

SUMMARY

DR. SHANTHI THAMILVAANAN (CPSO# 97508)

1. Disposition

On June 20, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Thamilvaanan to appear before a panel of the Committee to be cautioned with respect to proceeding with treatment without having a patient's chart available in a non-emergent situation.

2. Introduction

A family member of the patient complained to the College that Dr. Thamilvaanan administered an incorrect immunization and did not inform her that the clinic was only for adults. The family member had previously taken the patient to the same clinic, where he had received an incorrect vaccine; after the mistake was discovered, the clinic ordered the correct vaccine for the patient, who could receive it in four to six weeks. When the patient returned after this timeframe had elapsed and the vaccine had been received at the clinic, Dr. Thamilvaanan administered the same vaccine the patient had received a few weeks earlier, a second time.

Dr. Thamilvaanan responded that during the appointment, the computer froze, which prevented her from reviewing the patient's chart. She says she had no information from the patient, the family member, or the electronic medical record (EMR) detailing the patient had received a vaccine at the clinic or that this was the second visit to the clinic for a vaccination. She said she looked at the patient's vaccination card and in the clinic fridge, where she could only find the vaccine she administered. Dr. Thamilvaanan explained this was an unexpected and rare situation regarding providing vaccinations for children right before a deadline, and therefore, she took the history quickly, asked routine questions, and administered the vaccine.

3. Committee Process

A General 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

The Committee was concerned that Dr. Thamilvaanan proceeded to provide treatment without access to the patient's medical record. There was no urgency or emergency involved in this situation. There was no medical indication to proceed in the absence of having the patient's medical record. Doing so demonstrated poor judgement. This situation could have been avoided had Dr. Thamilvaanan taken the time, as she should have, to wait for the patient's chart to review before deciding on and proceeding with treatment.

The Committee was sufficiently concerned about Dr. Thamilvaanan's actions in this case that it decided to require her to attend to be cautioned in person, as set out above.

The Committee accepted that the clinic in question does provide service to all ages, and took no action on that point.