation and made efforts to find coverage if she felt her personal circumstances intervened with her ability to provide care. She had a duty to attend to these patients as the on-call ER physician.
- One hour after their arrival in the ER, nursing called Dr. Jefremova again and informed her that one of the patients had bradycardia (a very low heart rate); again, Dr. Jefremova failed to attend.
- When she did arrive in the ER about three hours after the patients' arrival, Dr. Jefremova failed to conduct an appropriate assessment. When dealing with significant burns, the role of the ER physician is to assess for airway compromise, determine the intravenous (IV) fluid requirements, and then assess the degree of the burns. By failing to properly expose the wounds to assess their depth, she demonstrated poor skill and lack of knowledge on burn assessment. Her initial management of the IV fluids was inadequate, and showed a lack of burn knowledge. Finally, she showed a lack of judgment by not transferring both patients immediately to a burn centre.

The Committee agreed with the IO provider and noted that it was particularly concerning that Dr. Jefremova failed to recognize the urgency and seriousness of burns in elderly patients and the high risk of poor outcome and complications in such patients (including a high risk of death), and that she failed to attend to assess the patients in a timely manner. When Dr. Jefremova finally did attend three hours later, she failed to conduct and document an appropriate assessment. Finally, the record supports that Dr. Jefremova did not recognize the

need for urgent transfer and was not even considering an admission for one of the patients, who had extensive burns and was admitted to a burn unit for 17 days.

The Committee considered referring this matter to Discipline given the very poor clinical care Dr. Jefremova provided to these burn patients. However, a parallel investigation which examined Dr. Jefremova's emergency medicine practice more broadly did not reveal other clinical concerns, and thus the poor clinical care in this case, while very troubling, appeared to be isolated. As a result, the Committee was satisfied that these concerns could be addressed through education and a caution in person.