

ORIGINAL

BEFORE THE NEVADA STATE BOARD OF OSTEOPATHIC MEDICINE

IN THE MATTER OF THE COMPLAINT

AGAINST

MING-WEI WU, D.O.,

RESPONDENT.

**NV STATE BOARD OF
OSTEOPATHIC MEDICINE**

Case No.: **AP090307**

Filed: **MAR 04 2009**

By: 
FILED
Executive Director

COMPLAINT

Pursuant to the provisions of Chapter 633 of the Nevada Revised Statutes, and by virtue of the authority vested in it by said chapter, the Investigative Board Member of the Nevada State Board of Osteopathic Medicine ("Board"), having a reasonable basis to believe that MING-WEI WU, D.O., hereinafter referred to as "Respondent" or "Dr. Wu," has violated the provisions of said chapter, hereby issues its formal Complaint, stating the Investigative Board Member's charges and allegations, as follows:

I.

General Allegations/Jurisdiction

1. That Respondent is licensed in active status to practice medicine in the state of Nevada, and at all times alleged herein, was so licensed by the Board of Osteopathic Medicine of the State of Nevada pursuant to the provisions of Chapter 633 of the Nevada Revised Statutes.

2. That NRS 633.511(1) provides that unprofessional conduct is a ground for the initiation of disciplinary proceedings by this Board.

3. That NRS 633.511(5) provides that professional incompetence is a ground for the initiation of disciplinary proceedings by this Board.

4. That NRS 633.131(1) defines "Unprofessional conduct," in part, as follows:

- (f) Engaging in any:
 - (1) Professional conduct which is intended to deceive or which the board by regulation has determined is unethical;
 - (2) Medical practice harmful to the public or any conduct detrimental to the public health, safety or morals which does not constitute gross or repeated malpractice or professional incompetence. . . .

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1 11. On March 13, 2006, Dr. Wu performed the following procedures on the patient:
2 diagnostic laparoscope converted to exploratory laparotomy; aorta repair, small bowel repair,
3 appendectomy, and aspiration of right ovarian cyst. He noted in his operative report that the
4 patient's condition was stable and indicated complications of "aorta and small bowel injury"
5 and such is consistent with the operative report of Dr. Cottrell.

6 12. More specifically, Dr. Wu stated in his operative report of March 13, 2006, as
7 following concerning the aorta and small bowel injury: A "10 mm trocar was introduced in the
8 subumbilical midline fascia however the gas valve was not sealed, so as the trocar was
9 entering the abdomen, there was an air leak and as the 10 mm trocar was introduced, there
10 was a small bowel and aorta injury, approximately at the IMA region."

11 13. The operative report of Dr. Cottrell of March 13, 2006, indicated that during Dr.
12 Wu's operation on the patient, "the patient developed massive bleeding and an intraoperative
13 consultation was called. I was in the operating room preparing for an anterior exposure of the
14 spine and went to the operating room to assist with a patient in extremis. After scrubbing,
15 intraoperative evaluation revealed a retroperitoneal injury in the region of the distal aorta." "[A]
16 vascular clamp was placed on the distal aorta above the perforation as well as the iliac artery
17 vessel loops were cinched up. This controlled and there was some back-bleeding through the
18 lumbar's." Dr. Cottrell also noted that a "bowel perforation was encountered and was repaired
19 by the surgeon," i.e., Dr. Cottrell. Dr. Cottrell additionally noted that "[f]urther exploration
20 revealed no ruptured appendix although the appendix was removed by the primary surgeon
21 and the right ovary had a large cystic structure. The aorta was reinspected, was thoroughly
22 irrigated, was hemostatic. There was a small bleeder from a lumbar which was oversewn
23 using 4-0 Prolene." Dr. Cottrell noted that at that point, the primary surgeon, Dr. Wu, indicated
24 "he had good control" over the situation and Dr. Cottrell "left the room and left the closure to
25 the other surgeon."

26 14. The CT scan of the patient's abdomen and pelvis with contrast taken on March 18,
27 2006, provided the following as the impression: "moderate amount of mixed density within the
28 retroperitoneum extending anterior to the aorta and psoas muscles, located at the level of the

1 kidneys and extending into the upper pelvis. This could represent inflammatory change or
2 phlegmon due to the recent episode of appendicitis. Retroperitoneum hemorrhage can also
3 present with this appearance. Complex fluid collection suspected within the upper pelvis
4 possibly postop collection such as seroma or hematoma. Generalized ileus. Midline surgical
5 incision with suspected ventral wall hernia inferiorly. Bilateral lower lobe atelectasis with small
6 bilateral pleural effusions.”

7 15. A chest x-ray taken of the patient on March 14, 2006, indicated that the
8 endotracheal tube had been advanced into the proximal right main stem brochus and that it
9 should be pulled back by 4 cm, with a note that the floor nurse should be notified “right away.”
10 The patient developed pneumonia pursuant to a chest x-ray on March 20, 2006.

11 16. The discharge summary of May 15, 2006, indicated that the patient “had an
12 appendectomy, but the procedure was complicated by a ruptured aorta and the small bowel.
13 After the procedure, she was sent to the ICU intubated. She was extubated the following
14 day.” It was noted that her “vascular condition remained stable.” The patient was discharged
15 on March 24, 2006. The discharge summary was prepared by Dr. Julie Wu and was dictated
16 on May 15, 2006. Dr. Julie Wu indicated that the patient was to return to her for additional
17 surgery.

18 17. Because of Respondent’s failure to properly treat the Patient at issue herein, by
19 rupturing the aorta as well as perforating the small bowel during an appendectomy, and/or
20 implement appropriate and established medical procedures with respect to the treatment of
21 Patient N.C., Respondent has violated NRS 633.041, gross negligence, and in particular
22 Subsection 3, willful disregard of established medical procedures.

23 18. Because of Respondent’s failure to properly treat the Patient at issue herein, by
24 rupturing the aorta as well as perforating the small bowel during an appendectomy, and/or
25 implement appropriate and established medical procedures with respect to the treatment of
26 Patient N.C., Respondent has violated NRS 633.111, professional incompetence, and in
27 particular Subsection 1 thereof, i.e., apparent lack of knowledge and/or training.

28

1 **III.**

2 **UNPROFESSIONAL CONDUCT**

3 19. The allegations contained in paragraphs 1 through 7 of Section I, General
4 Allegations, and Paragraphs 8 through 18, Count I pertaining to Patient N.C.'s care and
5 treatment, inclusive, of this Complaint are incorporated herein by reference, as though each
6 such allegation was more specifically set forth in full herein.

7 20. With respect to the treatment rendered by Respondent to the Patient at issue in
8 this matter, said Respondent has failed to exhibit the professional competency required of an
9 osteopathic physician and has failed to safely and skillfully practice osteopathic medicine in
10 this community. NRS 633.111.

11 21. Pursuant to NRS 633.131(1)(f), discipline is warranted as the medical care
12 rendered to the Patient at issue in this matter by Dr. Wu did not rise to the appropriate
13 standard and/or established medical procedures, and such medical practice was harmful and
14 detrimental to the public and its safety, especially to the Patient at issue in this matter.

15 **IV.**

16 **UNETHICAL CONDUCT**

17 22. The allegations contained in paragraphs 1 through 7 of Section I, General
18 Allegations; Paragraphs 8 through 18 of Count I pertaining to the Patient's care and treatment;
19 Paragraphs 19 through 21 of Count III, Unprofessional Conduct, all inclusive, of this complaint
20 are incorporated herein by reference, as though each such allegation was more specifically
21 set forth in full herein.

22 23. With respect to the treatment rendered to the Patient at issue in this matter,
23 rendered by Respondent, Respondent has engaged in conduct that constitutes an unfitness to
24 practice osteopathic medicine in this community. NAC 633.350(9).

25 **V.**

26 **SUMMARY SUSPENSION**

27 24. The allegations set forth in paragraphs 1 through 23 of the foregoing complaint are
28 incorporated herein as if they were repeated more fully in this Section.

1 and costs of the investigation and the administrative and disciplinary proceedings;

2 4. That the Board immediately conduct a summary suspension hearing concerning
3 Respondents and summarily suspend his license to practice osteopathic medicine in the State
4 of Nevada until a formal administrative hearing can be held; and

5 5. For such other and further relief that the Board deems appropriate under the
6 circumstances of this case.

7 DATED this 3 day of March, 2009.

8 NEVADA STATE BOARD OF
9 OSEOPATHIC MEDICINE

10 By: 

DANIEL CURTIS, D.O.,
Investigating Member of the
Nevada Board of Osteopathic Medicine

13 Submitted by:
14 CATHERINE COREZ MASTO
Attorney General

15 By: 

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