SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Albert Yun-Pai Chang (CPSO #114631)
Internal Medicine; Critical Care Medicine
(the Respondent)

INTRODUCTION

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the care the Respondent provided to the Patient, and about the Respondent's conduct.

The Patient, a young adult female had a medical abortion. About two weeks later, the Patient attended the Emergency Department (ED) with concerns of abdominal pain and vaginal bleeding. She was assessed and discharged home.

About a week later, the Patient returned to the ED with progressively worsening abdominal pain and was again discharged home. The Patient returned to the ED again the next day with severe abdominal pain and having vomited blood. The Patient was admitted. Physicians from the Internal Medicine team requested a consultation from the Intensive Care Unit (ICU) due to concerns the Patient may require transfer to the ICU. The Respondent was the physician on call for the ICU. He assessed the Patient and determined she did not require admission to the ICU.

Upon request, the Respondent reassessed the Patient three hours later and again determined she did not require ICU admission. About an hour later, the Patient went into cardiac arrest. She was resuscitated and transferred to the ICU. Regrettably, the Patient passed away the following day.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of June 21, 2024. The Committee required the Respondent to appear before a panel of the Committee to be cautioned with respect to: recognizing the signs and symptoms of a deteriorating patient and escalating the care for optimal patient outcomes; minimizing the role of cognitive biases in clinical decision-making, such as in considering alternative causes of severe pain in a young patient; and communicating professionally and effectively with the interprofessional clinical team.

The Committee also accepted an undertaking from the Respondent.

COMMITTEE'S ANALYSIS

The Committee's role is to determine if the Respondent's care was appropriate, as opposed to determining whether the Respondent caused or contributed to a particular outcome—in this case, the Patient's death.

After reviewing the medical record, the Committee was concerned that the Respondent did not recognize the signs and symptoms of a deteriorating patient and escalate the care for optimal patient outcomes. The Committee determined that the Respondent needs to be aware of the role of cognitive biases in clinical decision-making, such as in considering alternative causes of severe pain in a young patient; and further needs to improve his communications with the interprofessional clinical team.

In the Committee's view, the Respondent missed many clinical signs/symptoms or "red flags" that the Patient was very sick and was experiencing end organ dysfunction, and thus should have been admitted to the ICU sooner, if not at the Respondent's first assessment, definitely by the Respondent's second assessment when the Patient had not responded to fluid resuscitation in the ED. The clinical signs and symptoms included that this was the Patient's third ED visit for the same concern (abdominal pain) that had progressively worsened; her vital signs were abnormal (including extreme tachycardia); her blood work was abnormal (including high liver function tests, high INR, high troponin levels, and high lactate levels); the Patient had a large nasogastric output, was vomiting up blood (hematemesis), and a guarded abdomen with signs of peritonitis, as well as a concerning pelvic CT scan result.

Given these clinical findings, the Committee noted, the Patient met the criteria for Level 2 ICU admission for monitoring and resuscitation. Sepsis should have been at the top of the differential diagnosis and appropriate treatment, including antibiotics and source control, should have been started sooner.

The Committee was concerned that in his response to the complaint, the Respondent showed little insight or reflection about the care he provided to the Patient, suggesting that he would not have done anything differently, that the Patient's condition did not warrant ICU admission, and that her cardiac arrest was unexpected.

The Committee pointed out that, in particular, the Respondent should have recognized and taken into consideration that the Patient was likely able to compensate and had reserves, given she was otherwise young and healthy. Instead, there was a huge delay in administering antibiotics to the Patient, and source control was not achieved because

of the delay in care. The Committee was further concerned the Respondent may have allowed cognitive bias to interfere with his clinical decision-making.

As reflected in the record, the Respondent failed to recognize the concerns of nursing staff and other physicians about the severity of the Patient's condition as well as the need for a central line. The Committee noted that, given the Respondent is relatively early in his career, it is important that he recognize and listen to other members of the health care team, many of whom may have more experience than him. When dealing with a critically ill patient, physicians must have clear and professional communication with nurses and the rest of the care team to ensure that everyone is on the same page and that concerns are heard.

The Committee therefore determined that an undertaking and a caution in person were appropriate dispositions of this matter to address our concerns about the Respondent's management of the Patient as well as his communications with the health care team.

This is a summary of the Committee's decision as it relates to the caution and undertaking disposition.