SUMMARY

Dr. Ng Thow Hing (CPSO# 26452)

1. Disposition

On October 15, 2015, the Inquiries, Complaints and Reports Committee ("the Committee") required General Practitioner Dr. Ng Thow Hing to appear before a panel of the Committee to be cautioned with respect to the assessment and management of patients who are taking anticoagulants and have a head injury, and thorough documentation.

The Committee also ordered Dr. Ng Thow Hing to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Ng Thow Hing to complete:

- a Medical Record Keeping course
- a review of the indications for and mechanism for the reversal of anticoagulated patients with acute, life-threatening bleeding; the relevant Clinical Practice Guidelines (e.g. Canadian CT Head Rules); and the College Policy on *Medical Records*, and provide a written summary of these documents with a reference of how it is applicable to this case and his practice
- a 9-month supervision to include monthly meetings with a clinical supervisor who will review 20 charts and meet with Dr. Ng Thow Hing to review his recordkeeping and the management of closed head injury in the elderly, and undergo a reassessment of his practice 6 months after completing the education and remediation program

2. Introduction

A family member complained to the College about the care Dr. Ng Thow Hing provided to an elderly patient after he fell in a driveway and was taken to the Emergency Department. According to the complainant, Dr. Ng Thow Hing failed to adequately assess, investigate, diagnose, treat and prematurely discharged the patient from the hospital.

Dr. Ng Thow Hing informed the College that he assessed the patient 25 minutes after his arrival at the Emergency Department. At that time, the patient was alert and oriented, with equal and receptive pupils. He examined the patient's neck and scalp, and did not find any tender areas or

signs of bleeding; there were also no signs of a skull fracture or intracranial bleed. Dr. Ng Thow Hing stated that, in his opinion, the patient did not sustain a head injury requiring immediate intervention or further testing, and advised the patient's wife to closely monitor the patient's condition for 24 hours and bring him back if his condition worsened.

The following morning, the patient returned to the ED; a CT scan was completed and it showed a bleed in the brain. The patient was given medication to control the bleeding and transferred to another hospital for possible surgery.

3. Committee Process

A Family Practice Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint, as well as College policies and relevant legislation.

4. Committee's Analysis

Given the nature of the injury and the fact that the patient was taking an anticoagulant, the patient was at a high risk of intracranial bleeding. Dr. Ng Thow Hing should have ordered a CT scan and INR testing. Even if a CT scan was not available (though it was available at this hospital at that time of day), Dr. Ng Thow Ning should have kept the patient in hospital for prolonged observation, instead of discharging the patient about 20 minutes after the assessment.

Dr. Ng Thow Hing failed to recognize that the patient was taking warfarin (an anticoagulant) as documented in the EMS (Emergency Medical Services) record and the patient's prior hospital records. The Committee was of the view that Dr. Ng Thow Hing either failed to review the patient's prior record before the assessment and/or failed to take and document an appropriate history of this elderly patient.

In addition, the Committee found Dr. Ng Thow Hing's medical record for the patient to be inadequate. His notes were difficult to read and lacked sufficient detail. The Committee expects all physicians to be familiar with all of the prescribed components of medical records, which appear in sections 18 and 19 of Ontario Regulation 114/94 made under the *Medicine Act,* 1991. As indicated in the College's policy on *Medical Record*s, thorough and legible notes are a crucial

component of good medical care, and are an important measure of the quality of care received by a patient.

Dr. Ng Thow Hing has a lengthy history of complaints to the College, including being counselled with regard to his failure to assess, diagnose and treat a patient appropriately. Given these reasons, the Committee determined that the appropriate disposition is to require Dr. Ng Thow Hing to attend at the College to be cautioned with respect to the assessment and management of patients who are taking anticoagulants and have a head injury, and thorough documentation and to participate in a specified continuing education and remediation program ("SCERP").