

## **SUMMARY**

### **DR. SIN MING CHIEN (CPSO# 58496)**

#### **1. Disposition**

On February 12, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required respirologist and internist Dr. Chien to appear before a panel of the Committee to be cautioned with respect to his management of a high-risk patient with hematologic illness and the consent process for medical interventions.

#### **2. Introduction**

A family member of the patient complained to the College that Dr. Chien mismanaged the patient who developed a bowel obstruction while very ill with chronic lymphocytic leukemia and awaiting a scheduled bone marrow transplant. In particular, the family had concerns about Dr. Chien's decision to insert an NG (nasogastric) tube given the patient's extremely low platelet count (which led to a severe nose bleed, after which the patient went into cardiac arrest, suffered a loss of oxygen to the brain, and needed to be placed on a ventilator. The family also had concerns about Dr. Chien's professionalism in that they felt Dr. Chien deflected accountability for the patient's hemorrhage to the family, questioning why they did not tell him the patient had blood clotting issues.

Dr. Chien responded that given Mr. Hazelton's abdominal distension and to prevent complications, an NG tube was the only available strategy to relieve Mr. Hazelton's symptoms. Although at no time did the family warn him that the patient was susceptible to bleeding, he was aware of the patient's decreased platelet count but determined to proceed with the tube insertion without transfusion because the patient's situation had become life-threatening and waiting for a transfusion could have caused a significant delay. He noted that, prior to this event, he had never had a patient experience bleeding following insertion of an NG tube.

### **3. Committee Process**

An Internal Medicine 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](http://www.cpso.on.ca), under the heading "Policies & Publications."

### **4. Committee's Analysis**

The Committee noted that the patient was very ill and had an extremely low platelet count. The Committee remarked that Dr. Chien waited several hours to review the patient's abdominal x-rays and diagnose the bowel obstruction.

In the Committee's view, placement of the NG tube was not urgent— it would have been sufficient to keep the patient "NPO" (hold oral intake) and maintain him on intravenous fluids for the night. Insertion of an NG tube can be traumatic, as it was in the patient's case. The Committee questioned Dr. Chien's decision to proceed without ordering a blood transfusion given the patient's platelet count, of which he was aware (regardless of whether he had a discussion with the family about this issue). The Committee felt it should have been obvious to Dr. Chien that the patient had a risk of bleeding. The Committee also had concerns about the lack of documentation for consent to the procedure in the record, and no documentation that Dr. Chien had a discussion of risks of the procedure with the patient or family prior to the procedure.

For these reasons, the Committee decided to caution Dr. Chien as outlined above.