SUMMARY

DR. THIEN HOA TRANG (CPSO# 108149)

1. Disposition

On September 20, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required Dr. Trang (Family Medicine) to appear before a panel of the Committee to be cautioned with respect to:

- His management of a patient with complications of cirrhosis and gastro-intestinal ("GI") bleeding.
- His management of a patient in shock.
- His recognition and response to notification from nursing staff regarding changes in a patient's status.

The Committee also requested that Dr. Trang provide the Committee with a written report with respect to the three topics above.

2. Introduction

The College received a complaint from a late patient's family member raising concerns that Dr. Trang failed to appropriately respond to concerns from nursing staff regarding the patient, who was in hospital with serious complications from a chronic disease, in that he did not respond to nursing pages for one to one and a half hours and then ordered Haldol (a medication that can be used to treat agitation) without seeing the patient. Dr. Trang had taken over the patient's care from a colleague during a weekend shift at the hospital.

Dr. Trang described the first telephone call he received, where he provided orders related to fluid provision and requested the nurse to closely monitor the patient and if the patient decompensated, to call him and the Critical Care Outreach Team ("CCOT"). Dr. Trang described

a second telephone call he received, where he suspected the patient's reported discomfort was leading to agitation, thus he gave orders for pain medication and for the use of Haldol if needed. Dr. Trang said he felt the assessment relayed to him was sufficient for him to provide the orders he made. He commented that he did not feel that his presence would have altered the treatment plan. Dr. Trang described a third telephone call, where nursing staff reported a decline in the patient's status; he ordered a stat electrocardiogram ("ECG") and for nursing to contact the CCOT to evaluate the patient.

Dr. Trang maintains that he responded in a timely manner to the concerns from nursing staff. He said that on reflection and moving forward, he plans to heighten his critical thinking about each case, to look more broadly at each patient's circumstances, and to ensure that family and loved ones are accurately informed of the patient's condition and treatment plan.

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 recognized that Dr. Trang took over the care of a very sick patient in a challenging clinical scenario, and acknowledged that Dr. Trang indicates he has reflected on and learned from this case.

However, the Committee observed that the appropriate response in this situation would have been to see the patient sooner, as it is clear from the hospital records that the patient was confused, agitated and the patient's condition was deteriorating and of increasing concern to

the nurses on duty. The Committee noted this was a critically ill patient with a changing status and giving (repeated) telephone orders in this instance was not appropriate.

The Committee thus required him to attend at the College to be cautioned as set out above, and asked him to prepare a written report on the three issues of concern.