

## SUMMARY

### Dr. Jason Philip Cyriac (CPSO# 70168)

#### 1. Disposition

On December 7, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered Dr. Cyriac (Internal Medicine and Cardiology) to complete a specified continuing education and remediation program (“SCERP”). The SCERP requires Dr. Cyriac to:

- engage in focused educational sessions, in person, with a clinical supervisor acceptable to the College, for a six-month period, to focus on the following deficiencies:
  - Ensuring a comprehensive review of admission orders, in particular when the patient is transferred from another institution
  - Ensuring that progress notes document ongoing patient concerns as well as Dr. Cyriac’s thought process and management plan
  - Appropriately fulfilling the role of most responsible physician (MRP) for patients under Dr. Cyriac’s care suffering from acute illness
  - Ensuring respectful and courteous interactions with patients, their families, and others involved in the provision of health care
  - Acknowledgement and discussion of adverse outcomes with patients or their substitute decision makers
- complete the following courses: Documentation: Charting Medical Records eLearning Module (CMPA) and Documentation II: Principles of Medical Record Keeping eLearning Module (CMPA), and discuss them with his clinical supervisor
- review the College’s Policies on *Medical Records*, *Physician Behaviour in the Professional Environment*, and *Disclosure of Harm* and submit a 2000 word report to the College with reference to current standards of practice, how they are applicable to his situation, and how he has changed his practice
- submit a written summary of the roles and responsibilities as MRP of acutely ill inpatients and, in response to his care in this case, a description of changes the hospital has subsequently made

- approximately six months following the completion of the education outlined above, undergo a reassessment, with an assessor selected by the College.

The Committee also ordered Dr. Cyriac to be cautioned in person with respect to his communications, and his clinical care and record-keeping, which contributed to a lethal medication error in this case.

## 2. Introduction

A patient's family member complained to the College about Dr. Cyriac's behaviour and care during the patient's hospital admission in February 2016. The patient had undergone insertion of a pacemaker and two drug-eluting stents following a heart attack, and was transferred from another hospital into Dr. Cyriac's care. Six days later, the patient experienced a second heart attack as a result of stent thrombosis. Sadly, he passed away the following month (after being discharged home with palliative care services from another hospital, where he had been transferred after his second heart attack).

The patient's family member expressed concern that Dr. Cyriac did not see the patient regularly during his admission and failed to maintain an adequate medical record; that he failed to prescribe Aspirin and Plavix for the patient, which potentially precipitated his second heart attack and contributed to his death; that he behaved in an unprofessional manner and made inappropriate comments; and that he failed to attend to assess the patient when he was experiencing his second heart attack, despite being paged by nursing staff, and inappropriately informed the nursing staff they should "do whatever they wanted".

Dr. Cyriac acknowledged that he did not see the patient daily, as he felt the patient was stable, but stated that he regularly reviewed the medical record and the nursing notes respecting the patient. He also acknowledged that he failed to document his interactions with the patient (after writing his initial consultation note), or his review of the chart. Dr. Cyriac apologized for the medication omission, and acknowledged that it is likely that the stent thrombosis from the missed medications contributed to the patient's final heart attack. He noted that the hospital performed an internal review which concluded that multiple stakeholders were responsible for the oversight and led to recommendations for improvements to guard against similar incidents in the future.

Dr. Cyriac acknowledged the comments set out by the patient's family member, but stated that they were taken out of context. He did express regret for not having had the opportunity to interact more with the family during the patient's admission, which he noted may have contributed to the family's distress.

In terms of the events surrounding the patient's second heart attack, Dr. Cyriac stated that the bedside nurse paged him a number of times, but that the bedside nurse did not characterize the matter as serious or of any particular concern. He therefore voiced his frustration to the nurse. Dr. Cyriac stated that he reminded the nurse about the hospital's escalation policy, which states that when the MRP is not immediately available, the hospital's Rapid Assessment of Critical Events (RACE) team or the on-site on-call cardiologist can and should be notified, and left it to her discretion how to proceed from there.

### 3. Committee Process

A General 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 stated that there is no set standard for the frequency of physician visits to patients in the hospital, but noted that contrary to Dr. Cyriac's assertion, the patient's condition was not stable, as he had just had a recent MI and was hypertensive. The Committee noted that in its experience, in the case of an acutely ill patient (such as the patient in this case), it is necessary for the MRP to see the patient daily, at a minimum. The Committee felt that it was not sufficient for Dr. Cyriac to rely on a review of the medical chart and the nursing notes (which he did not document), rather than personally assessing the patient, and was of the view that this represented unacceptable, superficial care in the circumstances.

The Committee was also concerned by Dr. Cyriac's failure to ensure that the patient was receiving the necessary and important anti-platelet therapy that should have been included in the admission orders when the patient was repatriated from the hospital where he had undergone his pacemaker and stent insertion. While the Committee appreciated that there were systems issues involved in the medication omission in this case, which the hospital has attempted to deal with through the implementation of new recommendations stemming from its internal review, it felt that Dr. Cyriac must also bear some of the responsibility, as the MRP. The Committee noted that if Dr. Cyriac had provided more attentive care to the patient, this might have afforded more of an opportunity to note the medication omission at an earlier time.

In terms of the complaint regarding Dr. Cyriac's manner and communications, the Committee noted that Dr. Cyriac acknowledged the comments attributed to him. The Committee commented that it seemed that, overall, the patient's family was most troubled by the lack of access to Dr. Cyriac to discuss their concerns and the patient's progress and status. The Committee pointed out that Dr. Cyriac acknowledged his minimal interaction with the family when he stated that he regretted not having the opportunity to interact more with them, which may have contributed to their distress.

As for the events surrounding the patient's second heart attack, the Committee noted that it is undisputed that nursing staff paged Dr. Cyriac on several occasions that day with concerns, and that he advised them he was not available to attend. The Committee felt that the detailed nursing notes documented a negative and problematic interaction, which called into question Dr. Cyriac's level of professionalism during these events. They noted that in particular, the nursing notes indicated that Dr. Cyriac was not listening to the nurses, who were concerned about the patient's condition. In the circumstances, the Committee questioned why Dr. Cyriac did not contact the on-call cardiologist to discuss the situation and ensure that the on-call cardiologist assessed the patient.

The Committee noted that although Dr. Cyriac did ultimately meet with the family to discuss the medication oversight and his role in the patient's care, they would have expected him to have taken earlier steps to speak with the patient and his family about what had occurred.

Overall, the Committee was concerned by the number of serious deficiencies evident in Dr. Cyriac's care in this case.