COLLEGE OF PHYSICIANS & SURGEONS OF MANITOBA
INQUIRY PANEL DECISION

INQUIRY: IC2134
DR. MARIA LEE WOWK-LITWIN

INTRODUCTION AND BACKGROUND

On June 22, 2015, a hearing was convened before an Inquiry Panel (the "Panel") of the College of Physicians and Surgeons of Manitoba (the "College") for the purpose of conducting an inquiry pursuant to Part X of *The Medical Act*, into charges against Dr. Maria Lee Wowk-Litwin ("Dr. Wowk-Litwin") as set forth in an Amended Notice of Inquiry dated December 5, 2014.

The Amended Notice of Inquiry charged Dr. Wowk-Litwin with committing acts of professional misconduct, contravening Article 6 of the College's Code of Conduct, contravening Statement 169 of the College and displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine. The Amended Notice of Inquiry alleged that:

> "1. On or about October 31, 2012, you did not meet the standard of the profession in attempting endotracheal intubation by way of rapid sequence intubation (RSI) without adequate ancillary equipment being available and/or without a back-up plan, thereby displaying a lack of knowledge of or a lack of skill or judgment in the practice of medicine. …
>
> 2. On or about October 31, 2012, you did not meet the standard of the profession and/or the requirements of Article 6 of the Code of Conduct established pursuant to Article 21.1 of By-Law No. 1 of the College in the manner in which you responded to one or more of your failed attempts to intubate Patient X, thereby

displaying a lack of knowledge of or a lack of skill or judgment in the practice of medicine. …

3. On or about October 31, 2012, following the death of Patient X, you did not meet the standard of the profession when you reported Patient X's death to the Medical Examiner thereby displaying a lack of knowledge of or lack of skill or judgment in the practice of medicine. …

4. On or about October 31, 2012, following the death of Patient X, you did not provide full and frank disclosure to Patient X's family thereby committing acts of professional misconduct, breaching the requirements of Statement 169 of the College and/or displaying a lack of knowledge of or a lack of skill or judgment in the practice of medicine."

In addition to the foregoing, the Amended Notice of Inquiry also contained additional factual particulars.

The hearing proceeded before the Panel on June 22, 2015, in the presence of Dr. Wowk-Litwin and her counsel, and in the presence of counsel for the Investigation Committee of the College. Dr. Wowk-Litwin, entered a plea of guilty to all of the charges outlined in the Amended Notice of Inquiry, thereby acknowledging that the facts alleged in the Amended Notice of Inquiry were true and also acknowledging that she was guilty of professional misconduct and of contravening Article 6 of the Code of Conduct, Statement 169 of the College, and of displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine.

Counsel for the Investigation Committee moved for an order under Subsection 56(3) of *The Medical Act* for the non-disclosure of the names of any patients or other third parties referred to the proceedings. Counsel for Dr. Wowk-Litwin consented to such an order. The Panel therefore granted an order for the non-disclosure of the names of patients and other third parties, specifically referred to during the hearing, or in any documents filed as exhibits at the hearing.

The Panel reviewed and considered the following documents, all of which were filed as exhibits in the proceedings by consent:

1. The original Notice of Inquiry (Exhibit 1).

2. A Request for Particulars sought by counsel for Dr. Wowk-Litwin (Exhibit 2).

3. Particulars provided on behalf of the Investigation Committee (Exhibit 3).

4. The Amended Notice of Inquiry (Exhibit 4).

5. A Statement of Agreed Facts, containing 38 paragraphs (Exhibit 5).

6. The Book of Documents (Exhibit 6).

7. The Joint Recommendation As To Penalty (Exhibit 7).

REASONS FOR DECISION

Having considered the guilty plea of Dr. Wowk-Litwin in the context of the above noted exhibits, and the submissions of counsel for the Investigation Committee of the College and counsel for Dr. Wowk-Litwin, the Panel is satisfied that all of the charges set forth in the Amended Notice of Inquiry and the particulars recited therein have been proven. The Panel is also satisfied that the Joint Recommendation As To Penalty is appropriate and ought to be accepted. The Panel's specific reasons for its decision are outlined below.

Background of Dr. Wowk-Litwin

1. Dr. Wowk-Litwin graduated from the Faculty of Medicine, University of Manitoba in 2001. She received her Certification in Family Medicine from the College of Family Physicians of Canada ("CFPC") in July, 2006. She became conditionally registered with the College on February 21, 2006 to provide primary care, no anesthesia. Dr. Wowk-Litwin completed the CFPC Emergency Medical Training Program in March, 2007 and met the requirements for full registration in April, 2007.

2. At all relevant times, Dr. Wowk-Litwin practiced at the same rural hospital in Manitoba, both as a Hospitalist and in the Emergency Department. She began working at that hospital in or about 2007. Prior to that time, she had worked as a Hospitalist and in Emergency Departments in Winnipeg. She left the rural hospital in January, 2013. Dr. Wowk-Litwin began working as a Hospitalist in Winnipeg in March 2013 and continued to work in that capacity until November 5, 2014. On November 14, 2014, she signed an undertaking with the College to cease practice because of health concerns not directly related to these proceedings. As of the date of the hearing of the Inquiry Panel, June 22, 2015, Dr. Wowk-Litwin was not practising medicine.

Overview of Events Leading to the Charges Against Dr. Wowk-Litwin

3. On October 31, 2012:

(a) At 20:41 Patient X arrived at the Emergency Department of the rural hospital at which Dr. Wowk-Litwin was practicing by ambulance experiencing intermittent chest pain and respiratory distress; and

(b) At 22:12 Patient X was pronounced dead in the trauma room of the ER following Dr. Wowk-Litwin's unsuccessful attempts to intubate him, a successful intubation by the anaesthetist and failed attempts to resuscitate him.

4. At all relevant times, Dr. Wowk-Litwin was on duty in the Emergency Department. There were several nurses on duty at the time, including two nurses, R and C. Patient X was brought in by two EMS personnel, L and G. Nurses R and C and EMS personnel L and G were each involved in X's care before and during X's being intubated and all of them remained in the Emergency Department until after X died. Members of X's family, including his partner, attended the Emergency Department and were with X for much of the time prior to him being sedated for the purposes of intubation. Additional members of X's family were waiting in a room designated for family while X was being intubated and were present following his death.

5. On the basis of information compiled from the hospital record, and interviews with Dr. Wowk-Litwin, the nurses, EMS personnel, and family members of Patient X, the following facts have been established:

(i) Patient X's partner has stated that X returned from a lengthy trucking trip in the United States just before the ambulance was called to take him to hospital. He had driven that day, but he was not feeling well. X was able to drive without difficulty up to and including October 31, but he was having difficulty in performing some of his duties as a truck driver in the weeks preceding his visit to the ER, including walking for more than short distances and carrying bags to and from the truck.

(ii) According to EMS personnel, L and G, X had been alert and able to communicate with them, including during an episode of respiratory distress and tightness in his throat while transferring to the ambulance. His vital signs before and after the episode were stable. During transport, he was on oxygen-3L per min. via nasal prongs and there were no further episodes during transport. He was coded by EMS personnel as non-urgent.

(iii) Upon arrival at the ER, X's care was transferred to the nursing staff and he was put in the trauma room. At this point, Nurse R became the nurse who was primarily responsible for X's care in the ER. The suspected "Acute Coronary Syndrome" (ACS) Chest Pain Protocol was initiated immediately. Patient X's partner and one or more family members were at X's side for much of the time before he was sedated for intubation. X was sedated at 21:40 so that Dr. Wowk-Litwin could perform a rapid sequence intubation (RSI).

(iv) Dr. Wowk-Litwin's decision to intubate Patient X was communicated by Nurse R to Nurse C who thereafter became

involved in X's care, including assisting in the preparation for the intubation and assisting with the intubation and resuscitation of X.

(v) Patient X was a large man with a BMI over 50. The EMS personnel and Nurses R and C and X's partner all described X as still verbalizing and alert and oriented right up to the time he was sedated for intubation at 21:40. Neither the EMS personnel nor Nurses R and C shared Dr. Wowk-Litwin's sense of urgency in proceeding to sedate X and to attempt RSI, but all accepted Dr. Wowk-Litwin's decision to proceed as the physician in charge of his care.

(vi) Dr. Wowk-Litwin described Patient X as struggling to maintain his airways and stated that his level of consciousness was deteriorating to the point that he was becoming unresponsive before she made the decision to proceed with RSI on an emergent basis.

(vii) Although there are differences in Dr. Wowk-Litwin's recollection, the recollections of the family and the recollections of the nurses and EMS personnel as to Patient X's level of discomfort, consciousness and the sense of urgency in respect to the timing of the intubation, the following is agreed as to Patient X's condition right up to the time he was sedated for intubation at 21:40:

a) His oxygen SATs were fluctuating between as low as 66% and as high as 100% based on the monitoring equipment readings;

b) Patient X experienced intermittent episodes of very severe chest pain and/or shortness of breath and was having difficulty breathing when he was assessed by Dr. Wowk-Litwin at 21:25;

c) He maintained his gag reflex and did not have an oropharyngeal airway in place;

d) He was not suctioned for and did not have excessive secretions prior to the attempts to intubate.

(viii) Whereas there are differences in the recollection of the nursing staff and Dr. Wowk-Litwin as to whether Dr. Wowk-Litwin requested a CO2 monitor prior to attempting to intubate Patient X and as to whether it would have been available if she requested it, Dr. Wowk-Litwin acknowledges that:

a) She proceeded with the intubation without a back-up plan to address possible complications, including failure to intubate and/or tube misplacement.

b) She proceeded with the intubation without ensuring that the end tidal CO2 monitor was readily available to her if requested.

c) She did not request the CO2 monitor during her attempts to intubate Patient X.

d) The CO2 monitor was available to and used by the anaesthetist on call when the anaesthetist on call successfully intubated Patient X at 22:05.

(ix) The Nursing Reassessments and the Resuscitation Record contained in the hospital records document the following information regarding Patient X's condition and the care provided to him from 21:40 until 22:12 when Patient X was pronounced dead:

Nursing Reassessments:

- 21:40 - Preparing for intubation - Fentanyl 50 mg, Versed 5 mg, Propofol 250 mg, Succynylcholine 150 mg,. IV given, BP recorded as 104/45, pulse 75
- 21:43 - Dr. Wowk attempting to intubate; unsuccessful.
- 21:45 - Attempting intubation again. No. 8 FR ET tube ++ secretions in tube; suction done.
- 21:50 - CPR started. No pulse O2 65% being bagged. Epi 1 mg. I.V. going in, patient pale.
- 21:55 - PEA, CPR held, no pulse, CPR started, Epi 1 mg. I.V. going in - attempting intubation per Dr. Wowk.

Resuscitation Record:

- Initial event date October 31, 2012. Time 2150. Rhythm or diagnosis PEA.
- 21:59 - Rhythm PEA. Pulse no. Treatment Epi 1 mg. I.V. and 20 cc ns flush. Other treatment - intubation being attempted CPR held. I.V. ? to left ACF, ++ suctioning through ET, AE bilat.
- 22:02 - Rhythm PEA. Pulse no. Treatment NS infusing c500cc. Ventilation - bagging. Other treatment CPR started. CPR held. Emesis through ET tube.
- 22:03 - Rhythm PEA. Pulse no. Treatment CPR held. ++ emesis through ET, ++ suctioning, CPR started.
- 22:04 - Treatment Epi 1 mg. I.V. reattempting intubation per on-call anaesthetist.
- 22:05 - PEA and CPR held for intubation. Other treatment - CPR started. Bagging, 8 ET placed, no AU heard. CO2 detector set up and getting CO2 return.

- 22:08 - PEA Pulse and treatment O2 89% bagged. Other treatment CPR stopped and restarted. Held CPR, CPR restarted.
- 22:10 - Rhythm PEA.
- 22:12 - Rhythm PEQA. Pulse none. Other treatment CPR stopped. Time of death 22:12

(x) Dr. Wowk-Litwin acknowledges that after her first attempt to intubate failed, she was quite frustrated and upset with herself. She states that she did not call for help after the failed attempt as she was focused on attempting to get the intubation done and assist the patient. She also states that it was because of her confidence in her ability to intubate that she believed it was more prudent and safer for the patient for her to continue with the intubation rather than wait for assistance.

(xi) Sometime thereafter, Dr. Wowk-Litwin stated she asked for the on-call anaesthetist to be called and that the anaesthetist arrived at around 22:04 hours at which time the anaesthetist listened to X's chest, removed the present tube, suctioned and introduced a new tube successfully ventilating Patient X. Unfortunately, X had been pulseless electrical activity ("PEA") since 21:55 and could not be resuscitated.

(xii) Whereas there are differences in the recollections of those involved in the intubation, the following is admitted by Dr. Wowk-Litwin in respect to the manner in which she responded to one or more of her failed attempts to intubate Patient X:

a) At no time during the attempts to intubate Patient X did Dr. Wowk-Litwin use or request that any of the staff assisting

her use an end tidal CO2 monitor to ensure correct tracheal placement on the endotracheal tube;

b) Dr. Wowk-Litwin should have recognized that she had intubated the esophagus sooner than she did;

c) When the nurses initially asked Dr. Wowk-Litwin if she wanted the anaesthetist on call to come in to assist, she initially did not think it would be a problem, but that that she later agreed that the anaesthetist on call should be brought in.

d) Dr. Wowk-Litwin should have sought the assistance of the anaesthetist sooner than she did.

(xiii) After X was declared dead, Dr. Wowk-Litwin reported the death to both the family members of Patient X, who were waiting in a room designated in the ER for family, and to the Medical Examiner, after waiting for and reviewing Patient X's old chart from previous visits to the hospital.

(xiv) Dr. Wowk-Litwin acknowledges that she failed to ensure that the Medical Examiner was aware of her failed attempts to intubate Patient X and that she ought to have advised the Medical Examiner of those facts, so as to ensure that the Medical Examiner had sufficient information to determine the cause and manner of death and/or whether the death warranted investigation, including an autopsy.

(xv) In respect to Dr. Wowk-Litwin's communications with Patient family following his death, Dr. Wowk-Litwin acknowledged that she did not tell them about the failed attempts to intubate X and that she advised them that there would be no autopsy. She did not believe that she had a responsibility to advise the family of the failed

attempts to intubate and believed that the decision as to whether there should be an autopsy had been made by the Medical Examiner and that his decision was that no autopsy was required in this case.

6. Prior to the hearing on June 22, 2015, the Panel, with the consent of the Investigation Committee and Dr. Wowk-Litwin received the written opinions of two independent emergency physicians, one engaged as a consultant on behalf of the Investigation Committee and one engaged as a consultant on behalf of Dr. Wowk-Litwin. The Investigation Committee and Dr. Wowk-Litwin agreed that the opinions were provided to the Panel in their entirety on the basis that neither party accepted the premises or factual assumptions of each consultant in their entirety, but that when read together and based on the Statement of Agreed Facts and the admissions of Dr. Wowk-Litwin, the opinions expressed by the consultants provide the necessary foundation for the Panel to accept Dr. Wowk-Litwin's guilty plea.

The Joint Recommendation as to Disposition

This is a tragic and troubling case. Within that context, the Panel's task is to determine the appropriate disposition pursuant to s. 59.6 of *The Medical Act*. The Panel has had the benefit of a Joint Recommendation As To Penalty made by counsel for the Investigation Committee and counsel for Dr. Wowk-Litwin.

In determining the types of orders to be granted pursuant to s. 59.6 of *The Medical Act*, it is useful to consider the several objectives of such orders. Those objectives are:

(a) The protection of the public. Orders under s.59.6 of *The Medical Act* are not simply intended to protect the particular patients of the physician involved, but are also intended to protect the public generally by maintaining high standards of competence and professional integrity among physicians;

(b) The punishment of the physician involved;

(c) Specific deterrence in the sense of preventing the physician involved from committing similar acts of misconduct in the future;

(d) General deterrence in the sense of informing and educating the profession generally as to the serious consequences which will result from breaches of recognized standards of competent and ethical practice;

(e) To protect against the betrayal of the public trust in the sense of preventing a loss of faith on the part of the public in the medical profession's ability to regulate itself;

(f) The rehabilitation of the physician involved in appropriate cases, recognizing that the public good is served by allowing properly trained and educated physicians to provide medical services to the public;

(g) The sentence should be proportionate to the conduct of the physician involved.

The Joint Recommendation As To Penalty being made in this case is that:

1. Dr. Wowk-Litwin be reprimanded pursuant to ss.59.6(1)(a) of *The Medical Act*;

2. The following conditions be imposed on Dr. Wowk-Litwin's entitlement to practice medicine pursuant to ss.59.6(1)(e)(vii) of *The Medical Act*:

    a. Dr. Wowk-Litwin shall not be permitted to practice until she satisfactorily completes remedial education and/or training in the following areas as approved by the Investigation Chair:

i. Ethical communications when delivering bad news to the patients and/or families and ethical and legal requirements surrounding reporting of and handling adverse events to appropriate parties, including administrators and, in the case of death, the Medical Examiner; and

b. When Dr. Wowk-Litwin resumes practice, she be restricted from performing intubations and be restricted to practicing only at locations and/or in circumstances in which she will not be called upon or expected to perform intubations until she satisfactorily completes remedial education and/or training in the following areas as approved by the Investigation Chair:

i. Intubation, including decision making surrounding intubation such as when to intubate, assessing difficulty to intubate, anticipating and preparing for complications and performing intubations and including responding to improper tube placement and/or failure to intubate.

In respect to both of these conditions, the Investigation Chair will have complete authority to:

1. approve the remedial education and/or training; and

2. pending satisfactory completion of the remedial education and/or training in intubation, approve Dr. Wowk-Litwin's practice circumstances and/or locations before she commences practicing in any circumstances and/or at any

location to ensure that she is practicing at a location and in circumstances in which she will not be called upon or expected to perform intubations; and

3. receive reports from the provider(s) of the remedial education and/or training; and

4. release Dr. Wowk-Litwin from these conditions upon being satisfied that she has satisfactorily completed the required remediation.

3. The payment by Dr. Wowk-Litwin of the costs of the Investigation and Inquiry in the agreed amount of $18,000.00, payable in full by Dr. Wowk-Litwin to the College by certified cheque or by a trust cheque from her lawyer's law firm on or before the date of Inquiry, pursuant to ss. 59.7(1) of *The Medical Act*.

4. Publication, including Dr. Wowk-Litwin's name, as determined by the Investigation Committee pursuant to ss.59.9 of *The Medical Act*.

ANALYSIS

The Panel has reviewed the objectives of orders which are granted pursuant to s.59.6 of *The Medical Act*, relative to the Joint Recommendation As To Penalty, to satisfy itself that those objectives will be fulfilled by an acceptance of the Joint Recommendation.

Dr. Wowk-Litwin's actions in relation Patient X caused or contributed to a disastrous and tragic outcome. The Investigation Committee has expressed a justifiable concern that Dr. Wowk-Litwin had an unrealistic and inflated assessment of her own abilities and demonstrated a reluctance to seek assistance which was readily available to her. The Investigation Committee also has expressed great concern about a lack of

insight and the failure on the part of Dr. Wowk-Litwin to appreciate the significance of the failed intubations.

On the other hand, there are mitigating circumstances present in this case, which are acknowledged by the Investigation Committee. Significantly Dr. Wowk-Litwin has no prior disciplinary record with the College nor has there been any prior indication of serious issues relating to patient care or competency on the part of Dr. Wowk-Litwin. She has also been cooperative with the Investigation Committee's investigation, and in the context of the facts of this case, she has acknowledged her shortcomings and deficiencies and agreed to a remedial plan. Her guilty plea to the allegations outlined in the Amended Notice of Inquiry has resulted in a sensible and non-contentious outcome to these proceedings.

One of the challenges in determining a fair and reasonable disposition is striking a balance whereby the penalties imposed are neither too harsh, nor to lenient. Dr. Wowk-Litwin is undoubtedly a good candidate for rehabilitation. She has recognized and acknowledged the errors which she made in relation to Patient X and has indicated a willingness to undergo remedial education and/or training in the areas noted in the Joint Recommendation As To Penalty. Rehabilitation is a very important aspect of this case from the perspective of both the Investigation Committee and Dr. Wowk-Litwin.

In practical terms, Dr. Wowk-Litwin has not been practicing medicine for a period of eight months, for reasons not directly related to this case. The Panel accepts the proposition that there is no inherent value in imposing a further period of suspension on Dr. Wowk-Litwin, and that the protection of the public can be effectively accomplished by the imposition of the conditions contemplated by the Joint Recommendation.

There are punitive aspects to the Joint Recommendation made by the parties. A reprimand is a serious and formal denunciation of Dr. Wowk-Litwin's conduct as particularized in the Amended Notice of Inquiry. It is a forceful statement by this Panel of its disapproval of Dr. Wowk-Litwin's conduct. The reprimand, coupled with payment by Dr. Wowk-Litwin of the costs of the Investigation and Inquiry and the

publication of a summary of these proceedings and their outcome and of Dr. Wowk-Litwin's name, represent an adequate punishment of Dr. Wowk-Litwin. The reprimand, the payment of costs by Dr. Wowk-Litwin and publication as noted above will specifically deter Dr. Wowk-Litwin from committing similar misconduct in the future.

The publication of these proceedings will also inform and educate the profession generally as to the serious consequences which will result from breaches of recognized standards of competent and ethical practice and will fulfill the objective of general deterrence.

Patient safety and the protection of the public generally will be achieved by the conditions which are recommended pursuant to ss.59.6(1)(e)(vii) of *The Medical Act*. In particular, the requirement that Dr. Wowk-Litwin complete remedial education and/or training in the areas of ethical communications when delivering bad news to patients and fulfilling the ethical and legal requirements surrounding the reporting of and handling adverse events to appropriate parties, including the Medical Examiner and the prohibition against Dr. Wowk-Litwin performing intubations until she satisfactorily completes remedial education and/or training as approved by the Investigation Chair will fulfill the objective of protecting patient safety and the public generally.

The cumulative effect of all the above-noted elements of the Joint Recommendation will prevent a loss of faith on the part of the public in the medical profession's ability to regulate itself, and will provide for the rehabilitation of a physician who still has many years left in her career to serve the public by providing competent medical care.

The Panel has therefore decided that the objectives of an order granted pursuant to s.59.6 of *The Medical Act* will be adequately fulfilled, if the Joint Recommendation of the Investigation Committee and Dr. Wowk-Litwin is accepted. The Panel has been advised that prior to the hearing, Dr. Wowk-Litwin had paid the full costs of the Investigation and Inquiry in the amount of $18,000.

The Panel's decision is therefore is to accept the Joint Recommendation.

Accordingly, the Inquiry Panel orders that:

1. Dr. Wowk-Litwin is hereby reprimanded pursuant to ss. 59.6(1)(a) of *The Medical Act.*

2. The following conditions are hereby imposed on Dr. Wowk-Litwin's entitlement to practice medicine pursuant to ss. 59.6(1)(e)(vii):

    a. Dr. Wowk-Litwin will not be permitted to practice until she satisfactorily completes remedial education and/or training in the following areas as approved by the Investigation Chair:

        i. Ethical communications when delivering bad news to the patients and/or families and ethical and legal requirements surrounding reporting of and handling adverse events to appropriate parties, including administrators and, in the case of death, the Medical Examiner; and

    b. When Dr. Wowk-Litwin resumes practice, she be restricted from performing intubations and be restricted to practicing only at locations and/or in circumstances in which she will not be called upon or expected to perform intubations until she satisfactorily completes remedial education and/or training in the following areas as approved by the Investigation Chair:

        i. Intubation, including decision making surrounding intubation such as when to intubate, assessing difficulty to intubate, anticipating and preparing for complications and performing intubations and including responding to improper tube placement and/or failure to intubate.

In respect to both of these conditions, the Investigation Chair will have complete authority to:

1. approve the remedial education and/or training; and

2. pending satisfactory completion of the remedial education and/or training in intubation, approve Dr. Wowk-Litwin's practice circumstances and/or locations before she commences practicing in any circumstances and/or at any location to ensure that she is practicing at a location and in circumstances in which she will not be called upon or expected to perform intubations; and

3. receive reports from the provider(s) of the remedial education and/or training; and

4. release Dr. Wowk-Litwin from these conditions upon being satisfied that she has satisfactorily completed the required remediation.

3. Dr. Wowk-Litwin shall pay the costs of the Investigation and Inquiry in full in the agreed amount of $18,000.00 pursuant to ss. 59.7(1) of *The Medical Act*.

4. There shall be publication of these proceedings, including Dr. Wowk-Litwin's name, as determined by the Investigation Committee pursuant to ss. 59.9 of *The Medical Act*.

Dated this 14th day of August, 2015.