COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "D"

Dr. Marwan Tolba
License Number 013210

Investigation Committee "D" of the College of Physicians and Surgeons of Nova Scotia (the College) concluded its investigation into a complaint against Dr. Marwan Tolba by Decision dated January 28, 2018. The Investigation Committee reached agreement with Dr. Tolba with respect to the disposition of the complaint. A summary of the complaint and its disposition appears below.

PROCESS

This matter was initiated by a complaint letter from the Complainant regarding care received by her relative, the Patient. The complaint letter was received on December 22, 2016. A response from Dr. Tolba was received on February 1, 2017.

Investigation Committee "D", formed in accordance with the *Medical Act* of Nova Scotia, 2011, was responsible for the investigation of this complaint.

In addition to correspondence from the complainant and physician, the Committee considered all other documentation including practice assessments of Dr. Tolba, hospital policies and an interview with Dr. Tolba.

PARTIES

Dr. Marwan Tolba is a family physician, licensed to practise medicine in Nova Scotia since 2002. Dr. Tolba's main scope of practice is in Emergency Medicine. His practice is based in New Glasgow, Nova Scotia.

SUMMARY

Key points as reported by the Complainant

The Patient was assaulted and struck his head on the sidewalk. When police arrived, the Patient was lying on the ground, unconscious. An ambulance was called, and he was transported to the hospital.

Upon arrival at the emergency department at the hospital, the Patient was triaged at Level 2. The

Patient had a known head injury, was unresponsive at the scene and was bleeding from the nose and mouth. He was handcuffed to a stretcher and put in a room. The medical record states he was, "hollering, non-cooperative, difficult to assess".

The Patient was left handcuffed to a stretcher for eight hours with no medical treatment or assessment, other than some medication.

Many hours after the Patient's arrival, the Complainant was notified the Patient was at the hospital. The nurse she spoke with stated the Patient was psychotic. The records state he was talking to the wall. The nurse informed the Complainant they looked up the Patient's file and saw he was a mental health patient, but for what (illness) they did not know. The Complainant told the nurse the Patient suffers from anxiety and depression, but has never been psychotic.

It was only after that conversation things quickly changed. Within minutes, the Patient was transported to CT. When the report came back, it was clear the Patient was not drunk or psychotic. He had suffered severe, traumatic, life-threatening brain injuries, and was immediately airlifted to Halifax.

When the Patient arrived in Halifax, the physician in the emergency department saw the condition of the Patient's wrists from the handcuffs. The physician could not believe a patient suffered such injuries to his wrists while in a hospital. It was so severe both wrists were x-rayed to see if they were broken.

After the Patient was transferred to the Intensive Care Unit (ICU) the Complainant was made aware ICU staff could not believe the lack of care the Patient received at the emergency department. This is demonstrated by the minimal documentation in his chart.

The Complainant questions why soft constraints were not used in this case.

The Complainant believes assumptions were made about the Patient's condition, and those assumptions allowed for the possibility of a severe head injury to be overlooked. All the behaviors recorded in his chart are common in patients with head injuries. The Patient spent a lengthy period of time in a hospital and rehabilitation center for his injuries.

Photos of the Patient's wrists reveal the injuries from being handcuffed. The wounds have healed but the Patient has been left with deep scars on both wrists.

The Complainant understands and accepts it was police policy to handcuff the Patient, but questions who was responsible for his safety while in the hospital. She questions whether he was actually under such close supervision, as staff failed to notice the damage the cuffs were doing to his wrists. The Complainant questions whether the CT scan would have been delayed until morning if the Patient had not had an elevated blood ethanol level.

The Complainant does not believe such severe injuries to the Patient's wrists would have occurred during the five-minute drive to the hospital from where he was assaulted. If the injuries had occurred during the ambulance drive to hospital, she questions why there was no

documentation in the record, no initial treatment of the injuries, and why handcuffs would have been left on if the Patient arrived at hospital with injuries sustained from the handcuffs.

The Complainant is concerned with the length of time it took for the Patient to have a CAT scan.

Key points reported by the Respondent

Dr. Tolba was the emergency physician on duty on the night in question. Given how much time has passed, and the volume of patients he has treated in the intervening period, most of his comments are based on the Patient's medical records rather than specific recollection of the treatment.

The Patient was brought to the emergency department by police and EHS. The Patient was intoxicated when he was engaged in a fight. He had been punched in the face, and fell on the ground. He had a brief period of decreased level of consciousness.

The Patient was disruptive and agitated as he was being brought into the emergency department for assessment. He was in police custody and had been handcuffed by the police. Dr. Tolba states police routine is to restrain people who are agitated while intoxicated. This is to protect themselves and others from harm. The Patient may have sustained the handcuff marks prior to his arrival to the emergency department.

The Patient was triaged at 2:13 a.m. He was not cooperating with police and was taken to a room. This room is located in front of the emergency physician's desk and the Patient was under direct supervision.

Dr. Tolba assessed the Patient at 2:15 a.m. The Patient had been drinking alcohol that night but was able to answer questions appropriately. The Patient denied any neck pain, chest pain or abdominal pain.

The Patient was moving all extremities with no limitation. He was noted to have a non-suturable laceration and some blood from his nose and mouth. The Patient's blood was drawn for laboratory analysis. The Patient provided a urine sample to staff to be analyzed.

Dr. Tolba states the Patient required medication to control his behavior and protect him. The Patient received an intramuscular injection of Haldol 5mg and Ativan 1mg. Subsequently the Patient became reasonably more cooperative. He was kept under close supervision awaiting the results of lab work, as well as the completion of a CAT scan to rule out intracranial injury or facial bone fracture.

The Patient remained medically stable until he was taken for his CAT scan. Dr. Tolba ordered and arranged a CAT scan prior to signing over care of the patient at 8:00 a.m. to another emergency physician on call.

The Patient had a CAT scan at 08:43 a.m. The result was available after 11:00 a.m. and showed intracranial injury, as well as skull and facial bone fractures. A cervical collar was applied as a

precaution until obtaining a CAT scan of the cervical spine. The CAT scan of the cervical spine was found to be negative for any injury.

At 09:10 a.m., a nurse was unable to reach the Patient's next of kin because the number the nurse was given was incorrect. The Patient's relative was contacted at 9:50 a.m. He was at the bedside at 10:50 a.m., after the Patient's wrist dressing had been applied at 10:30 a.m., as documented by nursing staff.

At approximately 11:00 am the decision was made to transfer the Patient to the QEII. He was intubated and airlifted to the QEII for further assessment and treatment by neurosurgery.

Dr. Tolba states he did not order the Patient to be handcuffed. The Patient was handcuffed because of being aggressive prior to his arrival.

Dr. Tolba did not order the Patient to continue to be handcuffed or physically restrained to the stretcher. The Patient arrived handcuffed and in police custody. Dr. Tolba will ask the police to remove handcuffs if it is necessary for assessment or treatment, but this was not the case while the Patient was in Dr. Tolba's care.

The Patient was kept in a room located about two meters away from the emergency doctor's desk, under close supervision. A police officer was also present the whole time.

The Patient remained stable throughout the night and was eventually cooperative with the staff until he was sent for his CAT scan at 08:43 a.m. He did not require cervical spine immobilization, as he had denied any neck pain or any other pain otherwise. The cervical spine CAT scan was negative for fracture.

Dr. Tolba disputes it was "only after [the Complainant]'s phone call that things quickly changed", and a CAT scan ordered. Dr. Tolba ordered and arranged the CAT scan before shift change at 08:00 a.m., as documented in the emergency department record, as well as the CAT scan report. The patient was stable, fully conscious, and calm. There was no immediate concern to do an emergency CAT scan without any focal neurological defects.

Dr. Tolba also disputes the Complainant's allegation the Patient was "left handcuffed to a stretcher for eight hours with no medical treatment or assessment other than some medication". Dr. Tolba saw and treated the Patient only two minutes after he was triaged. The Patient may have sustained the handcuff marks prior to his arrival at the emergency department.

The Patient was intoxicated as per the laboratory results of his elevated ethanol level.

Dr. Tolba never referred to the patient as psychotic. The statement was allegedly made by nursing staff. There was no documentation to suggest the patient's previous mental health history had anything to do with his presentation that night.

Dr. Tolba was not at the scene when the Patient was resisting the police officers and paramedics.

It was unfortunate to learn the Patient went through this ordeal, and he suffered physically and emotionally. As a physician, Dr. Tolba's intention was to help him and alleviate pain and suffering, not cause it. Dr. Tolba believes he did his best.

Preliminary Investigation

Pursuant to Section 88 (1) of the *Medical Practitioners Regulations,* an Investigator was appointed to conduct a preliminary investigation of this complaint.

CONCERNS/ALLEGATIONS OF COMPLAINANT

The Complainant alleges:

- The Patient was left handcuffed to a stretcher for eight hours and this led to deep cuts on his wrists;
- there was a nine hour delay in diagnosis due to the gap of time that occurred between the initial assessment and receipt of CT scan results indicating the Patient had a brain injury;
- there was lack of care provided to the Patient overnight as demonstrated by the minimal notes documented in the chart;
- assumptions made about the Patient's condition allowed for the possibility of a severe head injury to be overlooked;
- it is unlikely the wrist injury occurred during the five minute ambulance drive ; and
- the use of soft restraints to restrain the Patient was not considered.

CONCERNS OF COMMITTEE

As with all complaints, the Investigation Committee is not limited to investigating only the concerns set out in the complaint. The Committee has the responsibility to look into all aspects of a physician's conduct, capacity or fitness to practise medicine that arise in the course of the investigation.

In this matter, after reviewing all available information, the Committee identified the following additional concerns arising from the investigation of this complaint:

- Dr. Tolba indicates he has no recall of this patient or the encounter;
- Dr. Tolba's failure to recognize the importance of blood alcohol level in his assessment of the Patient;
- there is no documented re-assessment of the Patient;
- the prescribing of the second dose of chemical restraints was done without proper re-assessment;
- the patient handover to the oncoming physician was not appropriate ;
- there was an inappropriate use of chemical and physical restraints;
- Dr. Tolba exhibits insufficient knowledge and application of accepted decision rules such as those used for C-Spine, CT Head.

The Committee is also concerned with systemic issues identified by two separate assessors

during the course of the investigation. These will be discussed in further detail below.

DISCUSSION

The Complainant alleges her relative, the Patient, was left handcuffed to a stretcher at the hospital, and this resulted in deep cuts to his wrists. She submitted a photo of a wound. The Complainant suggests it is unlikely the Patient's injury occurred during the short ambulance drive to the hospital. EHS had requested police assistance with the Patient. The Committee is unable to determine at what point in time the Patient's wrists were injured, but it appears the handcuffs were left on the Patient's wrists throughout Dr. Tolba's shift.

The ER record indicates at 2:13 a.m. EHS arrived at the hospital and the Patient was handcuffed. The EHS Patient Care Report indicated the Patient had an alcohol like smell on his breath and alcohol use was reported by others. An entry in the same record at 10:30 a.m. indicates a CT was done, skin on wrist broken and red from handcuffs, dressing applied. The materials confirm Constable "A" had to restrain the Patient to the stretcher with handcuffs when they initially arrived at the hospital due to the Patient's restlessness and combative outbursts. When Constable "B" arrived to relieve Constable "A" at approximately 7:50 a.m., the Patient was still handcuffed. Constable "A" notes from 8:00 a.m. indicate the Patient began pulling hard on the cuffs and yelling. There is no record of the handcuffs having been removed at any point between 2:13 a.m. and 8:00 a.m.

Dr. Tolba indicated in his response to the College he will ask the police to remove a patient's handcuffs if necessary for assessment or treatment, but this was not necessary while the Patient was in his care. During his interview, Dr. Tolba indicated because the Patient was not a fully cooperative patient he was kept in restraints for his protection and the protection of others. The immediate concern was to control his agitation and ensure everyone's safety.

The most responsible physician, Dr. Tolba, is responsible for deciding what the appropriate method of restraint may be. It does not appear Dr. Tolba had any discussion with police or considered the use of other types of restraints, such as appropriate chemical or acceptable methods for physical restraint while in the emergency department throughout the Patient's admission. Dr. Tolba did not meet the standards outlined in the Health Authority's *Least Restraint Policy.*

The Committee was concerned with the clinical decisions Dr. Tolba made with respect to the Patient's care. From a review of the file, the very limited chart notes, and Dr. Tolba's interview, it does not appear Dr. Tolba understands or appropriately applied the *Canadian CT Head Rule* and *Canadian C-spine Rule (CCR).*

The *Canadian CT Head Rule* states:

High Risk (for Neurological Intervention)

1. *GCS score <15 at 2 hrs after injury*
2. *Suspected open or depressed skull fracture**
3. *Any sign of basal skull fracture*
4. *Vomiting ≥ 2 episodes*

5. *Age ≥ 65 years*

Medium Risk (for Brain Injury on CT)

6. *Amnesia before impact ≥ 30 minutes*
7. *Dangerous mechanism ** (pedestrian, occupant ejected, fall from elevation)*

The standard of care for the need to immediately order a CT head for the Patient was not met. Dr. Tolba was under the impression the Patient was intoxicated upon arrival. The Patient experienced a loss of consciousness, dangerous mechanism, and continued to be impaired. The Committee does not accept Dr. Tolba's explanation there was no immediate need to complete the CT based on his finding the Patient did not have a decreased level of consciousness or any kind of apparent focal or neurological deficit.

The Committee does not support Dr. Tolba's decision to not apply a cervical collar upon the Patient's presentation at the emergency department. The *Canadian C-spine Rule* clinically clears cervical spine fracture without imaging. The Patient had suffered a fall with a period of loss of consciousness. Dr. Tolba understood the Patient to be alcohol intoxicated. Dr. Tolba should not have relied on the Patient's own denial of neck, chest, or abdominal pain if he understood the Patient was impaired. The Patient would be considered a high-risk patient, and in the case of a suspected inebriated but alert patient, one reasonable approach would be to leave the patient in a cervical collar until they are clinically sober.

The Patient's blood was collected at 2:30 a.m. His ethanol (blood alcohol) level was 17.6 mmol/L. Dr. Tolba acknowledged during his interview one would expect higher alcohol levels when someone is intoxicated. Dr. Tolba's expectation that morning was if the Patient became more controlled and less agitated after treatments, Dr. Tolba would just observe the Patient and see how he does, as "probably he's sober and probably in the morning even more". At that point Dr. Tolba would reassess him and talk with him as well.

In his interview Dr. Tolba stated he did not have much recollection as to his reassessment of the Patient after the bloodwork results were available. He said, based on what is in the record, the results would have come back and he would have initialed them. It appears he did so. There is nothing in the record to confirm whether Dr. Tolba ever reassessed the Patient after he signed off on the blood work results. When asked if he recalled going in to assess the Patient after he got the results back, Dr. Tolba stated he did not have any recollection about it.

It appeared Dr. Tolba, in this case, failed to recognize the significance of a relatively lower blood alcohol level in his assessment of a patient with a known head injury. The Patient was uncooperative and agitated. Dr. Tolba's failure to appreciate the Patient may have not been significantly impaired by alcohol contributed to his decision to delay the CT until the next morning. Dr. Tolba chose to wait until the Patient was, "more cooperative, hopefully sober in the morning". Dr. Tolba should have personally reassessed the Patient immediately upon receiving bloodwork results which could suggest the Patient was not alcohol intoxicated at a level consistent with his agitation and combativeness.

The Committee reviewed the emergency department record. There is glaring lack of documentation. Between the hours of 2:13 a.m. and 7:30 a.m. there is no documentation to indicate Dr. Tolba was monitoring or reassessing the Patient. The only notation between those hours indicates Haldol and Ativan were administered at 3:30 a.m.

The Committee noted Dr. Tolba did not document whether he reassessed the Patient before handover of care occurred. When asked during his interview if he recalled visiting the Patient in the morning, Dr. Tolba said he did not recall seeing any one of the patients. He indicated he must have reassessed the Patient based on the sign-out sheet, and acknowledged it is not written in the chart.

When asked if he thought his notes were sufficient in this case, Dr. Tolba responded, "I could have probably done more."

The Committee finds in this case Dr. Tolba did not meet the requirements of the College's *Professional Standard Regarding Medical Records*.

Dr. Tolba did write brief notes in the physician handover log. He also indicated he had a conversation with the physician taking over care and discussed a second dose of sedation being administered in advance of the CT scan. The Committee interviewed the physician who took over care. He confirmed Dr. Tolba ordered the second dose of sedation.

It appears to the Committee Dr. Tolba may not have provided adequate information at handover to ensure the Patient was appropriately reassessed in a timely manner. The Committee is concerned the Patient was given a second dose of sedation without his condition being reassessed.

The Committee finds Dr. Tolba did not meet the requirements of the College's *Professional Standard Regarding Transfer of Care*.

Based on the concerns raised in the complaint and the Committee's concerns, the Committee ordered an assessment of Dr. Tolba's emergency medicine practice. The assessor was asked to focus on files related to patients who presented with a head injury and/or agitation between 2016 and 2017.

The assessor noted the issues identified were related to inadequate notation of neurological examinations and deficiencies in discharge and follow-up instructions. The assessor noted clinical examinations were appropriate, and overall notation did meet the standard. Dr. Tolba accepted critical feedback with respect to deficiencies and recognized the importance of adequate charting.

Following this assessment and Dr. Tolba's interview before the Committee, the Committee remained concerned with Dr. Tolba's ability to safely practice in an emergency department setting. It appeared to the Committee Dr. Tolba was unsure of how to appropriately apply the *Canadian C-spine Rule* and *Canadian CT Head Rule*, and he did not seem to appreciate the significance of ethanol (blood alcohol) levels in head-injured patients.

The Committee requested a second assessment of Dr. Tolba's general care in the emergency department.

The second assessor commented Dr. Tolba's notes were brief but generally contained the most relevant information. There were pertinent aspects of the physical examination lacking in a few of the reviewed cases, but in general, the assessor found Dr. Tolba's reasoning and decision-making processes easy to follow.

The second assessor did comment Dr. Tolba over-investigated with respect to extensive lab-testing. This was a common trend in the cases reviewed. The second assessor noted this was not the case for diagnostic imaging procedures.

The Committee acknowledges Dr. Tolba was receptive to the comments made by the assessors. He indicated he would endeavor to improve his charting of discharge instructions. He further explained the excessive laboratory testing was done to optimize patient's care who may not have access to a family physician in a timely manner or at all. Overall, Dr. Tolba was pleased both assessors found he met the standard of care for documentation, triage times and clinical care.

In coming to its decision, the Committee turned its mind to the mitigating and aggravating factors in this case. The Committee was cognizant of the objectives of sanctioning in terms of:

- Public protection;
- The need to promote specific and general deterrence;
- The need to maintain the public's confidence in the medical profession;
- The degree to which the offensive conduct was regarded as the type of conduct that would fall outside the permitted range of conduct.

The Committee acknowledges Dr. Tolba was cooperative throughout this investigation. He participated in two generally positive assessments and attended an interview. Dr. Tolba has held a full license in Nova Scotia since 2009 and there is no complaint history since that time. The Committee noted the Patient's serious outcome appeared to be an isolated incident as opposed to the result of a pattern of poor practice.

Although cooperative with the investigation, the Committee is concerned with Dr. Tolba's lack of recall on this specific patient encounter. The Committee acknowledges the interaction was in 2014, however, this was a significant head injury that resulted in the patient subsequently being airlifted to Halifax once CT results became known. The Committee believes this was a significant case that would have warranted further discussion as he was made aware the next day that the patient had a poor outcome.

The medical record in this case is woefully inadequate. There is nothing in the record to confirm Dr. Tolba reassessed the Patient once the blood work results were available. There is nothing to confirm Dr. Tolba assessed the Patient prior to Haldol and Ativan being administered at 3:30 a.m. There is nothing in the record to confirm Dr. Tolba assessed the Patient prior to handing care over to another physician, with orders for another dose of sedation.

Dr. Tolba failed to appreciate the significance of the Patient's blood alcohol results within the clinical picture of a head-injured, aggressive and combative patient. He inappropriately applied the *Canadian C-spine* and *Head CT* Rules. The Patient remained restrained to a stretcher in police handcuffs for hours, with little to no supervision.

Although Dr. Tolba indicated the Patient was under close supervision throughout the night, Dr. Tolba's inability to recall much detail about the encounter, and the lack of documentation in the medical record, would suggest this was not the case. This lack of supervision and reassessment in a head-injured patient goes to the core of patient care, and the need to maintain the public's confidence in the medical profession is of utmost importance.

DECISION

In accordance with clause 99(5)(f) of the *Medical Practitioners Regulations*, the Committee has determined there is sufficient evidence that, if proven, would constitute professional misconduct incompetence or conduct unbecoming, warranting a licensing sanction.

Pursuant to clause 99(7)(a)(i) of the *Medical Practitioners Regulations*, and with Dr. Tolba's consent:

Dr. Tolba is ***Reprimanded*** for failure to appropriately diagnose, manage and reassess a patient with a significant head injury.

Dr. Tolba is ***Reprimanded*** for failure to document any clinical care provided to this patient in the emergency department for an extended period of time.

Dr. Tolba agrees to contribute an amount toward the College's costs in this matter.

Dr. Tolba agreed to accept this disposition on January 28, 2018.