

**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. Joseph Yao Min Wen (CPSO #74424)
(the Respondent)**

INTRODUCTION

The Respondent performed a small bowel resection for neuroendocrine tumour on the late Patient on March 15, 2021. He also resected some liver metastases during the surgery.

The Patient experienced several post-operative complications, including anastomotic leak, bleeding and abdominal compartment syndrome. The Respondent performed three more surgeries to address these complications. Sadly, the Patient died on March 30.

COMPLAINANT'S CONCERNS

The Complainant is concerned about the care the Respondent provided to his late wife. Specifically (as set out in the Complainant's letter to the College), the Respondent:

- **Failed to refer the Patient to an oncologist despite her request and was never sure whether to get her on chemotherapy or to get her surgery**
- **Failed for a second opinion on the case knowing the risks involved should have been done**
- **Never referred her for an MRI which could have given a better picture on her illness although she had a finding on the liver too**
- **Failed to assess the Patient in person prior to the decision for surgery and discussing why the urgent need of surgery (she was asymptomatic), all normal and doing daily chores of life**
- **Failed to perform a skilled surgery where the joint he made was leaking and all attempts were blamed on the tissues as he delayed and waited for seven days to be aware there was a joint leak**
- **Failed to discuss alternatives to surgery, this the doctor has to argue and say we got the consent form signed by the patient**
- **Failed to adequately discuss the risks and benefits of surgery for informed consent, again the argument that they got the consent signed**
- **Punctured renal vein and blood vessel during the surgery, performed three other surgeries to try and repair without success, total four surgeries performed and failed to keep the Complainant adequately informed of the post-operative complications and situation. The only information the Respondent could get was that he was taking her to the OR [operating room] for the same problem**

again and again.

COMMITTEE'S DECISION

A Surgical Panel of the Committee considered this matter at its meeting of August 20, 2021. The Committee required the Respondent to attend at the College to be cautioned in person with respect to following the guidelines for multidisciplinary cancer conferences (MCC) regarding pre-operative discussion and the importance of comprehensive pre-operative evaluation before complex operations.

COMMITTEE'S ANALYSIS

The Patient was found to have a large duodenal neuroendocrine tumour while she was being worked up for another complaint. She was not experiencing gastrointestinal symptoms. The Patient was morbidly obese and therefore a high-risk surgical candidate. The Respondent booked her for a challenging resection procedure after conducting a telephone consultation. He did not see the Patient in person until the morning of surgery.

It was distressing to the Committee that the Respondent did not present this case at an MCC prior to proceeding with surgery. According to Cancer Care Ontario's MCC guidelines, neuroendocrine tumours should be presented at MCC.

The Patient was asymptomatic, so there was no rush to get her to the OR. Further pre-operative evaluation, such as imaging of the liver, might have provided information about possible metastases and other surgical risks. Presentation to the MCC would have generated a group consensus on treatment recommendations, allowing the Respondent to provide a more accurate assessment to the Patient and family, and thus a more *informed* consent discussion. The Respondent's recommendation might still have been to proceed directly with surgery.

The Committee was troubled by the fact that the Respondent scheduled the Patient for surgery without having physically examined her or even seen her via videoconference. This was an elective operation on an asymptomatic patient, and the Respondent should have delayed until he had seen the Patient, at an absolute minimum, for a videoconference.

The Committee did not accept that there was little point to a physical examination because the Respondent would not have been able to palpate the tumour. Physicians can glean significant information by seeing a patient in person, as well as more easily

impress upon the patient the magnitude of the operation and the risk involved. In addition, it is often easier for the physician to establish rapport with the patient during a face-to-face discussion.

Despite the Respondent's claim that he discussed the resection surgery with the Patient and the Complainant, it was not apparent to the Committee that they understood the high-risk nature of the operation. The Committee could not be certain that the Respondent discussed all of the extensive potential complications with the Patient or the danger of death from this elective procedure for non-symptomatic disease.

The Committee had significant concerns about the Respondent's decision not to follow MCC guidelines regarding pre-operative review and his failure to conduct a comprehensive pre-operative evaluation before a complex surgery. These concerns were heightened by the Respondent's history with the College which included complaints regarding his informed consent process. On this basis, the Committee decided on the disposition set out above.