SUMMARY

Dr. Yue Yue Olivia Cheng (CPSO# 81193)

1. Disposition

On June 17, 2015, the Inquiries, Complaints and Reports Committee ("the Committee") required orthopaedic surgeon Dr. Cheng to appear before a panel of the Committee to be cautioned with respect to the inappropriateness of attempting an Achilles tendon repair in the face of infection and closing patient's skin as noted in the record under "quite a lot of tension."

2. Introduction

Patient A complained to the College that the care Dr. Cheng provided following surgery for a right heel spur and on the Achilles tendon was inappropriate. Specifically, Dr. Cheng jeopardized Patient A's short and long term health, was uneducated on procedures and wound care, withheld details of the procedures, and angered easily when questioned.

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, as well as College policies and relevant legislation.

4. Committee's Analysis

Dr. Cheng performed surgery on Patient A's Achilles tendon in July 2014.

Patient A experienced a postoperative infection. Surgery in the ankle area is at a higher risk of infection because of relatively poor circulation locally. Dr. Cheng specifically documented in the pre-surgery note and discussion in June 2013 that infection is a possible complication. Though Patient A experienced a postoperative complication this is not an indication that Dr. Cheng performed the initial surgery incorrectly.

In early October 2014, Dr. Cheng performed further surgery (an irrigation and debridement of the previous Achilles tendon surgery complicated by infection) on Patient A. However, in the

Committee's view, Dr. Cheng made a fundamental error in surgical judgement and technique when she decided to close Patient A's wound under tension in the middle of October 2014; closure should not have been attempted given Patient A's wound was infected. This is an egregious error, and fundamental knowledge that every physician learns early in their medical education. The wound required debridement later which suggests Dr. Cheng was not definitive in her wound care; the photographic record also demonstrates incomplete debridement.

Patient A indicates that she did not fully understand the surgical procedures or the condition of the wound. However, Dr. Cheng appropriately documented in the chart that she discussed the procedures with Patient A and had obtained informed consent, and had discussed the wound's condition.

The Committee felt some of the issues in this case appear to be due to inadequate or poor communication on the part of Dr. Cheng. Patient A noted that Dr. Cheng was often rushed in her explanations and did not appear to listen. Dr. Cheng has had prior complaints to the College in which there were concerns about communications. The Committee notes the physicians are expected to be professional and respectful in their communications with patients and suggests that Dr. Cheng consider taking a course to improve her communications. Given these reasons, the Committee decided to caution Dr. Cheng in person.