CENSURE: IC2402
DR. EMMETT JOSEPH ELVES

On November 7, 2014, in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Elves as a record of its disapproval of the deficiencies in his conduct. Censure creates a disciplinary record which may be considered in the future by the Investigation Committee or an Inquiry Panel when determining the action to be taken following an investigation or hearing.

I. PREAMBLE

The Code of Conduct states:

> Recognize your limitations and the competence of others and when indicated, recommend that additional opinions and services be sought.

When a patient's medical condition is outside the physician's experience or expertise, the physician must recognize that fact and consult with a colleague who has expertise in the field and, when warranted, transfer the patient's care to a colleague with the required expertise. Such consultation must occur in a timely way to avoid the risk of patient harm.

II. THE RELEVANT FACTS ARE:

1. At all material times, Dr. Elves practised as a pediatrician in Brandon, Manitoba.
2. X was born at 0330 on February 21, 2014.
3. Dr. Elves was called to attend X on February 21, 2014, as there was meconium at delivery and initial major depression, with an Apgar of 1 at 1 minute.
4. Dr. Elves treated X with initial intubation resuscitation and then fluid resuscitation. Saline bolus did improve X's metabolic status.
5. At about 5 hours of age, X developed hematochezia, although his vital signs remained stable. Dr. Elves ordered an abdominal x-ray and a CBC.
6. Dr. Elves reviewed the x-ray with a radiologist. The x-ray showed no gas past the stomach. Dr. Elves' interpretation of the x-ray was that it showed signs of a higher bowel obstruction. Dr. Elves' differential diagnosis included obstruction such as atresia or obstruction for reasons of functional impairment. Dr. Elves' plan was to monitor the vitals, the obstruction and any changes in the status.
7. Dr. Elves continued to monitor X on February 21, 2014. The record documents that Dr. Elves last examined X at 19:07 on February 21, 2014.
8. Another physician assumed X's care at approximately 20:00 on February 21, 2014. That physician documented a telephone consultation with a neonatologist at 20:30 on February 21, 2014. Thereafter, X was transferred to Winnipeg.
9. X had intestinal malrotation with volvulus. By the time X arrived in Winnipeg, X had complete and irreversible intestinal necrosis and died at day four.
10. In Dr. Elves' response to concerns about his care of X, he stated that:

(a) he had never seen a mid-gut volvulus before and in his experience a volvulus would present with vomiting, which X did not have.
(b) in retrospect, although he believed the obstruction was functional, he ought to have called the NICU and further investigated the cause of the obstruction.
(c) he regrets his delay in referral.

11. Timely diagnosis of the intestinal malrotation with volvulus may have resulted in a greater chance of salvaging X's bowel.
12. On or about May 4, 2011, Dr. Elves saw Y, born on February 7, 2011, on referral for jaundice. The referring physician reported that bilirubin and liver enzyme results were high. In Dr. Elves' report to the referring physician, he documented that stool was occasionally yellow but a lot whitish, and that the liver did not feel enlarged but that there was possibly a palpable gallbladder, so an urgent ultrasound of liver, gallbladder and bile ducts was ordered. Dr. Elves noted his concerns as being whether there was a choledochal cyst causing obstruction or some degree of problem with the biliary tree. Dr. Elves ordered repeat liver enzymes and bilirubin.
13. Dr. Elves transferred care of Y back to the referring physician after his May 4, 2011 assessment.
14. The ultrasound of May 19th was reported as normal. The liver enzymes and bilirubin test results continued to be abnormally high.
15. On June 28, 2011, after reviewing the ultrasound report, Dr. Elves spoke with Y's father, who reported that Y's colour was improving. Dr. Elves advised Y's father to return to the referring physician for repeat bloodwork.
16. Dr. Elves next saw Y on September 28, 2011. He noted that she had normal bowel movements, yellow in colour and that she was obviously jaundiced with scleral icterus. Dr. Elves' examination revealed some liver enlargement and a distended belly. Dr. Elves ordered a hepatic panel and an urgent ultrasound. Dr. Elves' advice documented was "congenital jaundice, previously cholestatic pattern with no definite diagnosis and liver enlargement." Dr. Elves planned to follow Y for her liver issues.
17. The ultrasound done on October 13, 2011 did not show abnormality; however, Y's biochemical profile continued to be abnormal.
18. On November 2, 2011, Dr. Elves saw Y and noted increased distention. He noted that Y needed a biopsy and a liver scan and that he attempted to contact the pediatric gastroenterology service by telephone on November 2, 2011 and afterwards, but was unsuccessful.
19. Another physician saw Y on November 10, 2011 for respiratory concerns, and referred Y to Winnipeg for further investigations.
20. In Winnipeg, Y was described as so jaundiced that she was literally green in colour, with florid cirrhosis and portal hypertension. The pediatric gastroenterologist made a provisional diagnosis of biliary artresia, for which bile duct surgery (Kasai procedure) by 2-3 months of age is the recommended treatment. However, Y was so ill that she was immediately transferred to Toronto where she was listed for life-saving liver transplantation.
21. In Dr. Elves' response to concerns about his care of Y, he acknowledged that an ultrasound has limited sensitivity in this type of case. Dr. Elves further acknowledged that his follow-

up plan should have been more explicit rather than relying upon the parents to monitor Y. Dr. Elves stated that since this case he has had a lower threshold for investigating jaundice in infancy, including an earlier consultation to gastroenterology and other diagnostic modalities (such as HIDA scans, which are more sensitive for biliary atresia).

22. Timely diagnosis of biliary atresia may have avoided the necessity of Y's liver transplant.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. ELVES' CONDUCT IN not meeting his professional responsibility to recognize his limitations and the competence of others and, given his limited experience with intestinal malrotation with volvulus and with biliary atresia, not promptly consulting colleagues for assistance and/or referring X and Y for care.

Dr. Elves paid the costs of the investigation in the amount of $2,472.50.