IN THE MATTER OF a Hearing conducted pursuant to the *Regulated Health Professions Act*, RSPEI 1988, c R-10.1, as amended;

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF PRINCE EDWARD ISLAND

AND

DR. SESHAGIRI BENGERI

HEARING COMMITTEE DECISION

Hearing Dates:
January 29, 30, 31, and February 1, 2, 2024.

Hearing Panel:
Dr. Margaret Bethune,
Dr. Kathryn Bigsby,
Jeremy R. Coffin

Counsel for the College of Physicians and Surgeons of Prince Edward Island
Douglas R. Drysdale, K.C., and
Melissa D. Trowsdale

Counsel for Dr. Seshagiri Bengeri
Janet M.R. Clark,
Gary G. Demeulenaere, K.C., and
Sean R. Seviour

INTRODUCTION

[1] The College of Physicians and Surgeons of Prince Edward Island ("the College") is a self-regulating body corporate responsible for the regulation of the medical profession in the Province of PEI, including all matters relating to professional standards and their enforcement, and is governed by the *Regulated Health Professions Act*, RSPEI 1988, c R-10.1 ("the RHPA").

[2] Dr. Sheshagiri Bengeri is an anesthesiologist, who was working as an anesthesia locum at the Prince County Hospital ("PCH"), in Summerside, Prince Edward Island, at the time material to this complaint. At that time, Dr. Bengeri had a license to practice as an anesthesiologist with Level 4 Supervision from the College.

[3] Ms. Norma Costain ("the Complainant") submitted a written letter of complaint to the College, dated June 14, 2021, and stamped as received on June 21, 2021, alleging, *inter alia*, that during a surgery performed on her common law husband, Richard Kelly, "*Dr Bengeri and the other anesthetist present, Dr Keeping, made errors that resulted in Richard's death*".

[4] This Hearing Committee ("the Committee") has been appointed under Section 54 of the *RHPA*, and is constituted of two medical practitioners and one member of the public. The mandate of the Committee is to determine whether Dr. Bengeri is guilty of the charges issued against him in the Notice of Hearing dated September 21, 2023, more specifically (and as amended),

> *Allegation A. [Dr. Bengeri] engaged in professional misconduct by failing to maintain accepted professional standards and procedures in the practice of medicine regarding recognition and management of significant bilateral pulmonary aspiration prior to, during, and after a surgical procedure on Patient "A"*[1]*, contrary to paragraph XI, 1(a) of the Regulations and subsection 32(c) of the Act;*
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> *Allegation B. [Dr. Bengeri] demonstrated lack of knowledge, skill, or judgment in the recognition and management of significant bilateral pulmonary aspiration while performing his role as anesthesiologist prior to, during, and after a surgical procedure on Patient "A", and was, therefore, an unfit member as defined in subsection 1(y) of the Act, contrary to subsection 32.1(1) of the Act;*
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> *Allegation C. [Dr. Bengeri] engaged in professional misconduct by failing to maintain accepted professional standards and procedures in the practice of medicine prior to, during, and after surgery, in communications with other members of the health care*

[1] Patient "A" – Richard James Kelly

team, including the surgeon who was conducting a surgical procedure on Patient "A", contrary to paragraph XI, 1(a) of the Regulations and subsection 32(c) of the Act;

[5] The following charge within the Notice of Hearing was withdrawn by the College at the hearing:

Allegation D. [Dr. Bengeri] engaged in professional misconduct by failing to communicate properly and effectively with other members of the health care team, including the surgeon who was conducting a surgical procedure on Patient "A", prior to, during and after surgery, while Dr Bengeri's ability to perform any professional service accordance with accepted professional standards was impaired by a disability, illness, addiction or condition to wit, poor hearing, contrary to section XI,1(b) of the Regulations referred to above.

ONUS OF PROOF

[6] In this matter, the Notice of Hearing alleges that Dr. Bengeri engaged in professional misconduct and/or was unfit in assessing and treating Mr. Kelly. The College bears the burden of proving the conduct alleged in the Notice of Hearing and of satisfying us that the conduct that is proven constitutes professional misconduct and/or unfitness in all of the circumstances.

STANDARD OF PROOF

[7] The standard of proof applicable to this hearing is the civil standard of proof, being that it is more probable than not, or on a balance of probabilities. The Committee is tasked with evaluating the relevant evidence to ascertain whether it is more likely than not that the alleged incidents occurred.

[8] In *F.H. v. McDougal*, 2008 SCC 53 (Can LI I), 2008 S.C.C. 53, the Supreme Court of Canada discussed at paras 40-49 the applicable standard of proof, explaining evidence must always be sufficiently clear, convincing, and cogent to satisfy the balance of probabilities test. The following paragraphs further describe this approach taken by the Supreme Court of Canada and also apply to the within allegations:

Like the House of Lords, I think it is time to say, once and for all in Canada, that there is only one civil standard of proof at common law and that is proof on a balance of probabilities. Of course, context is all important and a judge should not be unmindful, where appropriate, of inherent probabilities or improbabilities or the seriousness of the

allegations or consequences. However, these considerations do not change the standard of proof...

Similarly, evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. But again, there is no objective standard to measure sufficiency. In serious cases, like the present, judges may be faced with evidence of events that are alleged to have occurred many years before, where there is little other evidence than that of the plaintiff and defendant. As difficult as the task may be, the judge must make a decision. If a responsible judge finds for the plaintiff, it must be accepted that the evidence was sufficiently clear, convincing and cogent to that judge that the plaintiff satisfied the balance of probabilities test.

In the result, I would reaffirm that in civil cases there is only one standard of proof and that is proof on a balance of probabilities. In all civil cases, the trial judge must scrutinize the relevant evidence with care to determine whether it is more likely than not that an alleged event occurred.

APPLICABLE LEGISLATION

[9] At the applicable time for these allegations, members of the College were governed by the *Medical Act*, R.S.P.E.I. 1988, c. M-5, but that statute was subsequently replaced by the *RHPA* on November 1, 2021. Subsection 99(3.1) of the *RHPA* required the matter to be continued under the RHPA:

> *99(3.1) Where, under another Act, the conduct of a member was the subject of a complaint or an investigation, but was not ready to be set for a hearing, immediately before the day the health profession was designated as a regulated health profession and its college was continued under this Act, the complaint or investigation shall be continued and concluded under this Act and this Act applies with any necessary changes as if the complaint was made or initiated under section 36 or the investigation was commenced under this Act.*

[10] This is analogous to the *Interpretation Act*, R.S.P.E.I. 1988, c. I-8, which instructs:

> *8(1) The repeal of an enactment does not*
>
> *(d) affect a contravention of the repealed enactment or any penalty, fine, forfeiture or punishment incurred in connection with the contravention; or*
>
> *(e) affect an investigation, proceeding or remedy in respect of*
>
> *(i) a ... obligation or liability referred to in clause (c) ...*

(2) An investigation or proceeding referred to in clause (1)(e) may be commenced or continued and a remedy referred to in that clause may be enforced as if the enactment had not been repealed.

[11] In essence, the *RHPA* governs the Hearing, while it is the *Medical Act* which must be applied in determining whether any findings of "professional misconduct" or an "unfit member" have been proven by the College.

PRELIMINARY FACTUAL BACKGROUND

[12] James Richard Kelly, deceased on September 30, 2020, was a 62 year old male patient in the PEI health care system, who received care at the PCH at the time material to this complaint.

[13] Mr. Kelly underwent surgical repair of a large inguinal hernia on June 2, 2020, during which a sigmoid colon resection with primary anastomosis was also carried out. Subsequently, Mr. Kelly developed an intra-abdominal infection and underwent additional surgery on June 9, 2020, where bowel leaks were repaired, and an ileostomy was created. After a complicated postoperative course, Mr. Kelly was discharged home on July 7, 2020.

[14] On September 28, 2020, Mr. Kelly underwent surgery to reverse the ileostomy. However, on the evening of September 29, 2020, Mr. Kelly became unwell, with bowel contents leaking from his abdominal wound. He was assessed by the staff at PCH and a decision was made to change his antibiotics and plan for a laparotomy the following day to repair the bowel leak(s). Mr. Kelly exhibited signs of sepsis and respiratory compromise, necessitating oxygen therapy.

[15] On September 30, 2020, at all material times, Dr. Bengeri was the anesthesiologist for Mr. Kelly. Mr. Kelly appeared very ill, displaying signs of distress, including diaphoresis and retching. He required assistance to maintain a sitting position during the placement of an epidural catheter. His oxygen levels declined further during the surgery and, shortly after the procedure, he experienced a major respiratory deterioration attributed to aspiration, resulting in Adult Respiratory Distress Syndrome ("ARDS"). Despite efforts to stabilize him including transfer to the Intensive Care Unit ("ICU"), Mr. Kelly died several hours later.

WITNESSES AND EVIDENCE

[16] The Committee accepted 16 Exhibits into evidence and heard from 10 witnesses, either in person or by videoconference, and their evidence is summarized below in chronological order.

1. Ms. Norma Costain

[17] Ms. Costain is Mr. Kelly's widow and is the complainant in the present matter. She and Mr. Kelly had a common-law relationship for 12 years, up until Mr. Kelly's death. Now retired, she had previously been employed as a paramedic for 20 years.

[18] Ms. Costain testified that she visited Mr. Kelly daily from September 28 to 30, 2020. Following his ileostomy reversal surgery on September 28, Mr. Kelly appeared "OK." However, on September 29, he appeared unwell, and complained of persistent nausea and mild discomfort. Ms. Costain visited Mr. Kelly twice on September 30, prior to his return to the Operating Room (OR). She noted a further deterioration in his condition, with nausea persisting despite the administration of Gravol. Ms. Costain did not have direct communication with any physician before Mr. Kelly's surgery on September 30. She did not witness Dr. Bengeri's preoperative assessment of Mr. Kelly, although she recalls being occupied in the bathroom at the time.

[19] Dr. Perron contacted Ms. Costain at 15:14 on September 30, 2020, informing her that the surgery had concluded successfully, and she could expect to see Mr. Kelly in ICU within an hour. Upon arrival at the ICU, Ms. Costain was directed to wait in the waiting room. After a brief interval, she was permitted to visit Mr. Kelly's bedside, where she encountered a considerable number of medical staff. Ms. Costain asked Robin Rankin RN about Mr. Kelly's condition and was told that Mr Kelly had bilateral aspiration. Shortly thereafter, a Code Blue was called. Ms. Costain withdrew to allow the medical team to administer care to Mr. Kelly. Later, Dr. Carmody briefed Ms. Costain, indicating that Mr. Kelly's condition was deteriorating, with progressive organ failure. Mr. Kelly died at approximately 21:00 on September 30, 2020.

[20] Ms. Costain did not have the opportunity to meet or communicate with Dr. Bengeri. Subsequent to her departure from PCH following Mr. Kelly's death, she did not receive any communication from the attending caregivers. Desiring clarity on the events surrounding Mr. Kelly's demise, Ms. Costain, drawing on her experience as a former paramedic, recognized that an incident report had likely been submitted. Accordingly, she procured and reviewed the incident report authored by O.R. nurse Suzanne Burrell, as well as Dr. Keeping's report.

2. Dr. Lygia Perron

[21] Dr. L Perron is a surgeon specializing in vascular surgery. She completed her undergraduate medical education in Brazil and obtained certification from the Royal College of Physicians and Surgeons of Canada (RCPSC) in 2013. Since 2019, Dr. Perron has practiced at PCH, her first permanent position in Canada.

[22] Dr. Perron recounted that the ileostomy reversal surgery on September 28, 2020, presented challenges due to extensive adhesions, and lasted approximately 2 1/2 hours. On the evening of September 29, 2020, Dr. Perron received a call from the on-call surgeon, Dr. Sakhuga, reporting the presence of green fluid (bile) leaking from Mr. Kelly's surgical wound. Mr. Kelly's condition was deemed stable. Dr. Perron adjusted his antibiotic regimen and scheduled surgery for the following morning to address the bowel leak. She anticipated the surgical procedure would be technically difficult and sought guidance from her mentor, a surgeon in Saskatchewan. Mr. Kelly's surgery was delayed until noon on September 30, 2020, due to an emergency Cesarean section.

[23] In the morning of September 30, 2020, Dr. Perron called Dr. Bengeri regarding Mr. Kelly's case. She had met Dr. Bengeri briefly two days prior. Dr. Perron described the surgery on September 30 as proceeding "surprisingly well," lasting 1 1/2 hours. She repaired a small bowel leak without encountering any apparent difficulties during the procedure. However, approximately 10 minutes after completing the surgery, Dr. Perron was summoned back to the Operating Room because of Mr. Kelly's markedly low oxygen saturation. Subsequently, Mr. Kelly underwent a bronchoscopy, and green-colored fluid, which appeared to be enteric fluid, was suctioned from his airway. Dr. Perron stated that she was unaware of the pulmonary aspiration during the surgery, and believed she should have been promptly informed of such an event. She had expected Mr. Kelly's stomach to be empty pre-intubation, as he had only consumed minimal fluids. Dr. Perron emphasized the importance to the surgeon of knowing that there had been bile in Mr. Kelly's mouth immediately pre-intubation and expressed regret at not being given this information. She acknowledged her lack of awareness regarding the substantial amount of bile removed via the nasogastric (NG) tube, deeming it relevant information for her to be apprised of.

[24] During cross-examination, Dr. Perron affirmed that she encountered no difficulty in communicating with Dr. Bengeri pre-operatively. She maintained that if an anesthesiologist harbored suspicions of aspiration, it would typically be communicated to the surgeon.

3. Dr. Brenda Keeping

[25] Dr. Keeping is an anesthesiologist who served at the QEH from 2000 to 2001 and at the PCH from 2016 to 2021. On September 30, 2020, she worked in an operating room adjacent to Dr. Bengeri's. Her first encounter with Dr. Bengeri occurred in the early afternoon of September 30. Dr. Bengeri requested her assistance in inserting an arterial line in Mr. Kelly pre-operatively, as his own attempts were unsuccessful. Dr. Keeping concluded her own operating room list around 15:20-15:30 on September 30. Subsequently, she conversed with Dr. Perron, who conveyed that Mr. Kelly's surgery had concluded successfully.

[26] Shortly after Dr. Keeping arrived home around 15:35, she received a call from an RN in Dr. Perron's operating room. The nurse sounded shaken, and requested Dr. Keeping's immediate return. Dr. Keeping returned at 15:37 and heard a Code Blue being announced as she approached the operating room. Upon arrival, she observed Dr. Perron and Dr. Bengeri in the room, with Mr. Kelly displaying signs of severe distress. He was cyanotic and his pulse oximeter was not registering, indicating oxygen saturation below 50%.

[27] The end-tidal CO2 recording indicated that Mr Kelly's endotracheal tube (ETT) was in place, and Dr. Keeping manually ventilated Mr. Kelly with 100% oxygen. She used a glidescope to verify that the ETT was through the vocal cords. She noted green staining of the back of the tongue and throat, resembling bile. She replaced the #7 ETT with a larger size and increased positive end-expiratory pressure (PEEP), in an attempt to improve ventilation. Dr. Keeping suctioned bile from the ETT 2-3 times, with only marginal improvement in ventilation. She ordered a chest X-ray, which revealed widespread bilateral airspace disease.

[28] Dr. Keeping emphasized that the presence of any bile in the airway was abnormal and estimated suctioning approximately 2 ml of bile from Mr. Kelly's ETT.

[29] During her testimony, Dr. Keeping stated that she did not do a bronchoscopy and was unaware of one being done. She focused her discussions with Dr. Bengeri solely on Mr. Kelly's care requirements without specifically inquiring about any events at the beginning of the case. Dr. Keeping noted Dr. Bengeri's evident distress following Mr. Kelly's death.

[30] Dr. Keeping initiated a Quality Improvement (QI) activity concerning Mr. Kelly's care. The QI process was interrupted in December 2020, the reason for which is unknown. Dr. Keeping promptly informed Dr. Khan, Dr. Bengeri's supervisor, of Mr. Kelly's complication with severe hypoxemia.

4. Dr. Peter Dawes

[31] Dr. Dawes is a surgeon who received his undergraduate medical education in South Africa. He testified that he has over 40 years of surgical experience including practicing in PEI for 12-15 years until his retirement in 2012. Since then, he has occasionally undertaken locums and provided surgical assistance at PCH.

[32] On September 30, 2020, Dr. Dawes met Dr. Bengeri and served as the surgical assistant for Dr. Bengeri's two cases that day, including the one preceding Mr. Kelly's surgery. The earlier surgery proceeded without incident. Dr. Dawes observed that Dr. Bengeri encountered difficulty in initiating an arterial line and sought assistance from Dr. Keeping for this task.

Notably, Dr. Bengeri did not express any concerns during Mr. Kelly's surgery. The procedure concluded successfully, following which Dr. Dawes departed promptly.

[33] At least 30 minutes after the surgery had concluded, Dr. Perron contacted Dr. Dawes, informing him of Mr. Kelly's significant aspiration. Until this communication, Dr. Dawes had not been apprised of any concerns regarding aspiration or oxygen saturation during the surgery.

5. Ms. Suzanne Burrell

[34] Ms. Burrell is a Registered Nurse who graduated from the PEI School of Nursing in 1988. She has been employed at PCH since 2003, initially working in the ICU and the Emergency Room ("ER") until 2016, before transitioning to the OR where she has been employed since 2016. On September 30, 2020, Ms. Burrell was the circulating nurse in the OR for Mr. Kelly's surgery.

[35] Upon Mr. Kelly's arrival in the OR, Ms. Burrell observed him exhibiting profuse sweating, retching, and pallor. Positioned in front of Mr. Kelly, Ms. Burrell provided support to maintain his sitting position while an epidural catheter was inserted, which required several attempts. Subsequently, an arterial line insertion was attempted by Dr. Bengeri, and then successfully performed by Dr. Keeping. The elapsed time from Mr. Kelly's arrival in the OR to the induction of anesthesia was approximately one hour, as documented in the anesthesia record. Immediately prior to intubation, Dr. Bengeri administered anesthetic induction drugs. Following the administration of these medications, Ms. Burrell observed Mr. Kelly's mouth to be "open and full to his lips with bile". Ms. Burrell suctioned the bile before Dr. Bengeri proceeded with intubation. Notably, the endotracheal tube (ETT) was not suctioned until after the conclusion of the surgery.

[36] Ms. Burrell affirmed that she did not hear Dr. Bengeri express any concern to anyone about aspiration or low oxygen saturation prior to the completion of the surgery. Ms. Burrell brought Mr. Kelly's blood gas report, indicating acidosis, to Dr. Bengeri's attention at the start of the surgery; however, she did not witness any ensuing discussion about the acidosis.

[37] Shortly after the surgery concluded, Mr. Kelly experienced a significant deterioration, prompting Dr. Bengeri to summon Dr. Keeping. Subsequently, a Code Blue was called. When Dr. Keeping arrived, she inquired about the possibility of aspiration, to which Dr. Bengeri replied in the affirmative.

[38] Upon her return to the OR for cleanup after Mr. Kelly was transferred to the ICU, Ms. Burrell discovered the blank paper anesthetic record labeled with Mr. Kelly's patient sticker. The

anesthetic machine was still turned on, and so still retained the information from Mr. Kelly's case.

[39] Ms. Burrell did not overhear any discussion about an NG tube during the one-hour period in the OR preceding intubation. Mr. Kelly's nasogastric (NG) tube was inserted after intubation, just prior to the initial surgical incision. She also did not hear Dr. Bengeri communicate about the large volume of bile removed from the NG tube.

[40] Ms. Burrell completed the online document "Provincial Safety Management System (PSMS)," also known as an Incident Report (Exhibit 3), starting on September 30, 2020, and finalizing it on October 1, 2020. Mr. Burrell had prior experience using the PSMS and volunteered to complete the form on behalf of the nurses involved with Mr. Kelly's OR on September 30, 2020. The form included the pre-populated phrase "incident report is for quality improvement purposes". Upon submission, Ms. Burrell lost access to the report, as it was classified as "severity level 5 - patient death". She later regained access to a copy of her report for her interview with the Investigation Committee of the CPSPEI. When asked about her rationale for completing the report, Ms. Burrell expressed that it is customary to do so in the event of a "*near-miss*" or reportable incident, with the underlying goal of identifying areas for potential improvement. She expressed specific concerns regarding the intubation process, particularly the perceived lack of urgency on Dr. Bengeri's part and the possibility of aspiration.

6. Dr. Peter MacDougall, *expert witness for the College*

[41] Dr. MacDougall earned his MD degree in 1993 and is trained in general and thoracic anesthesia. He has been practicing anesthesia as a specialist since 2005. The College retained his expert opinion, and his report was presented as Exhibit 6.

[42] According to Dr. MacDougall's testimony, in a patient like Mr. Kelly, an NG tube would typically be inserted well before entering the operating room, serving both as a comfort measure to alleviate nausea and as a safety precaution. However, in this case, the NG tube was placed after intubation, and a significant volume of 1000-1500 ml was drained, consistent with Mr. Kelly's reported nausea and retching.

[43] Dr. MacDougall emphasized that although bile was observed in the patient's mouth, he agreed surgery should have proceeded, as Mr. Kelly was already under anesthesia. The best opportunity for removing bile from the airway was immediately after intubation, prior to positive pressure ventilation. Performing a bronchoscopy with saline lavage and suctioning is advantageous as it dilutes the aspirate, reducing its potential damage. Hence, the best opportunity to do bronchoscopy and lavage to minimize lung injury is early on, shortly after aspiration occurs. Following surgery, a substantial amount of bile was suctioned from the

endotracheal tube, confirming aspiration. The post-operative chest X-ray indicated evidence of ARDS, which Dr. MacDougall believes was likely caused by aspiration. Managing airway problems concurrently with the surgery proceeding would have been acceptable, with a brief delay in starting the surgery.

[44] Dr. MacDougall stressed the importance of good communication in ensuring patient safety, but noted that communication styles were culturally unique to each OR. He stated that if a problem is suspected, the anesthesiologist should inform the surgeon promptly. In Mr. Kelly's case, his oxygenation status began deteriorating 15 minutes after induction and continued to worsen. Dr. MacDougall testified that it would be below the standard of care for Dr. Bengeri not to have notified the surgeon either after induction when aspiration was suspected or midway through the surgery as Mr. Kelly's condition deteriorated.

[45] Regarding the incomplete anesthesia record, Dr. MacDougall noted that Page 3 appeared to have been recorded after the initial Code Blue, possibly after Mr. Kelly was transferred to the ICU. This is standard procedure. Page 2 of the anesthesia record, containing the flow chart, appeared to accurately represent the events, suggesting that notes were made as the case progressed or information was retrieved from the anesthesia machine's memory.

[46] Dr. MacDougall testified that it is highly likely that Mr. Kelly's stomach was full despite being NPO (nothing by mouth), due to his probable ileus. Dr. MacDougall emphasized that the risk of aspiration is primarily due to the acidity of the stomach contents rather than particulate matter. Any fluid originating from the stomach is acidic.

[47] Dr. MacDougall underscored the importance of assessing the amount of aspiration by suctioning the airway. Ideally, a bronchoscope should be used to visually inspect for evidence of aspiration and perform lavage to mitigate the risk. Without visual confirmation, the extent of aspiration cannot be determined. Dr. MacDougall explained that using an adult bronchoscope through a #7 endotracheal tube would almost completely obstruct the tube, whereas a #8 tube would permit ventilation while conducting bronchoscopy.

[48] While there is no data indicating that early airway suctioning reduces the risk of lung injury, factors affecting the outcome of aspiration include the volume and acidity of the fluid and the presence of particulate matter.

7. Ms. Sharon Schurman

[49] Ms. Schurman obtained her RN designation in 1991. On September 30, 2020, she was working full-time in the OR at PCH and served as a circulating nurse for Mr. Kelly's surgery on that date. Although she was not present for the induction of anesthesia or the initial intubation, Ms.

Schurman was in Mr. Kelly's OR for most of the time during the epidural procedure, and for approximately 50% of the surgery, including the end of surgery and the first Code Blue.

[50] During the epidural attempts, Ms. Schurman observed Mr. Kelly's distress, characterized by diaphoresis, difficulty sitting, swaying, retching, belching, and obvious nausea. The presence of a fecal odor indicated to her that this was not a routine case. Ms. Schurman did not perceive any "red flags" during the surgery and did not overhear any comments regarding aspiration or oxygen saturation. She also did not engage in any conversation with Dr. Bengeri on September 30, 2020.

[51] Ms. Schurman completed a "Critical Incident Documentation" (Exhibit 1, Volume 9, tab 6, pg 29-30 of 67) because a Code Blue was called, although Mr. Kelly did not experience a cardiac arrest. The Code Blue was initiated because the staff in Mr. Kelly's room required additional assistance. The personnel present at the time of the Code Blue included Ms. Burrell, Dr. Bengeri, Janet Pickering RN, and Sharon Schurman.

[52] At 15:53, dark phlegm-like fluid was suctioned from the endotracheal tube (ETT) for approximately one minute. A bronchoscopy conducted by Dr. Bengeri followed at 16:08, followed by a chest X-ray at 16:16. Ms. Schurman recollects that the chest X-ray was interpreted by either Dr. Bengeri or Dr. Keeping as indicating "bilateral aspiration,". She does not recall Dr. Bengeri mentioning aspiration before this point. She believes that Ms. Burrill's Incident Report (Exhibit 3) accurately reflects the events.

[53] Ms. Schurman noted that she is accustomed to working with and accommodating locum anesthesiologists. She observed that Dr. Bengeri appeared to struggle more in his interactions with patients, exhibiting fumbling behavior and taking a longer time to perform tasks. She also observed multiple attempts by individuals to communicate with Dr. Bengeri to gain his attention.

8. Dr. Douglas Carmody

[54] Dr. Carmody obtained his MD in 1987 and his Internal Medicine certification in 1995. He practiced general Internal Medicine at PCH from 1995 to 2022 and has been employed as a full-time locum since 2017. On September 30, 2020, he was on call for Internal Medicine.

[55] Dr. Carmody recalls receiving a call from Dr. Bengeri from the OR, inquiring about an ICU bed for "a patient with mild oxygenation issues." Later, he heard a Code Blue being called. Upon arriving at the Code Blue, he observed a significant number of staff already present, so he left to prepare an ICU bed for Mr. Kelly. Approximately 20 minutes later, Mr. Kelly was transferred to the ICU, with Dr. Bengeri providing a verbal report to Dr. Carmody in the

hallway outside room 3 in the ICU. Dr. Bengeri indicated that the operation went smoothly, with oxygenation being a concern during the procedure but not deemed major. However, significant oxygenation issues arose afterward, and aspiration was suspected.

[56] Initially, Dr. Carmody understood that aspiration had occurred at the end of the surgery. Approximately an hour or two later, he learned from the nursing supervisor that aspiration may have happened at the start of the procedure.

[57] Dr. Carmody noted that the paper anesthetic record did not accompany Mr. Kelly to the ICU. He is unsure of when the paper record arrived in the ICU, but recalls seeing it approximately one hour later, around the time he made a phone call to the Queen Elizabeth II Hospital ("QEII") in Halifax. The purpose of the call was to discuss the possibility of transferring Mr. Kelly to the QEII for Extracorporeal Membrane Oxygenation ("ECMO"). Ultimately, it was determined that Mr. Kelly was too ill for transfer.

[58] Dr. Carmody does not recall being informed about Mr. Kelly's mouth being full of bile just before the initial intubation. Had he been aware, he might have initiated a call to Halifax earlier. He found page 2 of the anesthetic record (the flow chart) to be alarming. Additionally, he does not recall being informed that the insertion of the epidural catheter took a significant amount of time and that Mr. Kelly experienced pronounced retching during this process, which he believes would have been pertinent information. Dr. Carmody testified that he did not find Dr. Bengeri's verbal hand-over report adequate, particularly given the information he later gleaned from examining Mr. Kelly and reviewing the paper anesthetic record.

9. Dr. Sheshagiri Bengeri

[59] Dr. Bengeri completed his anesthesiology training in 1993. He underwent a hiring interview via Zoom for a locum position at PCH on June 11, 2020, as evidenced by Exhibit 11D. On the same day, he received an email offering him the locum, specifying a one-week orientation followed by two weeks of locum, as indicated in Exhibit 12D. He arrived in PEI on September 12, underwent a two-week quarantine due to the pandemic, and then participated in an orientation on September 28, 2020, where he was familiarized with equipment locations and electronic charting procedures. He administered anesthetics at PCH on September 29 and 30, 2020.

[60] Regarding the incorrect date on the paper anesthetic record, Dr. Bengeri clarified that the correct date was September 30, 2020. He noted that the pre-operative assessment on page 1 was written after seeing Mr. Kelly on September 30, 2020. Dr. Bengeri assessed Mr. Kelly's preoperative status as (American Society of Anesthesiologists) ASA-3, a patient with severe

systemic disease. The anesthesia record on page 2 includes checkmarks indicating "air entry equal" and "capnograph".[2]

[61] When questioned about his memory of September 30, Dr. Bengeri expressed difficulty recalling most of that day and described it as extremely challenging, leading to feelings of guilt, anxiety, depression, and suicidal thoughts.

[62] Regarding the immediate suctioning of the endotracheal tube (ETT) after intubation, Dr. Bengeri stated that if there is no record of it, either he did not perform it or does not remember. He testified to not observing aspiration at the time of intubation and did not recall mentioning aspiration during the initial intubation.

[63] In response to the allegations in the Notice of Hearing, Dr. Bengeri denied witnessing pulmonary aspiration or seeing fluid entering the windpipe. He confirmed that if he had taken any steps to determine if any liquid entered the lungs, he would have recorded it on the anesthetic record, which he did not. When Dr Bengeri was asked "*did you communicate to team members in the OR that you observed bile in his mouth and suctioned it out*?", he replied "*I did not document it myself, but the nurse saw it, so she knew*". When he was also asked "*was the nurse obliged to report it to the surgeon*?", Dr Bengeri replied "*no*". He acknowledged that he did not communicate concerns about decreased oxygenation during surgery as it was not documented.

[64] Dr. Bengeri testified that he did not recall his handover to Dr. Carmody in the ICU and stated that his usual practice is to utilize a structured SBAR (Situation, Background, Assessment, Recommendation) handover.

10. Dr. Atul Prabhu, *expert witness for Dr. Bengeri*

[65] Dr. Prabhu obtained his medical degree in India in 1994 and completed his anesthesia training in the UK in 2002, obtaining his FRCPC in 2008. Since 2003, he has served as a staff anesthesiologist in Toronto, primarily in neuro-anesthesia. In his report (Exhibit 14D), Dr. Prabhu outlined the documents he reviewed, noting that he only saw the Incident Report (Exhibit 3) after submitting his written report.

[66] Dr. Prabhu testified that he would have classified Mr. Kelly's pre-operative status as ASA-4, indicating severe disease with an immediate threat to life. He noted that the major risk factors for ARDS are pneumonia, sepsis, and aspiration. Dr. Prabhu also highlighted that standard

[2] For Context: Dr. Bengeri's response, dated November 2, 2021, to the complaint, includes the following excerpt: The EtCO2 was normal at 32 initially, and I noted the air entry was equal bilaterally. The airway pressures were normal with a normal EtCO2 trace (a normal square wave pattern of capnogram would have shown an obstructive pattern if Mr. Kelly had pulmonary aspiration and developed any bronchospasm).

personal protective equipment (PPE) in 2020 in the OR could exacerbate problems with communication and team dynamics.

[67] Explaining the rapid sequence induction (RSI) procedure to the Hearing Committee, he stressed that cricoid pressure is a controversial step in RSI, as its effectiveness is unclear. Dr. Prabhu emphasized that aspiration was a high-risk anticipated problem with Mr. Kelly. He highlighted the importance of promptly suctioning Mr. Kelly's mouth, inserting the endotracheal tube (ETT) quickly, inflating the cuff, and inserting the nasogastric (NG) tube to empty the stomach, all of which could mitigate the risk of subsequent aspiration.

[68] He noted that the first blood gas, taken at 13:49, met the criteria for moderate severity ARDS, suggesting prior micro-aspiration. Dr Prabhu stressed that during the induction of anesthesia, the vocal cords are not protected from aspiration. He mentioned that Mr. Kelly had several risk factors for aspiration, including emergency surgery, bowel obstruction, treatment with opioids and recent abdominal surgery.

[69] Prabhu emphasized the importance of promptly addressing fluid in the mouth, as most aspiration occurs during induction. He testified that when regurgitation occurs during induction, the risk of aspiration is 75%.

[70] He explained that bronchospasm typically accompanies aspiration, causing a change in the normal square wave of EtCO2 to an inclining line. Regarding suctioning via the ETT, he noted that this procedure requires disconnecting the ventilator, which takes time and poses a risk of damaging the mucosa.

[71] While he wasn't specifically asked to comment on communication, he did note the use of the OR checklist. However, he expressed uncertainty about the overall quality of communication among team members. He opined that it was acceptable for Dr. Bengeri to complete his anesthetic flow chart after the surgery was completed. Regarding the presence of bile in the mouth during induction, Dr. Prabhu asserted that it should be communicated to the surgeon. He also agreed that evidence of early oxygenation problems should prompt communication with the surgeon.

[72] Responding to Dr. MacDougall's opinion on early suctioning, Dr. Prabhu noted that while he wouldn't necessarily consider it standard of care, it would be prudent if there were signs of aspiration. Finally, Dr. Prabhu concurred that a large volume aspiration is more concerning than a small volume aspiration.

ANALYSIS OF THE ALLEGATIONS

Allegation A. [Dr. Bengeri] engaged in professional misconduct by failing to maintain accepted professional standards and procedures in the practice of medicine regarding recognition and management of significant bilateral pulmonary aspiration prior to, during, and after a surgical procedure on Patient "A", contrary to paragraph XI, 1(a) of the Regulations and subsection 32(c) of the Act;

[73] In exercising its authority to discipline members, the Committee is obligated to adhere to the enabling legislation. In doing so, the Committee turned to the *Medical Act* for the definition of "professional misconduct", which is set out in section 32:

> *32. A member may be found guilty of professional misconduct if, [inter alia]... (c) he has committed a breach of any provision of this Act or the regulations relating to professional misconduct. (emphasis added)*

[74] The *Regulations* made under the *Medical Act* include Section XI, 1(a), which states, for further clarity:

> *For the purposes of Part IV of the Medical Act, "professional misconduct" constitutes a failure to maintain the standards of practice of the professional and includes: (a) Failing to maintain accepted professional standards and procedures in the practice of medicine; ...*

[75] The Committee recognizes that it must respect the rights of the physician whose conduct is the subject of the hearing, and therefore applies the principle that for an act(s) to be professional misconduct, "*the conduct must be a marked departure from the standard expected a registrant of the profession*". (The Law of Professional Regulation, Salte, LexisNexis, 2015, at p.176).

[76] In the present matter, Mr. Kelly presented with a plethora of risk factors for pulmonary aspiration, including suspected ileus/ bowel obstruction, a full stomach, emergency surgery, previous GI surgery, a difficult airway, repeated retching during epidural attempts, treatment with opioids, and most notably, significant regurgitation observed at induction.

[77] Dr. Bengeri was aware, or should have been aware, of the high likelihood of aspiration occurring during induction, given the presence of multiple risk factors, including regurgitation, which posed a risk of at least 76%[3]. Additionally, Dr. Bengeri knew, or should have known, of the grave consequences of pulmonary aspiration, including a significant risk of death.

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[3] This number is cited in the journal article provided by both experts: *Perioperative Pulmonary Aspiration and Regurgitation Without Aspiration in Adults: A Retrospective Observational Study of 166,491 Anesthesia Records*, Ann Palliat Med 2021;10(4); 4037-4048.

Despite these risks, Dr. Bengeri did not perform endotracheal tube suctioning soon after intubation, which the College alleged would be the professional standard.

[78] During the two-hour surgery, Mr. Kelly's oxygenation deteriorated progressively indicating possible aspiration. Still, Dr. Bengeri did not perform any ETT suctioning until after the surgery was completed.

[79] Expert witness, Dr. MacDougall, opined that the failure to perform early suctioning of the airway through the endotracheal tube (ETT) or via bronchoscopy in the presence of a mouth full of bile fell below the standard of care.

[80] Similarly, the expert witness for the Defence, Dr. Prabhu, emphasized the need for a high index of suspicion for aspiration when fluid is observed in the mouth, stating that most aspiration events occur during induction. While Dr. Prabhu expressed uncertainty about labeling it as standard of care, he nonetheless acknowledged the importance of suctioning in cases of aspiration.

[81] Dr. Bengeri's failure to suction the airway through the ETT despite the risk of aspiration – at any point before or during the procedure – until after the surgery's completion, indicates, on the balance of probabilities, a repeated and ongoing deviation from the standard of care during anesthesia administration, constituting marked and repeated instances of negligence.

[82] This ongoing/repeated failure to suction can be contrasted with *Swart v. College of Physicians and Surgeons of Prince Edward Island*, 2014 PECA 20, ("*Swart*"), where a single minor lapse[4] did not amount to professional misconduct.

[83] Accordingly, this Committee finds that Mr. Kelly had an elevated risk of aspiration, and despite this risk, Dr. Bengeri failed to suction the airway on multiple occasions, therefore significantly and repeatedly deviating from standard procedures, constituting professional misconduct.

Allegation B. ***[Dr. Bengeri] demonstrated a lack of knowledge, skill, or judgment in the recognition and management of significant bilateral pulmonary aspiration while performing his role as anesthesiologist prior to, during, and after a surgical procedure on Patient "A", and was, therefore, an unfit member as defined in subsection 1(y) of the Act, contrary to subsection 31.1(1) of the Act;***

[4] In *Hosseini v College of Dental Surgeons of Saskatchewan*, 2022 SKQB 13 the Court opined *Swart* at para 100 – "*Thus, Swart involved a single minor error amounting to mere negligence...*"

[84] An "*unfit*" member is defined in section 1(y) of the *Medical Act*, as:

> *"a member who has demonstrated a lack of knowledge, skill, or judgment or a disregard for the welfare of the patient, of a nature and extent making it desirable in the interests of the public or the member that he no longer be permitted to practice or that his practice be restricted."*

[85] The PEI Court of Appeal provides binding guidance to this Committee in *Swart* with respect to "unfitness", instructing at paragraphs 104-105:

> *[104] It is not every failure of a physician that amounts to a finding of unfitness. Were it so, virtually every physician would, at some time or another over the course of his or her career, be found to be quite unfit as all human beings sooner or later make mistakes. The case law is consistent that mere negligence is not a sufficient basis for a finding of unfitness ... There must be a failure amounting to gross negligence ...or some quality of blatant disregard for the patient or the patient's well-being.*
>
> *[105] ... In order to make a finding that a member is unfit to practice his or her profession, something beyond mere negligence or carelessness is necessary.*

[86] While Dr. Bengeri demonstrated a lack of knowledge, skill, or judgment in the recognition and management of significant bilateral pulmonary aspiration, resulting in a finding of professional misconduct, *Swart* informs that this negligence must be gross in nature or demonstrate a blatant disregard for the patient's welfare to justify a finding of "*unfitness*".

[87] The evidence informs that significant pulmonary aspiration typically presents with findings such as abnormal breath sounds (wheezing, indicating bronchospasm), increased airway pressures required for ventilation, or the presence of bilious fluid in the endotracheal tube, as well as an abnormal EtCO2 waveform. In the present matter, none of these findings were recorded in the medical record, which may indicate their absence. Similarly, Mr. Kelly did not immediately exhibit dramatic findings highly suggestive of aspiration. Instead, he showed a slow deterioration in oxygenation over the course of his surgery.

[88] Dr. Bengeri did take steps that indicated a recognition of Mr. Kelly's increased risk of aspiration. He planned a Rapid Sequence Induction, used a glidescope and a smaller endotracheal tube for intubation (given Mr. Kelly's prior anesthetic history indicating a difficult airway), inflated a cuffed ETT after intubation, and initiated the use of an NG tube to empty Mr. Kelly's stomach. Dr. Bengeri also showed remorse and empathy for Mr. Kelly at the hearing.

[89] Accordingly, we are unable to find evidence of either gross or willful negligence, nor do we perceive that there was a blatant disregard for Mr. Kelly's welfare by Dr. Bengeri. The Committee therefore finds that Dr. Bengeri was not an unfit member in this matter and thus is not guilty of this charge.

Allegation C. [Dr. Bengeri] engaged in professional misconduct by failing to maintain accepted professional standards and procedures in the practice of medicine prior to, during, and after surgery, in communications with other members of the health care team, including the surgeon who was conducting a surgical procedure on Patient "A", contrary to paragraph XI, 1(a) of the Regulations and subsection 32(c) of the Act;

[90] Expert testimonies, including those of Dr. MacDougall and Dr. Prabhu, underscored the importance of effective communication for patient safety. The experts also emphasized the importance of anesthesiologists informing surgeons about regurgitation or suspected aspiration during anesthesia. Dr. MacDougall stated that failing to communicate such information would fall below the standard of care. Dr. Prabhu testified about the critical role of communication in the operating room but acknowledged its sensitivity to cultural nuances.

[91] In the present case, the Committee finds that Dr. Bengeri failed to convey critical information to the surgical team and other healthcare professionals regarding Mr. Kelly's condition, including his regurgitation during induction, high risk of aspiration, and deteriorating respiratory status during surgery.

[92] The relevant caselaw informs that the Committee in making any finding against Dr. Bengeri cannot do so in a retrospective manner and should, in some capacity, afford Dr. Bengeri, the benefit of hindsight.[5]

[93] The Committee accepts that both experts recognized communication styles vary from hospital to hospital, operating room to operating room, and team to team, with each setting having its own unique cultural norms. Achieving good, consistent communication remains an area requiring continual professional development between the whole medical team. The Committee places weight on the fact that it was only Dr. Bengeri's third day in the PCH OR despite being employed under the premise of a one-week orientation, and questions whether he had a sufficient opportunity to acclimate to the environment.

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[5] *Bendah v. Dr. Farine and Dr. Fleming*, 2024 ONSC 624, at para 31; *Lapointe v. Hopital Le Gardeur* [1992] 1 S.C.R. 351, at para 28

[94] The committee also places weight on several other factors that may have exacerbated the breakdown in communication, thus mitigating Dr. Bengeri's culpability. These factors include his potential failure to recognize Mr. Kelly's aspiration risk during induction, the stress of dealing with a critically ill patient on only his second day of duties, language barriers, and the necessity of COVID precautions with N95 masks and face shields. Moreover, communication is also a 'two-way street'; there was also a lack of inquiry from the operating surgeon, Dr. Perron, to Dr. Bengeri into Mr. Kelly's condition before his deterioration.

[95] Dr. Bengeri did demonstrate some level of communication by seeking assistance from Dr. Keeping and acknowledging aspiration after Mr. Kelly's post-surgery deterioration, as evidenced in Ms. Burrill's incident report.

[96] For these reasons, the Committee cannot conclude that Dr. Bengeri's communication, or the alleged lack thereof, rose to a level which would constitute a significant deviation from the expected standard for a member of the profession, thus warranting a finding of professional misconduct.

CONCLUSION

[97] We have unanimously concluded that Dr. Bengeri engaged in professional misconduct by failing to maintain accepted professional standards and procedures in the practice of medicine regarding recognition and management of significant bilateral pulmonary aspiration prior to, during, and after a surgical procedure on Mr. Kelly.

[98] We have further unanimously concluded that Dr. Bengeri is not guilty of the remaining charges.

[99] Having found professional misconduct, we request counsel and the College to canvass dates for the hearing of disposition matters.

[100] We wish to express our appreciation for the very thorough and capable work done by both counsel for the College and for Dr. Bengeri.

IT IS THEREFORE ORDERED THAT

A. Dr. Bengeri is found guilty of Allegation A;
B. Dr. Bengeri is found not guilty of Allegation B; and
C. Dr. Bengeri is found not guilty of Allegation C.

DATED at Charlottetown, Prince Edward Island, this 3 th day of May, 2024.

Margaret D. Bethune	Kathryn M. Bigsby	
Dr. Margaret Bethune, Chair	Dr. Kathryn Bigsby	Jeremy R. Coffin

[END]

Signature: Peggy Bethune (May 6, 2024 10:30 ADT)

Signature: K Bigsby