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. Ivan Alexander Hunter (CPSO #19979)
(the Respondent)

INTRODUCTION

The Respondent provided care to the Patient for many years in a long-term care setting. In September 2018, a member of nursing staff telephoned the Respondent to inform him that the Patient was noted to have lethargy, face droop and left leg weakness.

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care of the Patient.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the Respondent's care and conduct. Specifically:

- **The lack of immediate transfer to hospital with initial symptoms of stroke**
- **The delay of approximately 17 hours to transport to hospital caused unnecessary brain damage, debilitating the Patient**
- **The Respondent's cavalier attitude when he described the medical situation to the Complainant and his lack of initiative to treat his patient.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of May 2, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to inadequate documentation, including the failure to document care-planning decisions at the end of life, and inadequate assessment, decision making and communication, particularly regarding end-of-life care with the patient and substitute decision-makers.

COMMITTEE'S ANALYSIS

The Committee had no way to know exactly how the nurse described the Patient's altered condition in the telephone call she made to the Respondent. In hindsight, it was clear to the Committee that the Patient's symptoms were suggestive of a stroke and she should have been sent to the hospital, but the Committee was aware of the possibility that the nurse conveyed the Patient's new symptoms in a way that did not raise suspicion for cerebrovascular accident (CVA).

Upon discussion with the nurse, the Respondent believed that the Patient had had a seizure. It is a physician's responsibility, however, to ask pertinent questions to get all the answers necessary to make a sound clinical decision. Decisions should always be based on all relevant information one is able to obtain. Based in part on the lack of documentation in the medical record (addressed further below), it appeared to the Committee that the Respondent's judgement about the Patient's condition on the day in question was not based on all available information.

When the Respondent assessed the Patient approximately five hours after the nurse telephoned him, he indicated that it was obvious that the Patient had suffered a severe stroke. He notified the Complainant of his opinion. He determined that the damage caused by the stroke was done and it was appropriate to wait until the morning to decide on next steps.

There is no documentation in the medical record of the Respondent's care of the Patient on that day or of his discussion with the Complainant. Nursing staff noted "exam per MD," but the Respondent did not make an entry into the medical record at the time. He did not document his findings upon assessment of the Patient or his reasons for not transferring the Patient to hospital that evening. He made no note of the Complainant's reaction to his explanation or whether she was in agreement with his plan to determine the appropriate course of action the following morning.

The Committee found the Respondent's decision not to refer the Patient to hospital in the evening when he examined her to be concerning. The Respondent denied that his attitude was cavalier, as the Complainant indicated, but it appeared to the Committee that he had a pessimistic view of the Patient's clinical circumstances. The delay in treatment could have contributed to further brain damage. Stroke treatment is not always successful and is not without risks; nevertheless, it is the current standard of care unless there are contraindications.

The Plan of Treatment for CPR form in the Patient's medical file, completed in September 2014, clearly indicated that the Patient's wish was to be resuscitated in the event of a medical emergency. This form was valid on the date the Patient had her stroke. The Respondent indicated that he knew through discussion with the Patient at care conferences that she did not wish to be resuscitated in the event she became very ill or for care providers to take any heroic measures to keep her alive. If the Respondent learned through discussion with the Patient that her wishes had changed since the September 2014 form was completed and she no longer wanted to be resuscitated, he should have documented this in the medical record at the time and ensured the Plan of Treatment for CPR form was updated. The Respondent should have recorded why his actions in response to the Patient's stroke were reflective of the Patient's current wishes.

The Respondent's failure to document appropriately was not limited to the day of the Patient's stroke. In fact, the Respondent wrote virtually no notes in the medical record from July to November 2018. There were nursing notes over this period, but there was little indication that the Respondent documented any of his care of the Patient or his discussions with the Patient or her substitute decision-makers on end-of-life issues.

Overall, the Committee had a number of concerns about the Respondent's assessment and decision making (in regard to both the information the nurse provided him and upon seeing the Patient later in the day), as well as his communication and documentation in this case. The Committee decided that a verbal caution was warranted.