

SUMMARY

DR. EARL PHILLIP MORGAN (CPSO# 63392)

1. Disposition

On September 20, 2017, the Inquiries, Complaints and Reports Committee (“the Committee”) required internal medicine specialist Dr. Morgan to appear before a panel of the Committee to be cautioned with respect to the management and recognition of complications in a patient with cirrhosis and gastrointestinal (“GI”) bleeding, communication with physicians asking for consultation, and the response to requests for consultation for acutely ill patients.

The Committee also ordered Dr. Morgan to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Morgan to:

- Review and submit written summary reports to the College on the following:
 - Clinical Practice Guideline(s) on management of patients with cirrhosis
 - The College’s *Practice Guide*
 - Hospital Medical Advisory Committee (MAC) policies regarding response to consultation requests

2. Introduction

The College received a complaint from a late patient’s family member raising concerns that Dr. Morgan failed to assess, diagnose and treat the patient, who was in hospital with serious complications from a chronic disease, in a timely fashion.

Dr. Morgan, who was on call during the weekend in question and had been contacted by the hospitalist about the patient on Friday, responded that given there was no evidence of continued bleeding by the patient at the time of the notification, he would put the patient on his list to see over the weekend. He said that when he did attempt to see the patient during his

rounds on Saturday, the patient's condition had deteriorated, and when he tried again later on Saturday to see the patient in the Intensive Care Unit ("ICU"), the intensivist said it was not necessary. He indicated he did not think if he had assessed the patient it would have made any difference, given the patient's rapid deterioration. The patient passed away on Saturday evening.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee observed that Dr. Morgan's actions in not attending to assess the patient were not in keeping with typical hospital protocols about urgent consultations within a hospital setting, given he had been asked to see a complex patient with a potentially life-threatening complication (GI bleeding). In this regard, the Committee noted charting by the hospitalist about expectations that Dr. Morgan would see the patient "soon", as well as documentation that nursing staff reminded Dr. Morgan of the consultation request as well as the family's question about when he might see the patient, but that Dr. Morgan responded that he was very busy and would see the patient sometime over the weekend.

Overall, the Committee held the view that Dr. Morgan lacked insight in his response about the lack of proper care he provided in this case.

The Committee determined that the two-fold disposition set out above was appropriate in this case.