CENSURE: IC2936
DR. FAYEZ FOUAD FAHIM GOUDA

On December 11, 2018 in accordance with Section 47(1)(c) of *The Medical Act*, the Investigation Committee censured Dr. Gouda as a record of its disapproval of his conduct in failing to meet the standard of care of the profession, conducting himself in an unprofessional manner and displaying a lack of judgment in respect to management of X while he was on duty in the Emergency Department ("ED"), which includes on-call responsibilities for the personal care home ("PCH") where X was a resident on August 8 and 9, 2016, in that he:

1. failed to satisfy himself with respect to X's condition and respond to what was an urgent medical situation; and
2. failed to meet the standard of the profession in his communications with other healthcare providers.

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 physician-patient relationship is a fiduciary one in which the physician has an obligation to consider first the best interests of the patient. Integral to the discharge of this duty, the physician must demonstrate good faith and candour in dealing with the patient and other healthcare providers within the patient's circle of care. This fiduciary duty informs all ethical and legal obligations owed by physicians to their patients.

On-call physicians are crucial to the provision of good care within our healthcare system and, consequently, the responsibilities that come with assuming the role as an on-call physician are great. Ethical and professional obligations undertaken by an on-call physician are informed by the fiduciary duty that is owed by the physician to patients and by the expectations and procedures of the healthcare institution. Applicable professional obligations include the duty to promptly provide whatever appropriate assistance the physician can to any person with an urgent need for medical care and the duty to provide services to patients when the physician has accepted the responsibility to do so until they are no longer required or wanted, or until another suitable physician has assumed responsibility for the patient.

In caring for and managing patients, the physician is expected to demonstrate knowledge, clinical skills and a professional attitude in order to provide quality medical care. Specifically, quality medical care frequently requires communication with other healthcare providers and effective and professional communication skills are an expectation of the profession. In communicating with other healthcare providers, the physician must be respectful and attentive to details. Where disagreement arises, an attempt should be made to resolve the issue.

II. THE RELEVANT FACTS ARE:

1. X, age 62 at the material time, was a resident in the PCH who became ill while Dr. Gouda was the physician working in the ED in a rural hospital, which included on-call responsibilities for the PCH that required responding to emergent PCH matters on August 8-9, 2016.

2. X suffered from several chronic illnesses, with multiple sclerosis and diabetes being particularly significant. Her Advanced Care Planning (ACP) status was documented at the PCH as ACP-4 which included full treatment and resuscitation. She became ill with diarrhoea for several days leading up to August 8, 2016. Her care was generally being managed by her family physician ("X's attending physician").

3. During the afternoon and evening of August 8, 2016, X's condition deteriorated significantly. Per X's chart:
    a. X became ill having had loose bowel movements in the previous week and 4-5 episodes of diarrhea in the previous 24 hours.
    b. At 17:40, the nurse noted receiving verbal orders from X's attending physician for laboratory investigations and antibiotics (five-day course of ciprofloxacin). Vital signs at that time were: BP 156/79; pulse of 107; SPO_2 97%; RR 21; and a temperature of 37 degrees Celsius.
    c. X's condition continued to deteriorate that evening. At 22:30, the attending nurses noted that X's condition was becoming poor. Vital signs were: BP 145/79; pulse of 121; SPO_2 95%; and a temperature of 38.6 degrees Celsius. A Tylenol suppository was given.

4. The CMO of the regional health authority in which the ED is located, states that in a situation where nursing staff at the PCH have concerns about the medical condition of one of the residents outside office hours, the process is to call either the on-call ED physician or the resident's attending physician. Dr. Gouda believes that the resident's attending physician should be called first. He agreed that if the situation is emergent and the attending physician is not available, the on-call ED physician is contacted and is expected to respond. Dr. Gouda acknowledged that he was aware of and supportive of this responsibility.

5. Nurse 1 contacted Dr. Gouda on August 8, 2016 at approximately 23:15 regarding X's medical condition. He documented his conversation with Dr. Gouda as follows:

> Phoned Dr. Gouda [on-call doctor] on his cell phone and informed him about the resident's condition that she is getting poor and the family wants to do everything possible for her, wants to stick with ACP – 4, wants transfer her to the hospital to do IV therapy. Doctor denied to transfer her to the hospital and was getting mad at the nurse writer. According to Dr. Gouda give her comfort care for now and talk to the family doctor in the morning [August 9, 2016] when he comes in the office. Nurse tried to explain him again that the resident is getting dehydrated and eating nothing per oral also states that she is an ACP – 4

> and family wants the advanced care. Dr. still refuses to transfer her to the hospital.

6. Nurse 1 confirmed the accuracy of his note during the College's investigation. He advised that he felt Dr. Gouda's tone was disrespectful and was troubled by the fact that he was not listening to concerns about X.

7. Nurse 2 says that she had heard Nurse 1's side of the above phone conversation with Dr. Gouda at 23:15 and made the following late entry at 06:00 on August 9, 2016:

> Writer witnessed and heard nurse on duty [Nurse 1] phone conversation with Dr. Gouda on-call physician. Writer witnessed [Nurse 1] LPN explain resident's poor condition and request to transfer to hospital as per family's request and ACP 4. Dr. Gouda denied transfer. Resident's condition again explained and Dr. Gouda continued to deny seeing resident.

8. After speaking with Dr. Gouda, Nurse 1 called the PCH clinical manager who advised him to attempt to contact X's attending physician if the family wanted. Nurse 1 then phoned X's daughter and left a voice message for her response. He then attempted to reach X's attending physician. X's attending physician twice did not answer his cellphone and a message was left after the second call. X's daughter returned Nurse 1's call shortly thereafter, was informed about her mother's condition and stated she would be coming to the PCH.

9. Nurse 1 called the ED asking the nurse there if there was anything else that could be done. He says that he was told that if the doctor was not accepting the patient, then the patient could not be transferred to the ED.

10. The CMO states that if a nurse at the PCH believes a resident requires urgent care and the on-call physician refuses to transfer the patient to hospital, there should be an attempt to contact another physician, presumably the resident's attending physician, and keep the PCH's clinical manager apprised. It would generally not be acceptable to arrange for transport to the ED if the physician on-call advised same is not necessary or appropriate.

11. Dr. Gouda does not agree with Nurse 1's recollection of events, but acknowledges that:
    a. based upon subsequent review, the medical record reflects that X's medical condition required urgent attention when Dr. Gouda was first contacted by the nurses, though he states that at the time this was not his understanding;
    b. X's ACP status was 4, including full resuscitation, though Dr. Gouda states he understood her ACP status was 1, indicating comfort care, at the material time;
    c. Dr. Gouda's communication with Nurse 1 was influenced by his misunderstandings about X's ACP status and that Nurse 1 perceived him as angry and abrupt; and

d. although Dr. Gouda understood the request to be for a transfer to the hospital ward, there were no beds on the ward and Dr. Gouda did not suggest that X be brought to the ED for assessment.

12. Dr. Gouda stated that, when working as the on-call physician for the PCH, in situations where he receives a call from the PCH and believes the patient's situation is emergent, he would have that patient transferred to the ED for assessment. Dr. Gouda noted that generally patients may only be admitted to the hospital ward by the attending physician or, alternatively, the on-call physician after being assessed in the ED. Dr. Gouda also noted that he can only admit patients to the ward subject to the availability of beds. Dr. Gouda believes that residents of the PCH can be

brought at any time to the ED of the hospital by the PCH staff, without first contacting the on-call physician but usual practice is for the attending physician to call ahead.

13. X's daughter arrived at the PCH at 0445 on August 9, 2016. Upon arrival and seeing that her mother was in serious condition, X's daughter asked Nurse 1 to call Dr. Gouda again, which Nurse 1 did. X's daughter heard Nurse 1's side of the conversation. She states it was clear that Dr. Gouda was not accepting transfer of X and would not speak with her directly when asked. At 0545, Nurse 1 documented this phone call as follows:

> Nurse writer phoned Dr. Gouda on his cell phone as per resident's daughter's request and tried to explain the situation and family's wish. Dr. refused to listen to that and told the writer that he already answered the question and call the doctor in the morning after 0800 a.m. Family was present at the nursing desk while the nurse talk to the doctor.

14. Dr. Gouda stated that his understanding was that the appropriate protocol in this situation would have been for Nurse 1 to call X's attending physician. Dr. Gouda felt that it was up to X's attending physician to request and arrange the transfer to the ward of the hospital and it was his understanding as well that no beds were available at the time. It is Dr. Gouda's recollection that there was no discussion about the patient's poor condition and that Nurse 1 continued to emphasize that it was the family that wanted the transfer. Dr. Gouda's advice to Nurse 1 reflected this understanding and his being unaware of any attempts to call X's attending physician.

15. At 06:15, Nurse 1 left voicemails to two nurse managers seeking further advice. At 0640 the vital signs were noted to be BP 133/72, P131, T 38.4 and SPO2 96%. Another Tylenol suppository was given.

16. Through the night the PCH nurse(s) monitored X's condition. Nurse 1 did not document any attempt to contact X's attending physician between 23:35 and 06:50. At 06:50, X's attending physician was successfully contacted by phone and attempted to arrange a transfer to the ward of the hospital, but it was full and so X could not be admitted to the ward until 10:00. X's

attending physician subsequently arranged transfer of X to the ED. By 0800 another nurse documents that X was unresponsive, and her blood sugar was 29 mmol/L. Another ED physician assumed X's care when X arrived at the hospital from the PCH at 08:21.

17. When X arrived at the ED, she was unresponsive (Glasgow Coma Scale of 6), responding only with poor withdrawal to a very brisk sternal rub. Her heart rate was 132 and her blood pressure was 110/52 but quickly decreased to 92/48 despite fluid resuscitation. She was seriously dehydrated. Lab work revealed she had severe metabolic acidosis, hyperglycemia, hypernatremia and acute renal failure.

III. ON THESE FACTS, THE INVESTIGATION COMMITTEE RECORDS ITS DISAPPROVAL OF DR. GOUDA'S CONDUCT IN:

1. Failing to meet the standard of care, displaying a lack of judgment and failing to conduct himself in a professional manner in that he failed to provide appropriate assistance when X required urgent medical care on August 8-9, 2016. Particularly, in his responsibilities toward X as the on-call ED physician:
    a. Dr. Gouda's communication with the health care provider who sought his assistance was hampered by the unprofessional manner in which he approached the conversations;
    b. although Dr. Gouda had more than one opportunity to resolve the matter, as a result of the ineffective communication, he did not adequately inform himself about X's clinical status and Nurse 1's inability to reach X's attending physician; and
    c. Dr. Gouda provided advice to Nurse 1 that did not address the relevant concerns including the need for care in excess of what could be provided at the PCH.

    Dr. Gouda's failure to address the relevant concerns contributed to X's further deterioration. The Committee considered Dr. Gouda's lack of action in light of Nurse 1's requests for assistance particularly egregious.

Dr. Gouda paid the costs of the investigation in the amount of $9,727.50.