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. Jag Mohan Dhar (CPSO #78411)
Internal Medicine
(the Respondent)

INTRODUCTION

The Respondent provided care to the Patient, in his role as most responsible physician (MRP), on the telemetry medicine unit of the hospital where the Patient was admitted for suspected recurrence of autoimmune hemolytic anemia (AIHA). During the two days the Respondent acted as MRP, the Patient's condition deteriorated, and the Patient suffered a fatal cardiac arrest. He was 30 years old. The Complainant, a family member of the Patient, contacted the College of Physicians and Surgeons of Ontario (the College) to express concern about the Respondent's care.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to provide appropriate care to the Patient during his admission to hospital. Specifically, the Complainant is concerned that the Respondent:

- **was dismissive of, and failed to investigate, the Patient's repeated concerns of increasing chest pain and shortness of breath**
- **failed to provide the standard of care for a patient specific to a telemetry unit**
- **failed to perform a complete and thorough assessment of the Patient**
- **dismissed concerns of bilateral numbness in the Patient's feet radiating to his legs**
- **inappropriately diagnosed the Patient's concerns as anxiety, without assessing him, and provided no intervention**
- **behaved in an unprofessional manner towards the Patient; for example, laughed at the Patient the morning of his death.**

COMMITTEE'S DECISION

An Internal Medicine Panel of the Committee considered this matter at its meeting of May 8, 2023. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to inadequate assessment of an unstable patient with changing clinical status. The Committee also requested that the Respondent provide the Committee with a written report with respect to review of the assessment and management of an unstable patient with changing clinical status, and

reflection on the role of unconscious bias in treatment of a patient with a history of substance use issues.

COMMITTEE'S ANALYSIS

Regarding the first five areas of concern related to the Patient's care, overall the Committee had significant concern about the Respondent's assessment and management of the Patient.

It appeared to the Committee that the Patient received suboptimal monitoring by the medical team, and the Committee was further concerned that part of this suboptimal care may have been related to unconscious bias resulting from the Patient's history of substance use.

The Committee noted that the nursing notes provided clear documentation of a number of symptoms of concern affection the Patient, and pointed out that these were not adequately investigated, especially given that one would not expect a patient with warm AIHA to decompensate in the manner in which the Patient decompensated.

The Committee indicated that, at the very least, a broad differential diagnosis and work-up should have been initiated. The Respondent did order appropriate testing eventually, but by that time the Patient was too ill and most of the testing could not be completed prior to the Patient's fatal cardiac arrest. The Committee acknowledged the impact of the ongoing COVID-19 pandemic on the Respondent's ability to provide care, yet still remained concerned to the extent if felt that, given the identified shortcomings in care, the Respondent would benefit from a caution with homework as outlined above.

Regarding the concern about unprofessional behaviour, the Committee took no action on this aspect of the complaint. The Respondent strongly denied this allegation and the Committee was unable to reconcile the conflicting information before it.