

SUMMARY

DR. TARA LYNN TESHIMA (CPSO# 101927)

1. Disposition

On February 16, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required plastic surgeon Dr. Teshima to appear before a panel of the Committee to be cautioned with respect to: following the *Out-of-Hospital Premises Inspection Program (OHPIP) Program Standards* (including around patient transportation and communicating with the hospital); clinical care during post-operative management, including deep vein thrombosis (DVT) prophylaxis and recognizing signs of pulmonary embolism and the need for early investigation; and communication.

The Committee also requested Dr. Teshima to complete a written report summarizing the guidelines for safe practice in post-operative pharmaceutical and mechanical prophylaxis for DVT and pulmonary embolism; and summarizing the *OHPIP Program Standards* around “Urgent Transfer of Patients,” on mandatory reporting, and emergency transportation and communicating with the hospital.

2. Introduction

The patient, who developed bilateral pulmonary emboli after undergoing breast reduction, abdominoplasty and liposuction by Dr. Teshima in an out-of-hospital clinic, complained to the College that Dr. Teshima:

- a) failed to follow accepted protocols around the prevention of thromboembolism (i.e., provide prophylactic blood thinner or use Flowtron boots);
- b) failed to assess the patient or instruct nurses to call 911 when notified overnight that the patient’s oxygen saturation declined (requiring oxygen by mask) and her heart rate increased;

- c) failed to arrange transfer of care to the hospital by contacting the receiving hospital or arranging for an ambulance;
- d) disclosed personal health information in front of the patient's visitors without the patient's permission; and
- e) failed to provide the patient with the pathology reports from the tissue removed in a timely manner.

Dr. Teshima responded that the patient was at a low to moderate risk for complications, and hence did not require the use of blood thinners and only required mechanical compression during (but not after) the surgery. She said nurses did not contact her overnight about the patient's oxygen or heart rate. She acknowledges she did not follow OHPIP standards, and explained the clinic was new and its protocols were evolving. Dr. Teshima described changes to her and the clinic's practice going forward. She apologized for disclosing personal health information without first seeking the patient's permission. She explained the reasons for the delay in sending the pathology results, and apologized for the delay.

3. Committee Process

A Surgical 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

Dr. Teshima's initial choice of undertaking so many procedures at once in a private facility, and on a patient who was at least a moderate risk, reflected poor clinical judgment overall. Dr. Teshima's approach to post-surgical DVT prophylaxis was especially concerning. While there

are variations in guidelines and in practice, in this particular clinical scenario of a patient who was at least at moderate risk for complications, Dr. Teshima should have considered intermittent compression stockings along with pharmaceutical prophylaxis (i.e., anticoagulation via blood thinners) post-operatively.

Nursing staff did not notify Dr. Teshima of the overnight changes in the patient's oxygen levels and heart rate and Dr. Teshima did not learn of this information until she came in and saw the patient early in the morning, on the day after the surgery. However, at that point she should have been very concerned about the "red flags" in the patient's condition overnight, suspected pulmonary emboli, and pursued immediate investigations.

Although Dr. Teshima and the patient's accounts of the discussion vary, there is agreement that a decision was made that the patient's husband would drive the patient to the hospital from the clinic. Dr. Teshima did not act in accordance with the College's *OHPIP Program Standards*, which set out that in most situations of an urgent adverse patient event, transfer to hospital would be by ambulance. Dr. Teshima also acknowledged that she did not send a proper transfer note (although she did telephone the hospital).

In light of Dr. Teshima's apology for breaching patient confidentiality, the Committee took no further action, but given the patient's description of Dr. Teshima's manner in discussing the diagnosis at the time, and the importance of compassion in communicating a potentially very serious complication, the Committee decided to caution Dr. Teshima on this subject.

Dr. Teshima's explanation and apology around not realizing that the pathology results had not been copied to the patient's family doctor were reasonable and the Committee took no further action on that concern.

Overall, given there were several serious deficiencies in this case, in the circumstances the Committee determined that it was appropriate to caution Dr. Teshima and request that she complete a written report, as set out above.