CENSURE: IC5523
DR. AMRINDER SINGH MANN

On December 15, 2021, in accordance with Subsection 102(2)(d) of *The Regulated Health Professions Act*, the Investigation Committee censured Dr. Mann with respect to his care and conduct relating to the management of one of his patients in an Emergency Department ('ED") at a rural hospital and his response to inquiries in a review of his care by the CMO of the hospital and the Regional Health Authority. The concerns are that Dr. Mann failed to meet the standard of the profession and displayed a lack of judgment in respect to his care and conduct in the following respects:

1. Dr. Mann displayed a lack of judgment in the practice of medicine and failed to meet the standard of the profession when he failed to assess and physically examine a patient who should have been assessed by Dr. Mann as the physician responsible for his care before he was transferred by ambulance to a tertiary hospital in Winnipeg.

2. Dr. Mann failed to meet ethical and professional standards when he:
    a. documented a history and physical examination which was written by Dr. Mann the day after the patient was transferred as if he had taken the history and examined the patient himself while the patient was under his care when in fact Dr. Mann neither spoke with nor performed a physical examination of the patient before the patient was transferred; and
    b. attempted to justify and divert responsibility away from his conduct in the context of a review by the CMO of the hospital and the Regional Health Authority when he knew or ought to have known that the record he created made it appear that he had personally taken a history and performed a physical examination of the patient when in fact he had not.

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 and the physician has an obligation to promote the best interests of the patient. The physician must demonstrate good faith and candour in dealing with the patient and other health care providers within the patient's circle of care. This duty informs all ethical and legal obligations owed by physicians to their patients.

A physician is expected to demonstrate knowledge, clinical skills and a professional attitude in order to provide quality medical care. The physician's clinical approach must be rigorous in terms of assessing

the patient, including taking an appropriate history, conducting a physical examination, establishing a principal and differential diagnosis, investigation, treatment plans and follow-up. Medical care provided must be accurately and adequately documented to ensure continuity of care and that other care providers can rely on the record to inform their care of the patient should the need arise. This includes meeting CPSM's requirements and the standard of the profession for the creation and maintenance of adequate records.

Physicians must also demonstrate a high standard of ethical and professional behaviour. This requires that they not only practice medicine competently, but that they do so with integrity, honesty and candour.

Some details underlying this censure have been removed or anonymized to avoid providing identifying information about third parties.

II. THE RELEVANT FACTS ARE:

The Committee assessed the facts as follows:

1. On January 16, 2021, Dr. Mann was the physician on call covering the Emergency Department of a rural hospital when a 59 year old man arrived by ambulance with shortness of breath at 14:55. He had been diagnosed with COVID-19 six days earlier and had a history of asthma and type 2 diabetes. Paramedics had attended on him in the afternoon and documented that he began to feel short of breath that morning and his asthma inhalers were not providing relief. He had cough productive of yellow sputum and reported fever and chills. He had no chest pain. He was speaking in full sentences and was afebrile at that time of assessment. His vitals were recorded as respiration rate 32, pulse 140 and oxygen saturation of 96%.

2. In triage, the patient was assigned a status of CTAS 2 or "Emergent". Triage notes indicate that he had been diagnosed with COVID-19 on January 11th. He was short of breath +++ on exertion, and this had started in the morning. He had a productive cough for 2 days, with yellow sputum. He had a history of intermittent fever with chills. He was afebrile at that time. His heart rate was documented at 81, blood pressure was 128/82. Respiration rate was 28-30/min. Oxygen saturation was 95% on 2 litres of oxygen. He was assessed to be in moderate respiratory distress.

3. At 15:50, Nurse 1 documented a secondary assessment. There were some mild gastrointestinal symptoms but the main issue was increased work of breathing. There was occasional wheeze to the left chest.

4. At 16:05, multiple treatments were provided including Prednisone, azithromycin, Tylenol, Ventolin, and Atrovent on verbal orders that the nurse received from Dr. Mann over the phone.

5. At 16:10 the nurse documented a verbal order to transfer to the hospital in Winnipeg via ambulance.

6. This was followed by a late entry at 16:30 indicating a discussion with Dr. Mann about the required treatments. Vital signs showed a temperature of 37.1, pulse of 80, respiration rate of 30, blood pressure of 115/73. Oxygen saturation of 93% and 96% on 2.5 litres of oxygen by nasal prongs.

7. At 16:55 there is another entry by the nurse indicating that the patient was feeling better after Ventolin and Atrovent and not requiring oxygen. The nurse advised Dr. Mann of the improvement and documented that he was angry about a suggestion that the patient need not be transferred. Vital signs were again recorded as a temperature of 37.1, respiration rate of 26, blood pressure of 106/73 with oxygen saturation at 92 – 93%. He was still dyspneic on exertion.

8. At 19:10 the paramedics arrived to transfer the patient to hospital in Winnipeg via ambulance. He had eaten supper in the interim. The documentation that accompanied the patient in the ambulance included copies of all ED notes. There was no documentation from Dr. Mann including no encounter or transfer note.

9. Dr. Mann made the following entry in this patient's Emergency Treatment Record the following day:

    Pt was sent to HSC to Bed doctor [C] for assessment.
    Day 6 Covid +ve with SOB on oxygen 2 – 3 litres 93% saturation
    GCS 15/15
    Chest: B|L equal air entry, not using intercostal muscles
    Ø PND Ø orthop Ø B\L ankle swelling
    PMHx MI, type 2 DM, dyslipidemia/Asthma

10. The following concern about Dr. Mann's conduct and care was raised by the nurse manager to the CMO of the hospital:

    A COVID positive patient present to the ED with SOB [shortness of breath]. The nurse called Dr. Mann and received orders for treatment. Dr. Mann did not come in and assess the patient and made arrangements for the patient to be transferred to HSC. The patient had improved with the

> treatment, no longer had SOB and did not require [oxygen]. At no time between the patient arriving in [town] at 1450 on January 16, 2021 and being transferred out by EMS at 1930 did Dr. Mann come to the hospital to assess the patient.

11. On January 18, 2021, Dr. Mann was asked by the CMO to comment on this concern. In a series of emails Dr. Mann wrote to the CMO in which he attempted to explain his care, he acknowledged that while he did not personally examine the patient, he was aware he was not in distress. While Dr. Mann criticized the nurse in some regards, he also relied on her assessment in deciding not to examine the patient.

12. Concerns arising from both Dr. Mann's care and conduct, including his email communications, were communicated to the CMO and VP, Medical Services of the RHA. A formal review by another physician was requested by the CMO and VP. The reviewing physician noted that Dr. Mann made the following assertions about his care and conduct when Dr. Mann was interviewed by him on January 27, 2021:

    - Dr. Mann was always in the building during the time that the patient was in the emergency department.
    - The treating nurse in this case is a new graduate and Dr. Mann attributed some of
      the difficulty to the inexperience of the nurse.
    - Dr. Mann was concerned about COVID-19 exposure since he had previously been exposed to a COVID-19 patient and had to self-isolate.
    - Although Dr. Mann did not physically examine the patient, he charted as if he did. The physical examination findings he recorded were not his.
    - The treating nurse never advised Dr. Mann that the patient was deteriorating and that the patient had to be seen at that time.
    - Dr. Mann contends that he was available in the building, noting that his email to the CMO indicated that he was in the clinic which he interprets as being in the same building.
    - At the end of the interview, Dr. Mann acknowledged that he should have examined the patient and apologized for his conduct and indicated he wanted to commit to doing a better job in the future.

13. By letter dated February 12, 2021, from the CMO and VP of the RHA, Dr. Mann was restricted from any ED coverage in the region and the matter was reported to CPSM. That restriction remains in place.

14. Dr. Mann has cooperated with CPSM in its investigation of this matter, including providing written responses to the concerns and participating in an interview with the investigator in the presence of his legal counsel. In the context of this investigation:
    a. Dr. Mann acknowledged that he should have personally assessed and examined the patient on January 16, 2021 and he did not;
    b. Dr. Mann was unable to explain why he did not assess the patient but that a previous exposure to COVID-19 and following isolation may have influenced his actions despite the fact that there was adequate personal protective equipment available to Dr. Mann and protocols to prevent the spread of infection were in place at the time;
    c. Dr. Mann's documentation of an assessment of the patient in the Emergency Treatment Record creates the impression that he performed an examination and that the results recorded were based on that assessment when in fact they were taken from assessments performed by others and recorded elsewhere in the record;
    d. Dr. Mann has expressed remorse for his actions and committed to learning from this experience;
    e. Dr. Mann explained that he had not encountered a challenge of his care in Canada and he may have acted out of fear; and
    f. Dr. Mann's insight has increased over the course of the RHA investigation; and
    g. Dr. Mann took responsibility for his errors and omissions during this investigation and acknowledged his professional responsibility to be honest when dealing with the RHA and CPSM.

15. The following factors are relevant to Dr. Mann's care and conduct:

    a. Patients ill with COVID-19 at times require intubation. While Emergency Department physicians are expected to be able to intubate a patient, it is recognized that not all rural emergency providers have the same level of skill and experience and intubation of COVID-19 patients should be done by the most experienced available person. The Committee accepted that despite the improvement seen, and based on risk factors, it was appropriate to transfer the patient to another facility.

    b. This patient may have required an accompanying physician during the transport to the hospital in Winnipeg.

    c. Given this patient's multiple risk factors for severe illness, the relatively recent onset of significant shortness of breath, risk for severe disease was considerable

in this patient. As the treating physician, it was Dr. Mann's responsibility to conduct a history and physical examination for appropriate medical management, consultation and patient transfer. The standard of care in these circumstances required serial assessments by a physician over time, including and especially prior to an ambulance transfer.

d. Documenting a physical assessment that he did not perform was a serious breach of his professional responsibility and violates the expected standards of the profession for documentation, candour and integrity.

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

1. Failing to meet the standard of care by not performing an assessment of the patient before he was transferred, including taking an adequate history and conducting an appropriate physical examination, as would be expected of a reasonably prudent physician in the circumstances.

2. Failing to meet the expected standards of the profession in relation to documentation, transparency and candour in that Dr. Mann documented a physical examination that he did not perform in a manner which created the impression that he had in fact conducted the assessment himself.

3. Failing to meet expected standards of professionalism when Dr. Mann attempted to justify and divert responsibility away from himself in the context of reviews within the Regional Health Authority.

IV. ORDERS

1. The Investigation Committee directed, pursuant to subsection 104(2) of the RHPA, that this censure and a description of the circumstances that led to the censure be made available to the public.

2. Dr. Mann paid the costs of the investigation in the amount of $4,000.00.