SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "C"

RE: Dr. OLUWAROTIMI FASHORANTI

Investigation Committee "C" concluded its investigation into matters arising from a complaint concerning care provided to a patient in 2014. The following is a summary of the Committee's decision issued on April 1, 2016.

SUMMARY OF COMPLAINT AND RESPONSE:

Dr. Oluwarotimi Fashoranti is a physician, licensed to practise medicine in Nova Scotia since 1993 intermittently. Dr. Fashoranti is a family physician.

The husband of Patient M filed a complaint concerning the care provided to her by Dr. Fashoranti.

The complainant reports in mid January 2014 his wife was sent home from a hospital after seeing Dr. Fashoranti. Dr. Fashoranti reportedly refused to admit her after a malignant and infected cyst on her neck ruptured, causing severe pain. Dr. Fashoranti reportedly advised Patient M there were no hospital beds available.

Eight days later Patient M went to a health care facility where she was prescribed antibiotics by a physician other than Dr. Fashoranti. She then travelled to the hospital three times per day to receive IV antibiotics. She was later provided with a pump to administer the antibiotics at home.

In early February, 2014 Patient M was taken to the hospital with increased pain, vomiting and diarrhea. She was again advised there were no beds but refused to leave. She was eventually admitted under Dr. Fashoranti.

During this admission, Dr. Fashoranti continued antibiotic treatment, although he used different medications than those originally prescribed by another physician. Shortly after, Patient M was very ill and family were called in. The complainant reports Patient M was not receiving any IV fluids at this time. The following day the family requested a palliative care assessment for her. Dr. Fashoranti reportedly refused to arrange this consultation.

Two days later Dr. Fashoranti prescribed the pain medication Lyrica. Patient M had previously had two previous adverse reactions from this medication. Dr. Fashoranti advised the family he was discontinuing the antibiotics because she was not responding. As well, he was increasing the morphine for pain control. He advised she would be provided with "comfort care" only. The complainant reports this was not the family's choice.

The following day family members reportedly asked to have the antibiotics resumed. Dr. Fashoranti refused. Dr. Fashoranti advised the amount of pain medication required to control her pain would result in organ failure and she would likely die within a few days. The complainant

reports Patient M was receiving more than double the doses of morphine she had been taking at home and was experiencing adverse symptoms.

The request for palliative care was eventually initiated by a different physician while he was on call. Subsequently, a palliative care specialist assessed Patient M. Thereafter, the family requested she be moved to a different hospital in Amherst to continue under his care. She was transferred the same day, with a plan for antibiotics to be resumed and morphine tapered.

According to the family, within 24 hours the change in her condition was 'unbelievable". The following day she was mobile and eating. She was discharged home within 7 days. She died some six months later.

Dr. Fashoranti's response to this complaint summarized his involvement and Patient M's clinical course somewhat differently.

Dr. Fashoranti reported this patient had a type of carcinoma which had resulted in significant facial surgery. The cancer had recurred and she had reached the limits of curative therapy. He believed she had metastatic disease causing significant pain. Dr. Fashoranti reports when he was unable to secure a bed for patient M in mid January, 2014, he consulted with a physician in a different location but Patient M was unwilling to go to that location.

In late January after being prescribed antibiotics by another physician and continuing with that regime at home intravenously, Patient M saw Dr. Fashoranti in his office where he indicated he planned to continue the antibiotics and reassess her in one week.

In early February, Patient M was admitted to hospital where Dr. Fashoranti prescribed different medication. Her pain reportedly increased and she was confused. She was given medication. The palliative care nurse was consulted. Nursing staff contacted Dr. Fashoranti who was unavailable, so they consulted another physician who changed the medication.

At the family meeting later that evening, Dr. Fashoranti reports there was agreement that the patient would be kept as comfortable as possible and IV antibiotics were discontinued. Another physician was later consulted who believed Patient M's pain was opioid resistant. He noted "family would like patient transferred for symptom control". Dr. Fashoranti reports when he arrived back at the hospital that evening he was advised of the arrangements. Patient M's son asked him not to see her again.

ADDITIONAL INFORMATION

The College received correspondence from a physician outlining his concerns regarding the care provided by Dr. Fashoranti to Patient M. He reported he had been asked to see patient M when they were unable to reach Dr. Fashoranti as she was experiencing pain when medication was being injected. The physician reports he suggested the on-call palliative nurse be consulted regarding the injection site. She was able to provide some advice in this regard.

During this consultation, the physician reports he reviewed the chart of Patient M and found there was a brief admission note completed by one physician but there was no receiving note from Dr. Fashoranti, no progress notes, and no other history of her illness. The medication orders provided by Dr. Fashoranti at various stages were not clear and there was no care plan outlined to explain the medications prescribed or changed.

The physician reported the nurses seemed very uncomfortable with the patient's status and felt she was suffering a great deal. The physician found that no consultation had been made to the palliative care service such that he followed up with a consult note.

DETAILS OF INVESTIGATION:

Dr. Fashoranti met with the Committee. He reported he would often see patient M in her home, although he did not have a system for documenting home visits at the time. As such, his records did not reflect these visits.

The Committee noted that Dr. Fashoranti ceased to be patient M's physician following her discharge in February 2014. Office notes for encounters from January 2014 forward had been updated in May 2014, following receipt of the complaint. Dr. Fashoranti reports he saw Patient M almost daily during her admission but did not document all visits because he knew her so well.

In sum, the Committee formed concerns about the accuracy, adequacy and integrity of this documentation. In addition, the Committee formed concerns about Dr. Fashoranti's approach to documentation and the extent to which he appreciated the importance of adequate, accurate and timely medical record keeping.

Dr. Fashoranti reported that he held a family meeting with the intent of discussing pain management. He states he wanted to discuss a change in medication. At that meeting, he explained that Patient M was not responding to treatment, specifically to the pain medication or antibiotics. It was his understanding that the family wanted comfort care. He felt the antibiotics were not working, despite attempts at various types.

Dr. Fashoranti stated when he later assessed Patient M he did not see any signs of morphine toxicity at that time. After reviewing the notes, he recognizes now that this could have been the case. He advised the nurses to call him if there were concerns. He then left for another location and nurses were unable to reach him. When he returned, he was advised that Patient M had been transferred to someone else's care.

As a result of its review of the record and its interview of Dr. Fashoranti, the Committee formed concerns regarding his expertise in palliative care. Accordingly, the Committee obtained an audit of Dr. Fashoranti's hospital charts for palliative care patients. The auditor was asked to review 30 charts to be prepared by the hospital health records department. Only 16 charts were

provided. None of these charts included a discharge summary, despite being discharged between 2010 and 2014.

The auditor received correspondence from the health records department dated the day prior to the audit. It had been contacted by Dr. Fashoranti, who advised he had recently dictated a number of discharge summaries. The health records staff was unable to have these transcribed prior to the audit.

The auditor's summary stated:

"overall physician documents expected standard of care for admission and documentation of progress in hospital. Some lapses in documentation (procedures, consults to specialists, discharge summaries). Investigations could be more focused, treatment rationale could be better explained in progress notes. Further physical exam during admission should be recorded. Confusion to continuity of care when palliative care nurse involved. Overall competent rural physician with full scope practice".

During the interview portion of the audit, Dr. Fashoranti advised the auditor that many discharge summaries had been lost in the hospital system. He reported he had recently re-dictated many of these but they had not yet been transcribed.

Following the receipt of the audit report, Dr. Fashoranti provided comments to the Committee. He stated that he planned to incorporate many of the auditor's suggestions into his practice, including documentation of all physical examinations and more thorough documentation of histories, presenting complaints and indications for investigations.

Dr. Fashoranti also indicated that although palliative care nurses may be involved with a patient, he is still the most responsible physician and must ensure charting is clear in this regard. Dr. Fashoranti further acknowledged that he must dictate discharge summaries in a more timely fashion.

Due to the Committee's concerns regarding the possible lack of recognition of opioid toxicity, the Committee obtained Dr. Fashoranti's prescribing profile. The risk score assigned to Dr. Fashoranti at this time was 161. The mean score for family physicians is 36.89. As a general rule, a score of 80 will attract the attention of the Prescription Monitoring Program.

The Committee investigated concerns about the care, communication and clinical judgement provided in this case.

The Committee found this to be a tragic case of a woman who died prematurely. They identified extensive areas of concern regarding both Dr. Fashoranti's care, the documentation of his care and his judgment.

Dr. Fashoranti appears to have believed that Patient M was actively dying. He initiated comfort care measures, a plan of care that the complainant does not feel was consented to by the

family. When transferred to a different physician, the patient quickly improved to survive for 6 months. Although the Committee recognizes that medicine can be unpredictable, the course of events for this patient certainly suggests that Dr. Fashoranti's clinical assessment was wrong in this instance.

Although the audit identified areas of weakness, the Committee draws comfort from the auditor's general assessment of Dr. Fashoranti's overall competence. The Committee also noted that Patient M had been diagnosed with a disease that had reached its limits of curative therapy and that her family understood her prognosis.

The Committee found the record keeping of Dr. Fashoranti to be globally below the standard expected. Although the auditor felt this was not systemic, he did identify some areas of deficiency in most charts. He noted no discharge summaries had been completed for any of the charts he reviewed. The Committee did not accept Dr. Fashoranti's explanation that the summaries were lost.

Record keeping affects and reflects the quality of care. The Committee found the poor record keeping with respect to Patient M contributed to challenges encountered by other physicians and nurses involved in her care. Further, Dr. Fashoranti did not adequately document the family meeting regarding discontinuation of antibiotics and initiation of comfort care. The Committee believes this warrants a reprimand.

The Committee found that Dr. Fashoranti ignored consultants' recommendations regarding the treatment plan for Patient M and failed to consult with the palliative care service, even after this was requested by the family. It is, of course, available to treating physicians to consider but not follow the recommendations of consultants. In doing so, physicians should pay particular attention to setting out their reasons for doing so. Dr. Fashoranti did not do so in this case and appears not to do so as a matter of practice. The Committee noted the auditor documented concerns in this regard globally. The Committee believes this warrants a reprimand.

The Committee is of the view that Dr. Fashoranti failed to recognize or perhaps even consider the possibility of opioid toxicity in this patient. As was demonstrated, this is an entirely treatable condition. Given the patient's condition and medication regime, the Committee expects that this would have been recognized by a reasonable practitioner. Dr. Fashoranti instead concluded that his patient was imminently dying, and initiated a care plan consistent with this thinking.

DISPOSITION:

In accordance with clause 99(5)(f) of the regulations under the *Medical Act*, the Committee has determined that there is sufficient evidence that, if proven, would constitute professional misconduct and incompetence that warrants a licensing sanction.

The Medical Act defines professional misconduct to include: "such conduct or acts in the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional".

"Incompetence" is defined in part to mean the lack of competence in the physician's care of an individual that, having regard to all the circumstances, rendered the respondent unsafe to practise at the time of such care of the individual, or that renders him unsafe to continue in practice without remedial assistance".

In this case the Committee had serious concerns about the global deficiencies in Dr. Fashoranti's underlying knowledge and judgment demonstrated in the care of Patient M. The public interest requires that he be closely monitored to determine the extent of such deficiencies. The Committee also noted the mitigating circumstances demonstrated through the audit. As a result the Committee ordered, with the consent of Dr. Fashoranti:

1. Dr. Fashoranti is *reprimanded* for failing to adequately document patient encounters including progress notes, management plans, indications for medications, discussions with family regarding management and end of life decisions, and discharge summaries.
2. Dr. Fashoranti is *reprimanded* for failing to document the reasons he chose not to consider the recommendations of other health care providers and failing to seek appropriate consultation of the palliative care team.
3. Dr. Fashoranti is *reprimanded* for failing to meet the standards of care for skill and expertise in this instance, specifically his failure to consider, recognize and treat the symptoms of opioid toxicity.
4. Dr. Fashoranti's licence is subject to the following conditions:
    a. He must complete the next offering of a documentation course to be approved by the Registrar;
    b. His practice shall be monitored through a combination of observership and audit. In particular, on one day per month for each of the next three months, an observer appointed by the Registrar shall attend at Dr. Fashoranti's office and hospital practice to observe him in practice. In addition, within the next three months Dr. Fashoranti's office and hospital practice shall be the subject of an audit, directed through the CPSNS Compliance Office. Both the observerships and the audit shall be at Dr. Fashoranti's expense.
5. Dr. Fashoranti shall pay a contribution toward the College's costs of the investigation.

The Committee believes this disposition serves the public interest by strongly reinforcing with Dr. Fashoranti the importance of appropriate medical record keeping, consultation and decisions regarding end of life care.