

## **PUBLIC SUMMARY**

### **Dr. Ian MacDougall (CPSO# 86583)**

#### 1. Disposition

On July 9, 2015, the Inquiries, Complaints and Reports Committee (“the Committee”) required Dr. MacDougall (Family Medicine) to appear before a panel of the Committee to be cautioned with respect to differential diagnoses of confusion in the elderly, and the diagnosis and management of septic shock.

#### 2. Introduction

A family member of Patient A complained to the College that Dr. MacDougall failed to recognize the signs and symptoms of sepsis and treat the underlying infection in a timely manner, failed to transfer Patient A to the Intensive Care Unit (ICU), despite Patient A’s meeting the criteria and allowed Patient A’s Do Not Resuscitate status to influence his treatment, all of which contributed to Patient A’s death

#### 3. Committee Process

The Family Practice Panel of the Committee, consisting of both public and physician members, met to review the relevant records and documents related to the complaint, as well as College policies and the relevant legislation.

#### 4. Committee’s Analysis

The Committee decided that the appropriate disposition in this case was to caution Dr. MacDougall in person, as it was of the view that Dr. MacDougall was not proactive in his management of Patient A. He failed to consider, in a timely manner, that Patient A may have had a Urinary Tract Infection, given Patient A’s medical history and presenting symptoms of confusion despite a negative CT scan. He also failed to recognize signs that Patient A had gone into septic shock, which included gram negative bacteria in Patient A’s urine, a blood pressure of 70 to 80 mmhg, a high white blood cell count, deteriorating kidney function and the fact that Patient A was confused. As a result of his failure to recognize the signs of septic shock, Dr. MacDougall failed to request that patient A be transferred to the ICU in a timely fashion.

Dr. MacDougall informed the Committee that he is working closely with a sepsis working group and has arranged an education session with an ICU physician on sepsis for physicians and nursing staff. While the Committee acknowledged that it is a positive step, it did not mitigate its concerns about Dr. MacDougall's care in this case.