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. Anthony Sze-Leung Tang (CPSO #30099)
(the Respondent)

INTRODUCTION

In July 2016, the late Patient was diagnosed with non-ischemic cardiomyopathy with congestive heart failure following an episode of heart failure and atrial fibrillation. In May 2017, the Patient was referred to the Respondent for consideration of his participation in a research study to use catheter ablation to treat his atrial fibrillation and heart failure. The Respondent saw the Patient in the outpatient department in July 2017. The Patient underwent an echocardiogram to assess his suitability as a candidate for the study. There was no follow-up care after the echocardiogram.

The Patient died in September 2017 after suffering a cardiac arrest at home.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned the Respondent failed to:

- **Properly assess, investigate, refer, diagnose and treat the Patient's atrial fibrillation, resulting in his early demise**
- **Provide follow-up care after the echocardiogram**
- **Return the Patient's calls regarding test results and the treatment plan**
- **Document encounter notes in a timely manner.**

COMMITTEE'S DECISION

An Internal Medicine Panel of the Committee considered this matter at its meeting of July 22. 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his failure to follow up on abnormal test results, communicate adequately with the Patient, and document his care in a timely manner.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in cardiology and internal medicine. The Assessor opined that the Respondent failed to meet

the standard of practice in regard to following up with the Patient regarding a decision about implantable cardiac defibrillator (ICD) or cardiac resynchronization therapy with a defibrillator (CRT-D). The Assessor noted that, despite the delay, the Patient likely was not an appropriate candidate for an ICD or CRT-D, and it is uncertain that it would have prevented his mortality.

Concern that the Respondent failed to provide follow-up care after the echocardiogram

The Respondent recognized that the Patient was quite ill and appropriately ordered the urgent echocardiogram. The test showed significant left ventricular dysfunction.

The Respondent went to the laboratory to speak with the Patient but found that, due likely to a misunderstanding, the Patient had already left the premises. The Respondent acknowledged that he failed to call the Patient to book a follow-up visit to discuss the test results and treatment options. He had no further interaction with the Patient.

It was concerning to the Committee that the Respondent failed to follow up with the Patient after providing appropriate initial care by recognizing the indication for an urgent echocardiogram. The Committee agreed with the Assessor's conclusion that the Respondent fell below the standard in this aspect of his care. The Committee questioned why the Respondent did not call the Patient on the day of the test to say that he had missed him at the laboratory and to describe the plan going forward.

Concern that the Respondent failed to return the Patient's calls regarding test results and the treatment plan

The Committee considered this area of concern to be another illustration of the Complainant's failure to communicate adequately with the Patient. The Respondent should have contacted the Patient on the day of the urgent echocardiogram to "close the loop" on his care, and if he had done so, the Complainant and the Patient would not have had to leave messages to enquire about follow-up plans. The Respondent should also have a system in place in his office to ensure that patients are able to contact him.

Concern that the Respondent failed to document encounter notes in a timely manner

The Respondent dictated his consultation note four months after the encounter with the Patient. The note did not mention that the Respondent had failed to follow up with the Patient after the urgent echocardiogram or that the Patient had died two months earlier.

The Respondent indicated that he delayed completing the note with the intention of providing a more comprehensive and definitive treatment plan after discussion with the Patient. This did

not seem logical to the Committee, as most physicians dictate a consultation note and then complete a follow-up note.

Because the Respondent failed to dictate a consultation note in a timely manner, other health care providers who reviewed the Patient's record did not have access to his clinical opinion that the Patient was very sick. This was another failure on the Respondent's part to close the loop on his care.

The Committee took no further action on the concern that the Respondent failed to properly assess, investigate, refer, diagnose and treat the Patient's atrial fibrillation. The Respondent assessed the Patient and ordered an urgent echocardiogram, after which he was to make a decision about the care plan. The Patient was not eligible for the study and was not a candidate for ablation therapy. He was already on the appropriate drugs for his atrial fibrillation.

On the basis of the above, the Committee decided that a verbal caution was warranted in this matter.