SUMMARY

DR. EUGENIE ULRICA TJAN (CPSO #63892)

1. Disposition

On July 11, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required family physician Dr. Tjan to appear before a panel of the Committee to be cautioned with respect to lack of knowledge, skill and judgement in the provision of medical assistance in dying (MAID) and for failing to educate and prepare herself in advance of providing MAID.

The Committee also accepted two signed undertakings from Dr. Tjan.

2. Introduction

A family member of the patient complained to the College that Dr. Tjan was late for two appointments with the family in January and February 2017 and for the appointment for assisted death in February 2017 and failed to notify the coroner in advance of the procedure. He also expressed concern that Dr. Tjan gave the patient several medications, including some that they had not discussed at the pre-procedure appointment, left the patient's bedside for two and a half hours to obtain more medication while the patient was gasping for air, and was not aware of the medication kit available for medically-assisted dying patients.

Dr. Tjan acknowledged that there were many things that she could have done differently to improve the outcome in the patient's case. She stated that she was unaware of the MAID medication kit and heavily relied on her 23 years of palliative care experience. She expressed her view that the patient did not suffer during the procedure.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (IO provider) who is a family medicine specialist with a practice focus in palliative care. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

A 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 IO provider opined that Dr. Tjan's care did not meet the standard of practice and showed a lack of skill, knowledge and judgement. The IO provider concluded that if Dr. Tjan continued to perform MAID without further training and without accessing some mentoring from colleagues with experience, she was at risk of harming patients and should not perform the procedure. The IO provider was of the view that Dr. Tjan continued to underestimate the magnitude of providing medically-assisted death and the responsibility attached.

The Committee was disturbed to note that Dr. Tjan entered into the MAID process in this case without being adequately prepared. She did not read the College's *Medical Assistance in Dying* policy in advance of the procedure and was therefore unaware of the requirement to notify the coroner.

There was no indication that Dr. Tjan used any other resources available through the College, such as Physician Advisory Services, to prepare herself for performing the procedure, or that she contacted the Ontario Centre for Effective Practice for guidance about MAID.

It appeared that Dr. Tjan inquired about MAID medications at one pharmacy, which was unable to provide assistance, but did not ask at any other pharmacies. There was no indication that she consulted her colleagues about the procedure or conducted a robust internet search for information to guide her. Dr. Tjan did not contact the Canadian Medical Protective Association or the Office of the Chief Coroner for advice.

In palliation, the goal is to provide comfort while the natural dying process occurs during the final days and hours of the terminally ill patient's life. In MAID, the goal is to safely and humanely bring about death where death would not otherwise be imminent in the next few days.

There is a medication kit available through pharmacies that would have brought an effective and humane end to the patient's life. In this case, however, Dr. Tjan erroneously assumed that the medications she used for palliation were appropriate for use in MAID in larger doses. The drugs she used (Versed, Ativan, scopolamine, and hydromorphone) are inadequate for MAID even at high doses.

Hydromorphone was a poor choice because terminal patients are often already on high doses of narcotics and thus have developed tolerance. Scopolamine helps dry airway secretions and provides some sedation but is not lethal. Dr. Tjan indicated she would also have brought potassium chloride if she had had enough time to obtain some, but this is not a recommended drug for MAID either.

Dr. Tjan presented late for all three visits to the patient's home. This might have been excusable the first time, when she indicated she had difficulty locating the house, but not on the other

two occasions. The investigative record indicates that Dr. Tjan also failed to communicate adequately with the CCAC palliative team.

Dr. Tjan left the task of picking up the medication to the last possible minute, which caused her to be late to the patient's house on the day of the procedure. She started a butterfly IV, which is an unreliable method. The IV went interstitial, so Dr. Tjan had to rely on the patient's relative, a nurse practitioner, to start the IV.

Dr. Tjan gave dose after dose of the medications without causing respiratory arrest and sent the nurses who were present to the emergency room (ER) to get more of the same drugs. This was inappropriate, as the ER would not provide restricted drugs without authorization. Dr. Tjan then left the patient's home for more than two hours to obtain the MAID medication kit from a pharmacy while the patient's family waited, aware that the drugs keeping the patient in a coma might wear off before Dr. Tjan returned.

Dr. Tjan demonstrated a lack of professionalism by having a telephone conversation with the coroner in the presence of the patient's family members.

The Committee agreed with the IO provider's conclusions that Dr. Tjan's care fell below standard, and that she showed showed deficiencies in knowledge, skill and judgement. The Committee shared the IO provider's concerns about Dr. Tjan's lack of preparation and research regarding policy and drug protocols; lack of communication with other health care providers; and failure to perform the procedure using two IVs and the appropriate drugs.

As a result of this investigation, the Committee decided to seek an undertaking from Dr. Tjan to address the issues in question. Dr. Tjan signed two undertakings, dated May 8 and May 9, 2018, that provide that she will not engage in the practice of MAID in any respect, and, in her palliative care practice, will practise under the guidance of a supervisor, engage in professional education in palliative and end-of-life care, and undergo reassessment.

In addition to accepting the two undertakings, the Committee decided to require Dr. Tjan to attend at the College to be cautioned in person with respect to the care she provided in this case.