Indexed as: de la Rocha (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 60(6) of the **Health Disciplines Act**, R.S.O. 1990, c. H.4

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. CLAUDIO ALBERTO GONZALES DE LA ROCHA

PANEL MEMBERS: DR. L. ROBINSON (Chair)
DR. Y. de BUDA
DR. B. KAIN
MS. C. HYETT
MR. L. EDINBORO

HEARING DATE: APRIL 3-5, 1995

DECISION/RELEASE DATE:

APRIL 5, 1995

DECISION AND REASONS FOR DECISION

This matter was heard before the Discipline Committee of the College of Physicians and Surgeons of Ontario on April 3-5, 1995 at Toronto.

1) THE ALLEGATIONS

In the Notice of Hearing, it was alleged that Dr. de la Rocha was guilty of professional misconduct in that he had been found guilty of an offence relevant to the suitability to practice under what is now 61(3)(a) of the **Health Disciplines Act**, R.S.O. 1990, c.H.4. It was alleged in the alternative that Dr. de la Rocha had failed to maintain the standard of practice of the profession and had engaged in unprofessional conduct which is professional misconduct under what is now paragraphs 22 and 33 of Section 29 of Ontario Regulation 548 of the Revised Regulations of Ontario, 1990.

The offence of which Dr. de la Rocha had been found guilty in the Ontario Court (General Division) in April 1993, was that he "did administer a noxious substance, to wit, an injection of 40 milligrams of Morphine and 20 milliequivalents of Potassium Chloride with intent to endanger life" contrary to Section 245 of the **Criminal Code of Canada**. For this a suspended sentence and probation for three years was imposed.

2) THE PLEA

Through his counsel, Dr. de la Rocha pleaded guilty to the charge of professional misconduct, by reason of his criminal conviction.

At the outset of the hearing, the Committee was told that the College was not proceeding separately with the alternate allegation of "failing to maintain the standard of practice", in that, having committed a criminal act in the course of providing medical care to a patient, Dr. de la Rocha clearly failed to maintain the standard of practice, and this was acknowledged by him. The Committee was informed that, from the perspective of the College, the administration of 20 milliequivalents of potassium chloride (KCL) was unacceptable conduct. The College did not object to the administration of 40 milligrams of morphine for palliative care purposes in the circumstances of this case.

3) THE FACTS

An Agreed Statement of Fact was read to the Committee and established the following facts:

Ms. ZXU was a 68-year-old woman who had lived in the small town of BQD since childhood; she was widowed in 1969 and her son, JME, now lived with her. She had been a heavy smoker for more than 50 years, and suffered from a number of health problems, including chronic obstructive pulmonary disease (COPD), emphysema and asthma. She was referred to Dr. de la Rocha because of a lump in her neck, difficulty in swallowing, and a chest x-ray that showed a mass in the upper lobe of her left lung. The doctor who referred her had made a provisional diagnosis of carcinoma of the left upper lobe.

After examining her on October 9, 1991, and reviewing her x-rays, Dr. de la Rocha told Ms. ZXU that he thought she had cancer in two places, at the back of the tongue and in the area of her trachea. Arrangements were made for him to perform a bronchoscopy six days later, on October 15, 1991, at Hospital GIY, for the purpose of taking a biopsy and establishing the diagnosis. On the afternoon of October 14, 1991, Ms. ZXU was admitted to the hospital, having been driven there by her son and a niece, and at which time she was observed to leave the vehicle and enter the hospital "walking under her own steam".

Late that afternoon, an anaesthetist examined Ms. ZXU in anticipation of providing an anaesthetic for the bronchoscopy the next day. When he asked Ms. ZXU to lie down, she began to experience respiratory problems; he noted that she was markedly cyanosed with partial airway obstruction such that he was unable to hear any breath sounds over the left lung. The anaesthetist called Dr. de la Rocha in order to discuss Ms. ZXU's respiratory status and the possibility of performing a tracheostomy.

At about 1815 hours, Ms. ZXU's family physician visited her to explain the possible diagnosis and discuss further management of her illness. He noted that she was in good spirits and was not in any physical or emotional distress.

It was noticed by a nurse at 2020 hours that Ms. ZXU was unable to breathe properly, was coughing excessively and unable to expectorate phlegm. She told the nurse that it felt as though her throat was closing in on her. This was reported to Dr. de la Rocha, who came in to see her at 2035 hours. Ten minutes later Ms. ZXU was feeling better, but in view of her respiratory difficulties Dr. de la Rocha arranged for her to be taken to the operating room that same evening, for him to perform a bronchoscopy, mediastinoscopy and possibly a tracheostomy.

Dr. de la Rocha performed a transnasal bronchoscopy on Ms. ZXU shortly before 2200 hours. He found a large tumour mass in the lower half of the trachea, occluding the left main bronchus almost completely, and the right main bronchus by 50 percent. During the procedure, Ms. ZXU developed severe respiratory distress. She was successfully intubated and thereafter required mechanical respiration to keep her alive. Biopsies were taken, a radial artery line established to monitor blood gases, and Ms. ZXU was sent to the ICU in a deteriorating condition, arriving there at 2300 hours.

Within the next hour, Ms. ZXU's condition deteriorated; she developed high air-way pressure and became very difficult to ventilate. The anaesthetist was able to resolve her immediate crisis and concluded that her prognosis "was very poor, and she was not expected to survive the night". Her son and niece sat with her and were present as her priest administered the Sacrament of the Sick.

Ms. ZXU did survive the night, with her condition requiring close monitoring while remaining essentially unchanged. She was unconscious, her skin grey and cool to the touch. Another son, PYC, arrived during the night and at about 0930 hours on October 16, 1993, was told by Dr. de la Rocha that his mother was unlikely to survive the next 24 hours. On being asked what his wishes were, PYC told Dr. de la Rocha that, while he requested that no extraordinary measures be taken if his mother took a turn for the worse and that she not be revived, he hoped that she would be alive when his other brother RWC arrived later in the day. A "Do Not Resuscitate" order was then written by Dr. de la Rocha, and Ms. ZXU was provided with nursing care and medication to keep her as comfortable as possible. RWC arrived about 1530 hours and subsequently discussed his mother's condition with Dr. de la Rocha and was made aware of her prognosis.

About 1600 hours, Ms. ZXU opened her eyes and appeared to be alert and orientated, nodding and shaking her head in answer to the nurse's questions. She gave the nurse to understand that she wanted the tube removed, even though the nurse told her this would cause her to die. The family was called in around the bedside, and they were able to communicate with Ms. ZXU and confirm that removal of the tube was what she wanted and she was fully aware of the consequences. The family provided her with support and assured her that her request would be honoured. Ms. ZXU asked for assistance in removing her rings and discussed arrangements for her funeral with her family. RWC then asked for Dr. de la Rocha to be called to extubate their mother.

On Dr. de la Rocha's arrival about 1810 hours, RWC told him that he and his brothers supported their mother in her wish to have the tube removed and to be allowed to die. There was no discussion about hastening Ms. ZXU's death, or authorization to do so; her sons simply expressed their desire that she be made comfortable following extubation. Dr. de la Rocha spoke with Ms. ZXU, telling her that he was going to remove the tube and, once it was removed, she was going to die. She thanked him.

Dr. de la Rocha proceeded to extubate Ms. ZXU, and pulled the curtains around the bed to provide some privacy for the family. She was breathing on her own at this time with the assistance of 50 percent oxygen by mask. Her heart rate was steady and her oxygen saturation the same as before extubation. Dr. de la Rocha proceeded to administer 10

milligrams of morphine intravenously, followed shortly thereafter by a second 10 milligrams of morphine. Ms. ZXU's respirations were shallow and her heart rate remained steady. Dr. de la Rocha then administered another 20 milligrams of morphine and by this time she had stopped breathing with her heart rate dropping to the 50's.

Dr. de la Rocha then asked if there was any potassium chloride in the unit. The nurse told him there was but she would not get it for him. He proceeded to draw up 20 milliequivalents of KCL into a syringe himself. The nurse informed him of Ms. ZXU's status but received no response from him. Without waiting to observe the effects of the last dose of morphine, Dr. de la Rocha injected the KCL as a bolus into the IV tube. Within a minute, Ms. ZXU went into ventricular tachycardia, then into ventricular fibrillation and died at 1830 hours.

Dr. de la Rocha pronounced Ms. ZXU dead at 1835 hours and subsequently signed the death certificate, recording the immediate cause of death as respiratory failure due to carcinoma of the trachea and carcinoma of the tongue, with COPD a significant underlying condition.

Because of Dr. de la Rocha's highly unusual actions, the nurse in attendance expressed her concerns to her fellow nurses and the matter was subsequently reported to the ICU Nurse Manager, the Director of Nursing, the Hospital Administrator and the Chief of Medical Staff. In further discussions, Dr. de la Rocha admitted that he had administered large doses of morphine intravenously plus a bolus of KCL; that he had done so to hasten Ms. ZXU's death; that he believed in euthanasia; and that the family had given him their support by requesting their mother not suffer needlessly. He maintained that under the circumstances he had done the right thing.

4) THE COMMITTEE'S FINDING

Based upon the facts set out in the Agreed Statement of Fact, the Committee found that the charge of professional misconduct had been made out. The Committee therefore accepted the guilty plea and found Dr. de la Rocha guilty of professional misconduct.

5) SUBMISSIONS CONCERNING PENALTY

a) For the College

On behalf of the College, counsel directed the Committee to consider the facts of the case and in particular that, although Ms. ZXU's condition was grave and death was imminent after the bronchoscopy, her life was in fact terminated by administration of KCL by Dr. de la Rocha. He took it upon himself to administer the KCL without consulting another physician or the family. Dr. de la Rocha made an error in judgment. It was a clear case of failure to meet standards and the profession must realize this. A physician must not draw a line that is separate from the law of the land. The Committee was referred to the decision of the Supreme Court of Canada in the Rodriguez case.

The College asked for a penalty of:

A 12-month suspension of his Certificate of Registration, six months of which to be suspended if:

1) Dr. de la Rocha successfully completes a course in bioethics, approved by the College;
2) he successfully completes a course in palliative care, approved by the College;
3) in the six months following re-instatement of his Certificate of Registration, he refers all palliative care patients to a colleague for treatment;
4) thereafter he consults with a colleague for all palliative care patients;
5) in the year following re-instatement of his Certificate of Registration, he be monitored by a suitable physician (e.g. the Chief of Staff), approved by the College; and
6) this physician should report to the College any violation by Dr. de la Rocha of the imposed conditions.

No witnesses were called on behalf of the College and no precedents cited in which the Discipline Committee of this College had been called upon to address a similar case. Counsel stressed that the College required a clear message be sent to both the public and the profession that arbitrary termination of life was not allowed.

b) For Dr. de la Rocha

Through his counsel, the Committee was told that Dr. de la Rocha pleaded guilty because he agrees that he erred in administering 40 milliequivalents of KCL to Ms. ZXU. No argument was advanced to suggest there was validity in euthanasia.

(i) Evidence of Mr. PYC

The Committee heard testimony from Mr. PYC, the second son of Ms. ZXU. He described the course of events around his mother's death after he arrived at the hospital around 0400 hours on October 16, 1991, and this agreed with the facts as previously described. Mr. PYC was able to describe in more detail the communication between his mother and her family as they were gathered at her bedside, after she had regained consciousness. Although it was difficult for her to talk with the tube in her trachea, they would repeat the words she mouthed, and by her nodding or shaking her head they were certain they understood her. Ms. ZXU appeared to be quite lucid; she told her sons that she had had a good life, was going to a better place, and asked PYC to say "good-bye" to his boys for her. She was content that her life was ending and requested a peaceful and dignified death. She knew full well that removing the tube would cause her to die, and it was her clear wish that this should be done.

Mr. PYC and his brothers were very satisfied with the humane and compassionate manner in which Dr. de la Rocha had treated their mother. They thanked him for his care of her, and at the time they had no idea that anything untoward had occurred.

(ii) Dr. de la Rocha's Qualifications

Defence counsel did not call Dr. de la Rocha to testify but presented his curriculum vitae for the Committee's consideration. After gaining his M.D. degree from the National Autonomous University of Mexico in 1968, he pursued post-graduate training as a resident in general, cardiovascular and thoracic surgery at the University of Toronto from 1970 to 1977, gaining Fellowship of the Royal College of Physicians and Surgeons of Canada in General Surgery in 1976 and in Cardiovascular and Thoracic Surgery in 1977. After six months at McMaster University, he moved to Winnipeg, where he was an Assistant Professor, Department of Surgery, Division of Cardiovascular and Thoracic Surgery, University of Manitoba until 1984. Dr. de la Rocha then returned to Mexico to be Head of Cardiovascular and Thoracic Surgery at the Humana Hospital in Mexico City until 1986, when he moved back to Canada and opened his practice in BQD. Between 1972 and 1985 he published 28 articles in peer-reviewed journals, in 17 of which he was listed as principal author.

(iii) Expert Witnesses

The Committee heard the opinions of three experts in critical care: Dr. EDF, Dr. RQX and Dr. EKN. They agreed that Dr. de la Rocha's management of Ms. ZXU's care was appropriate in all aspects except for the administration of a bolus of KCL, which clearly fell below the standard of practice. They testified that, once the decision is made to withdraw life-support by removing the intra-tracheal tube, it is the attending physician's duty to do everything necessary to keep the patient comfortable and prevent suffering. Morphine is the drug of choice and should be given in doses to relieve feelings of suffocation and anxiety that would otherwise occur. The experts further testified that the physician should err on the side of giving too much rather than not enough, to ensure that this goal is reached. They also testified that whether morphine administration hastens death while relieving suffering, in a situation where death is imminent and inevitable, is immaterial. They were all in agreement that the administration of a large dose of KCL would only hasten death and is clearly inappropriate; in no way would it be used to relieve suffering.

Dr. EDF is a general surgeon and Co-Director, Surgical Intensive Care Unit, Hospital XWL. He was asked to clarify the sequence of events in the removal of life-support from a patient in Ms. ZXU's condition and the consequences of Dr. de la Rocha's actions. He stressed that removal of the tube was the seminal decision, as this made death imminent and inevitable, whether or not morphine and/or KCL were administered. However, it is the standard of practice for morphine to be given in such a situation to relieve distress and allow a dignified death. Without it, feelings of suffocation and air-hunger would cause considerable suffering to the patient and to the watching family. Morphine in large doses may hasten death because it suppresses respiration, but this is a secondary effect and not inappropriate. A bolus of 20 milliequivalents of KCL, on the other hand, would only be given to hasten death and for no other reason. It is clearly inappropriate.

Dr. RQX is Professor of Clinical Medicine and Anesthesia at University SOK and Associate Director, Medical-Surgical Intensive Care Unit at Hospital JLK. One of his areas of special interest is the management of withdrawal of life-support from the terminally ill, including the ethical and medical-legal issues involved. He has conducted research and published papers on these topics. His testimony supported that of Dr. EDF's and he agreed that administration of KCL was not appropriate. It was his opinion, however, that administration of KCL did not affect the outcome; the same effect would have been achieved if an additional 20 mgms of morphine had been given instead of 20 milliequivalents of KCL. It was his opinion that Dr. de la Rocha may have acted out of a combination of compassion and desperation; he knew Ms. ZXU was going to die from her terrible disease, he knew her wish and her family's wish that she be allowed to die with dignity, and he may have felt compelled to go further than he should have done.

Dr. RQX described research he was involved in that studied the withdrawal of life support from terminally ill patients in two hospitals in the city area of JQK. He told the Committee that it is an emerging area of medical practice that has not been previously included in medical training, and for which protocols are now being developed.

Dr. EKN is a thoracic surgeon and Head, Division of Thoracic Surgery, Hospital XWL. From 1978 to 1990 he was Director of the Surgical Intensive Care Unit at the same hospital. He testified that, in his opinion, the administration of KCL to Ms. ZXU, while clearly not within the standard of practice, is unlikely to have been of any clinical significance in her case. She had already stopped breathing; the ventricular tachycardia and fibrillation which she developed is consistent with low oxygen levels and may or may not have been affected by the KCL. It was his opinion that a possible reason for giving KCL was to terminate all electrical activity in the heart, which can continue for a short time after death, and is distressing for the family to watch on the heart monitor.

In his surgical ICU, Dr. EKN told the Committee, it was the practice for the physician responsible for the care of a terminally-ill patient to consult with a colleague before making the decision to remove life-support. However, this does not occur in many other hospitals and is not the "standard of care"; he did not think it reasonable to compare a surgical ICU in a tertiary care hospital, where there are numerous physicians on site, to the situation in a community hospital.

Dr. ZGQ was presented to the Committee as a family physician who could speak from experience on the management of death and dying. He has practised in the same city for 25 years, is on the staff of Hospital IAJ, and is an Assistant Professor, Department of Family and Community Medicine, University HEJ, in which capacity he is involved in teaching family medicine residents. Dr. ZGQ's testimony supported that of the previous expert witnesses. He affirmed that caring for patients who are terminally ill, where the goal is to provide the best possible comfort measures, and to sustain life as long as it is meaningful to the patient, is a familiar role for a family physician.

The Committee had no hesitation in accepting the testimony of the expert witnesses concerning the inappropriateness of the administration of KCL. It is unacceptable and clearly below the standard of practice to take any action the sole purpose of which is to hasten the death of a patient.

(iv) Character Evidence

The Committee heard from three character witnesses: Dr. HKR, a consultant neurologist at Hospital TNG who had been referring patients to Dr. de la Rocha since 1986; Ms. QHZ, an operating room nurse at the same hospital who both worked with Dr. de la Rocha and had been operated on by him; and Dr. HEK, an obstetrician/gynecologist who had practised in BQD from 1978 to 1990 and knew Dr. de la Rocha both professionally and socially. Their testimony revealed Dr. de la Rocha as a skilled general, vascular and thoracic surgeon, who is thoughtful, scholarly and up-to-date, and who displays excellent surgical judgment. His consultations are of a high standard and his patients very satisfied with the results of his surgery. He has brought new procedures to BQD, is extremely knowledgeable, and diligent in instructing operating room staff in what is needed. His teaching skills are appreciated by student nurses and family medicine residents alike. He sets high standards for himself and expects those working with him to do the same. He is very responsive in emergency situations, methodical in managing trauma patients, and "totally in control". He routinely speaks directly to a patient's family immediately after surgery, or telephones them if they are not present in the hospital.

This testimony was supported by the brief of some 44 testimonials, which the Committee had the opportunity to read. Many of the letters from patients described the manner in which Dr. de la Rocha explained clearly to them what was involved in the surgery he was recommending, his compassionate manner in relating to them and their families, the excellent results, and the diligence with which he managed their care after surgery.

In summary, defence counsel reminded the Committee that Dr. de la Rocha was genuinely contrite; a much sadder but wiser man. He has a criminal record for life. At the time of the criminal charge against him, the hospital publicly supported him and did not discontinue his privileges. His reputation is otherwise unblemished and he continues to make a significant contribution as a surgeon, an administrator and a teacher. While it was necessary to send a message to the public and the profession that Dr. de la Rocha's behaviour fell below the standard of practice and cannot be condoned, he himself needs no further deterrence. Over the past 3 1/2 years Dr. de la Rocha has continued to perform at a very high level and he should be allowed to continue his own rehabilitation.

(v) Precedents from Other Jurisdictions

Two similar, albeit not identical, cases were cited by defence counsel. The first was the 1991 case of an unnamed physician in the Province of Quebec who, on the request of a patient whom he had treated for two years and despite large doses of morphine was dying painfully from complications of AIDS, injected him with a lethal dose of potassium phosphate, thus causing his death. His penalty was a severe reprimand, a requirement to attend a course in palliative care, restrictions imposed on his medical practice for a three-month period, but no suspension.

The second case came before the General Medical Council of the United Kingdom in 1992 and concerned a Dr. Nigel Cox, a rheumatologist. He was convicted in Criminal Court of attempted murder and given a twelve-month suspended sentence after he administered two ampoules of undiluted KCL to one of his patients in 1991. The 70-year-old woman had deteriorated slowly and at the time of her death was in great pain, unaffected by repeated doses of analgesics. She asked Dr. Cox, as well as other medical staff, to help her die, and Dr. Cox promised to make her last hours as pain-free and as dignified as possible. The GMC neither suspended nor imposed any restrictions on his licence.

Defence counsel noted that in both these cases the patients were not at the point of death when potassium was administered. Ms. ZXU, on the other hand, was about to die within seconds or minutes when she received the KCL. Counsel also reminded the Committee that the judge in the Ontario Court had imposed only a suspended sentence on Dr. de la Rocha and a period of probation.

6. CONSIDERATIONS RELEVANT TO PENALTY

In coming to its decision, the Committee considered the general principles of sentencing and how they applied in this case:

a) Denunciation

Denunciation has already occurred. Dr. de la Rocha was charged and found guilty of a criminal offence in a widely-publicized criminal trial. He was now involved in this Discipline hearing, the results of which will be published in Member's Dialogue and circulated to all Ontario physicians. The Committee was of the opinion that the penalty for an offence as serious as this should be recorded on the Register.

b) General Deterrence

A clear and strong message must be sent out to the profession and to the public that arbitrary termination of life is not allowed. The public must know that it is protected from such behaviour. The profession as a whole must know that it is not for a physician to draw a line that is separate from the law of the land. The College must uphold the law and must be seen to do so. In the absence of other considerations the Committee was of the opinion that a period of suspension would be an appropriate penalty .

c) Specific Deterrence

Is Dr. de la Rocha likely to re-offend? In the three and a half years since Ms. ZXU's death, the Committee was told that he has continued to practice in his community and to perform at a very high level. He is contrite and a much sadder but wiser man. His reputation is otherwise unblemished. No evidence was introduced to suggest otherwise. The Committee was of the opinion that no further specific deterrence was needed.

d) Rehabilitation

Why did Dr. de la Rocha act in the way he did? Why did a skilled experienced surgeon administer KCL to hasten death in a patient whom he knew to be at the point of death and not apparently suffering? It was suggested by the expert witnesses that it might have been a combination of compassion and desperation; possibly to relieve the distress of the watching family. Did Dr. de la Rocha himself know why he did it?

The Committee heard testimony that portrayed Dr. de la Rocha as a surgeon of exemplary qualifications, who sets very high standards for himself and expects it of others who work with him. He is accustomed to taking charge in emergency situations, responding in a methodical manner yet able to make rapid decisions. He is "in control". Does he recognize that there are occasions when the opinions of others should be sought before a decision is made? When further consultation with health professionals, and patients and their families, is appropriate? How many others like him are faced with similar situations?

The Committee recognizes that the management of death and dying of most terminally-ill patients in a community hospital is usually the prime responsibility of the family physician and other members of the palliative care team, not of a surgeon. One exception would be for a patient such as Ms. ZXU who is in the ICU and for whom the decision has been made to remove life-support and allow her to die. Even so, any physician in such a situation, be they surgeon or other specialist, should realize that involving the family physician and others, including the family, would help them in making appropriate decisions.

The Committee further recognizes that removing a terminally-ill patient from life-support is not a common occurrence in a community hospital. Most patients requiring life-support are transferred to a larger centre where facilities and staff for providing such on-going sophisticated care are available. When it does occur in a community hospital, what is available to help the staff manage an unfamiliar situation appropriately? The Committee heard from Dr. RQX that only now are protocols being developed for critical-care units in tertiary hospitals, where it is a much more common occurrence.

After considerable deliberation, the Committee concluded that the most desirable outcome of this case would be to assist others in dealing with comparable situations.

Dr. de la Rocha's curriculum vitae lists his previous academic appointments, research and publications. The Committee heard that he is committed to teaching and is highly regarded as a teacher of family medicine residents, nurses and paramedics. He reads widely and keeps himself up to date. Dr. de la Rocha appears to be a compassionate physician who demonstrates a great deal of care and concern for patients who put their trust in them.

The Committee carefully considered various options before deciding on rehabilitative activities it would require of Dr. de la Rocha. It recognized that passive attendance at a course or courses may not achieve the hoped for change in behaviour. On the other hand, individualized study directed to an identified need, with a specific objective to be achieved, would likely be a more effective educational experience. Any guidance such activity might provide for other care-givers would be an added benefit. Dr. de la Rocha's professional activities up to now suggest that he could make a worthwhile contribution.

The final decision to be made concerned the matter of the suspension that the Committee felt was warranted in this case. Due consideration was given to the two cases cited by the defence, in neither of which was suspension imposed. Dr. de la Rocha's offence was somewhat different from the other cases, in that his patient was about to die whether or not he had administered the KCL. It was the opinion of the Committee that an appropriate penalty could be imposed without requiring an absence from practice.

7. DECISION AS TO PENALTY

Based on the foregoing considerations, the Committee decided on the following penalty:

1) The Certificate of Registration of Dr. de la Rocha shall be suspended for a period of 90 days. This period of suspension shall commence on a date which will be fixed by the Registrar, who shall take this action within 30 days of the date on which this decision becomes final. In any event, the term of the suspension shall commence not more than 60 days after the date on which the decision becomes final.

2) The suspension of the Certificate of Registration of Dr. de la Rocha shall itself be suspended provided that, within 15 days after the date upon which this decision becomes final, Dr. de la Rocha shall file with the Registrar a written undertaking to prepare a proposal for a protocol for use in community hospitals, concerning the withdrawal of life support from terminally ill patients, and provided further that:

a) Dr. de la Rocha shall, within 30 days of filing the written undertaking, submit to the Registrar an organizational plan for the development of the proposal for a protocol;

b) the proposal for a protocol shall address the pharmacological management of symptoms, as well as the subjects of informed consent, ethics, patient autonomy, and the involvement of the family and the family physician in the decision-making process;

c) in the course of preparation of the proposal for a protocol, Dr. de la Rocha shall review relevant literature and consult widely with experts in palliative care, ethics and critical care, and with patients' rights organizations;

d) the proposal for a protocol shall be of such a quality that it be suitable for submission to a peer-reviewed journal, and shall be submitted by Dr. de la Rocha for consideration for publication by such a journal;

e) Dr. de la Rocha shall, within 270 days of filing the written undertaking, submit to the Registrar a copy of the proposal for a protocol, and written confirmation that he complied with subparagraphs 2b), 2c) and 2d).

3) In the event that, having filed the written undertaking referred to in paragraph 2, Dr. de la Rocha fails to comply with the deadlines contained in subparagraphs 2a) or 2e), his Certificate of Registration shall thereupon be suspended for a period of 90 days, such suspension to commence immediately following such behaviour.

4) The result of this proceeding shall be recorded on the Register.