

## SUMMARY

### DR. TOMMY DANG (CPSO# 72481)

#### 1. Disposition

On September 30, 2015, the Inquiries, Complaints and Reports Committee (“the Committee”) required neurosurgeon Dr. Dang to appear before a panel of the Committee to be cautioned with respect to his failure to ensure pre-operative assessment (including radiological investigations) by appropriate specialists sufficiently ahead of surgery (laminectomy and lumbar decompression), for a high risk patient with known co-morbidities.

The Committee also advised Dr. Dang that he should have been more clear and emphatic about follow-up instructions.

#### 2. Introduction

A family member of a deceased patient complained to the College that Dr. Dang failed to provide adequate care to the patient, in that he:

- failed to assess the patient’s cardiac function prior to surgery, which contributed to his death post-operatively; and
- discharged the patient from hospital too early despite the patient’s valve problem.

Dr. Dang informed the College that the patient was referred to him by a family physician. He described his appointments with the patient and the investigative and treatment steps undertaken. Dr. Dang reported discussing surgical options with the patient, including the surgical risk, in detail. The patient decided to proceed with the surgery and he obtained the patient’s consent.

Dr. Dang informed the College that he made arrangements for pre-operative anesthetic and endocrinology consultations for medical clearance and optimization for surgery. Dr. Dang

stated that as he was not made aware of any major medical concerns, he proceeded with the patient's surgery.

### 3. Committee Process

A panel of the Committee, consisting of public and physician members, including physician members with surgical specialties, met to review the relevant records and documents related to the complaint, as well as College policies and relevant legislation.

### 4. Committee's Analysis

The patient had many co-morbidities, including a previous aortic valve replacement. Dr. Dang, as most responsible physician (MRP), asked an endocrinologist for a consultation to assist with the patient's post-operative diabetes management. The Committee was of the view that this was not a sufficient assessment for this high risk patient, from a cardiac perspective: Dr. Dang should have sought a full consultation from a cardiologist or internal medicine specialist, which would have included appropriate radiological testing.

The Committee expressed its view that in Dr. Dang's role as MRP, he should also have ensured that the patient's pre-operative anesthetic assessment occurred earlier than one day prior to surgery, and he should have looked further into a medical consultation that the anesthesiologist requested, but which was cancelled for reasons and by persons unknown. Dr. Dang's decision to proceed with surgery, without recognizing the gravity of the situation, was very worrying to the Committee.

Finally, the Committee issued advice to Dr. Dang that he should have been more clear and emphatic about follow-up instructions with the patient and family members.

*This summary was amended following an appeal heard by the Health Professions Appeal and Review Board ("HPARB") and a decision by HPARB dated January 26, 2017, and the Committee's consideration of the matter on May 19, 2017.*