SUMMARY

DR. MARIJANE DOYLE (CPSO# 32966)

1. Disposition

On October 22, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required paediatrician Dr. Doyle to appear before a panel of the Committee to be cautioned regarding her failure to adequately manage and assess a baby with bleeding after tongue tie release (frenulotomy) and her failure to obtain adequate consent.

2. Introduction

A family member of the patient complained to the College that Dr. Doyle: a) failed to explain the tongue tie clipping procedure; b) failed to allow the family member to stay with the patient during the procedure; c) failed to appropriately perform the tongue tie clipping, resulting in a complicated admission to hospital for the patient; and d) failed to advise the family member and obtain consent to use any medication during the procedure, or update the family member on the patient's condition after the procedure.

Dr. Doyle responded that she followed standard practice prior to the procedure by explaining that bleeding is usually controlled by applying pressure or sometimes by applying topical Otrivin. Dr. Doyle indicated that she also advised that excessive bleeding will rarely occur and, if it does, silver nitrate is used. Dr. Doyle also noted that the family member did not show concern or anxiety regarding the procedure or having it done in a separate room.

3. Committee Process

An Internal Medicine Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has

developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

Regarding the concern that Dr. Doyle failed to explain the tongue tie clipping procedure, the Committee noted that while some discussion took place, it is not clear from the documentation that a consent discussion occurred, including discussion of the potential risks of bleeding, infection, and injury to other oral structures. Given the shortcomings in this aspect of Dr. Doyle's management of the patient's care (consent), the Committee included this issue as part of its caution.

The Committee took no action with respect to Dr. Doyle's decision not to allow the family member to stay with the patient during the procedure, as this is standard practice and frenulotomy is usually a quick procedure.

The Committee noted that Dr. Doyle appears to have performed the clipping in the usual manner. The Committee also noted that, while bleeding occurred, this is a known complication of the procedure. The Committee had concerns, however, about the amount of silver nitrate used, and the off-label use of Otrivin. For this reason the Committee included this aspect of Dr. Doyle's care in the caution (management and assessment of a baby with bleeding after tongue tie release).

It does not appear from the record that Dr. Doyle obtained consent for the use of silver nitrate or Otrivin. While such consent does not have to be written, discussion of the risks and potential complications, and how they would be treated, should have been documented. Dr. Doyle also should have insisted that the patient complete a trial of breast feeding after the procedure, but she did not do so. These aspects of Dr. Doyle's management are also included in the caution.