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. Vicky Lee Ng (CPSO #66900)
(the Respondent)

INTRODUCTION

On May 23, 2014, the Patient was admitted to hospital and diagnosed with acute liver failure caused by hemophagocytic lymphohistiocytosis (HLH). The Respondent became involved in the Patient's care as his hepatologist.

The Respondent discharged the Patient on June 16 with a peripherally inserted central catheter (PICC) line in situ. The Patient's condition deteriorated after discharge and he returned to the hospital on June 18, 19 and 20. The hepatologist who saw the Patient on June 18, and the Respondent, who saw him on the other two occasions, assessed him and sent him home.

On the evening of June 21, the Patient collapsed at home and was taken to the emergency room. He was diagnosed with septic shock and admitted to the intensive care unit. Blood cultures revealed a staph infection that was attributed to the PICC line. The Patient died on June 29.

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

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to provide adequate care to the Patient in June 2014. Specifically, the Respondent:

- **Failed to act on the Patient's elevated white blood cell count**
- **Failed to respond to concerns of abdominal pain, decreased mobility, muscle aches and weakness**
- **Falsified the medical record by making late entries and collaborating with the nurse practitioner.**

COMMITTEE'S DECISION

A General Panel of the Committee required the Respondent to attend at the College to be cautioned in person with respect to record keeping and assessment of a patient at high risk for sepsis. The Committee also requested that the Respondent submit a written report with

respect to record keeping and assessment of immunosuppressed patients presenting with signs of infection but no fever.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in paediatric critical care. The Assessor opined that:

- The Respondent's care of the Patient did not meet the standard of practice in that she failed to consider and exclude (via blood culture) new bacterial infection as a possible cause of progressive neutrophilia, and multiple risk factors.

- The Respondent displayed a lack of clinical judgement regarding her assessment of progressive neutrophilia in a systematically unwell, immune-suppressed patient, and a lack of proactive investigation.

- Excluding a critically important aspect of the differential diagnosis, without taking basic steps to rule it out objectively, may expose patients to harm.

Patient Care

- The Respondent knew that the Patient was immunosuppressed and had an indwelling PICC line. As such, she should have been aware that patients who are immunosuppressed may not have typical signs of infection, such as fever. However, it appeared that the Respondent was overly fixated on the Patient's lack of fever and therefore did not appropriately consider that he may have had an infection.

- The Committee was concerned by the Respondent's failure to investigate the Patient for sepsis when she last saw him in follow-up on June 20. The Assessor was also critical of the Respondent's care in this regard and the Committee decided to require her to attend at the College to be cautioned on this aspect of her care.

The Medical Record

- The Respondent did not make contemporaneous entries into the record at the time of the Patient's clinic visits on June 19 and 20. It was not until June 27 that she documented her earlier assessments of the Patient. When the Respondent later discovered that the late notes she had made had disappeared, she recreated them. The Committee nevertheless saw no information to support the concern that the

Respondent falsified the medical record with these late entries or that she collaborated with the nurse practitioner.

- The Committee was concerned, however, that the Respondent failed to make contemporaneous notes of her care of the Patient and decided to caution the Respondent on this issue.

- The Committee also found that the Respondent's documentation indicated that she did a poor assessment of the Patient. She failed to adequately assess his pain, failed to adequately consider the significance of the neutrophilia, and failed to adequately assess his difficulty walking (based on collateral information and subsequent events).

In light of its concerns with the Respondent's assessment and record keeping, the Committee decided that the caution as described above was warranted.