SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)

Information about the complaints process and the Committee is available at: https://www.cpso.on.ca/Public/Services/Complaints

Dr. Patrick Wing Nin Yau (CPSO #66515)

INTRODUCTION

The College's Out of Hospital Premises Inspection Program (OHPIP) received a report indicating that a patient on whom Dr. Yau performed a colonoscopy (the Patient) was transferred to the hospital following the procedure and diagnosed with a bowel perforation. OHPIP informed the College's Investigations and Resolutions department. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Yau's practice.

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of February 22, 2019. The Committee required Dr. Yau to attend at the College to be cautioned in person with respect to the maintenance of appropriate records, and on following College OHPIP Program standards (including the process for urgent transfer of patients after an adverse event) and the Cancer Care Ontario (CCO) guidelines for interval screening; and to complete a specified continuing remediation and education program (SCERP) consisting of:

- successfully complete the University of Toronto Medical Record-Keeping Course, the Canadian Medical Protective Association (CMPA) e-learning modules on medical records; and SAEGIS Successful Patient Interactions
- complete one-to-one instruction in clinical ethics and communications to the satisfaction of the College
- review OHPIP Program Standards, CCO guidelines for colo-rectal screening, College policies on *Medical Records*, and *Physician Behaviour in the Professional Environment,* and the CMPA Good Practices Guide on Communication, and provide a written summary with reference to current standards of practice (where applicable), how it is applicable to Dr. Yau's situation, as well as how Dr. Yau has made---or plans to make---changes to his practice
- a 12 month period of clinical supervision
- a reassessment with an assessor selected by the College approximately six months after completing the education plan.

COMMITTEE'S ANALYSIS

As part of this investigation, the Registrar appointed a medical inspector (the MI) to review a number of Dr. Yau's patient charts, observe Dr. Yau's performance of endoscopic procedures, interview Dr. Yau, and submit a written report to the Committee. The MI concluded that Dr. Yau's care met the standard of practice in the files reviewed; however, the MI noted that Dr. Yau's charting was suboptimal. For example, when polyps were encountered, the operative note did not document the size, exact location or method of excision, which information is important when making recommendations on future screening intervals, and in the case of post-procedure complications. In the case of the Patient, the MI noted that there was no documentation by Dr. Yau after the procedure, and there was no mention of whether Dr. Yau had spoken to anyone at the receiving hospital or why the Patient was sent. The MI also noted that Dr. Yau was not following any screening guidelines to determine when a patient should be brought back for a follow-up colonoscopy. In terms of Dr. Yau's clinical skills, the MI reported that during the observational component of the assessment, Dr. Yau was able to demonstrate adequate proficiency in performing both colonoscopies and gastroscopies.

The Committee expressed concern regarding Dr. Yau's failure to adequately document the procedures he performed, and the fact that when Dr. Yau was notified of post-operative concerns with the Patient, he did not attend to assess the Patient himself, but rather, instructed staff to call 911 to have the Patient transferred to the hospital. While the Committee acknowledged that it was correct in the circumstances to transfer the Patient to the hospital, it was important for Dr. Yau to take the time to assess the Patient himself and fully document his clinical assessment prior to initiating the transfer, which he failed to do. The Committee noted that OHPIP Program Standards require the most responsible physician (MRP), if not accompanying the patient, to contact the receiving physician/premises immediately. No other means of communication will be deemed sufficient." The Committee stated that Dr. Yau clearly failed to comply with his obligations as MRP for the Patient by failing to contact the receiving physician/hospital at the time of the Patient's transfer.

The Committee pointed out that Dr. Yau has a considerable history with the College. It noted that while the majority of the history relates to Dr. Yau's practice in another area (i.e. bariatric surgery), the nature of the issues raised in this investigation (record-keeping, communications, post-operative follow-up) mirror those that have arisen in previous matters addressed by the Committee and are fundamental to all areas of practice. The Committee noted that the MI was not privy to Dr. Yau's history in formulating her opinion regarding his care, and as such, was not aware of the continuous and long-standing nature of the deficiencies she noted in his records and his follow-up care, despite numerous interventions by the College to address such deficiencies.

Based on all of the above, the Committee was of the opinion that the caution and the SCERP were necessary to address the issues raised in this investigation.