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. David Scott Homuth (CPSO #95750)
(the Respondent)

INTRODUCTION

The Patient died at home of cardiac arrest due to heart disease one day after seeking care in the emergency department (ER) for ongoing symptoms of dizziness, nausea and vomiting, chest tightness, and shortness of breath. The Respondent was the ER physician who assessed the Patient and discharged him from the ER. The Complainant 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 about the care the Patient received from the Respondent in the ER in April 2019. Specifically, the Complainant is concerned that the Respondent:

- **failed to provide the Patient with appropriate care**
- **advised the Patient that there was not a cardiologist available to see him on April 2, 2019**
- **discharged the Patient home without his seeing a cardiologist.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of November 7, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to: 1) assessment and management of a patient presenting with cardiac symptoms in the ER setting; 2) lack of professionalism in excusing poor care based on external factors (flooding in the ER, recent paternity leave and resultant fatigue); and 3) professional obligation to be fit to report to work given the higher standard to which physicians are held. The Committee also requested that the Respondent prepare and submit to the College homework on: assessment and acute coronary risk stratification of patients presenting to the ER with chest pain; ER management of patients with chest pain, multiple cardiac risk factors, and an elevated Troponin-I (TpI) level; and interpretation and management of TpI levels in ER patients with chest pain.

COMMITTEE'S ANALYSIS

The Patient was a male in his late 60s with significant risk factors for coronary disease, a history of palpitations (possibly arrhythmias), chest pain and dizziness, abnormal cardiogram and an

abnormal heart muscle enzyme (troponin) level that required follow-up prior to discharge from the ER. While the Committee cannot determine if the tragic outcome would have been preventable had the Patient not been discharged, it is very unfortunate that he was not investigated further the day he presented to the NYGH ER.

The Respondent appeared to recognize that he made an error in allowing the Patient to go home without repeating the TpI test or putting the Patient on a monitor in the ER. Regardless, the Respondent's medical judgement in his management of the Patient at the time did not meet the standard of care for diagnosis and referral to a cardiologist. The Committee was also concerned that the Respondent excused the shortcomings in his care of the Patient on the basis of the restricted ER setting related to a recent flood and sleep deprivation as a result of his return from a two-week paternity leave. The Committee did not accept these reasons as cogent mitigating factors, and noted it was neither professional nor appropriate to make such excuses. When physicians are on duty they are expected to be fit enough to perform to an acceptable standard.

Given its concern about the care provided and considering the outcome for the Patient, the Committee decided to caution the Respondent.