

## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Wee Lim Sim, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the witnesses or any information that could disclose the identity of the witnesses under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

Every person who contravenes an order made under ... section 45 or 47... is guilty of an offence and on conviction is liable,

- (a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or
- (b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v.  
Sim, 2015 ONCPSD 28**

**THE DISCIPLINE COMMITTEE OF THE COLLEGE  
OF PHYSICIANS AND SURGEONS OF ONTARIO**

**IN THE MATTER OF** a Hearing directed  
by the Inquiries, Complaints and Reports Committee of  
the College of Physicians and Surgeons of Ontario  
pursuant to Section 26(1) of the **Health Professions Procedural Code**  
being Schedule 2 of the ***Regulated Health Professions Act, 1991***,  
S.O. 1991, c. 18, as amended.

**B E T W E E N:**

**THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. WEE LIM SIM**

**PANEL MEMBERS:**

**DR. J. WATTS (CHAIR)  
D. DOHERTY  
DR. P. POLDRE  
J. LANGS  
DR. R. SHEPPARD**

**Hearing Date:** June 2, 2015  
**Decision Date:** June 2, 2015  
**Release of Written Reasons:** July 16, 2015

**PUBLICATION BAN**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 2, 2015. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Sim committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has failed to maintain the standard of practice of the profession; and
2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Sim is incompetent as defined by subsection 52(1) of the Code.

### **RESPONSE TO THE ALLEGATIONS**

Dr. Sim admitted the first and second allegations in the Notice of Hearing, that he failed to maintain the standard of practice of the profession and that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the allegation of incompetence in the Notice of Hearing.

### **THE FACTS**

The following facts were set out in an Agreed Statement of Facts and Admission that was filed as an exhibit (Exhibit 2) and presented to the Committee:

## **PART I - FACTS**

1. Dr. Sim is a specialist in Obstetrics and Gynecology who received his certificate of registration to practice in Ontario in 1974.

### ***The October 2012 Complaint***

2. On or about October 25, 2012, the College of Physicians and Surgeons of Ontario (the “College”) received a letter of complaint from Patient A expressing concerns about the sanitary conditions of Dr. Sim’s office, as well with him pressuring her to have an endometrial biopsy in the office for \$20 when she advised that she wished to have it performed elsewhere.
3. On or about February 7, 2014, the College received a report from a Medical Inspector in relation to Patient A’s complaint. The opinion provider concluded that the main problem in relation to the issues raised in the complaint was a “lack of proper communication”. The Medical Inspector concluded that Dr. Sim “showed a lack of judgement in that he did not refer [Patient A] to another obstetrician/gynecologist for a second opinion concerning her endometrial biopsy and whether it should be performed in an office setting or in a hospital with a hysteroscopy and D &C.” This report is attached at Tab 1 to the Agreed Statement of Facts and Admission.

### ***The 2011 Out of Hospital Premises Inspection Report and April 2012 Inquiries, Complaints and Reports Committee Decision***

4. In May 2011, the clinic at which Dr. Sim engaged in a therapeutic abortion practice was inspected by the Premises Inspection Committee and received a “fail”. Accordingly, Dr. Sim was prohibited from performing any “procedures”, as defined in Section 44(1) of O.Reg.114/94 made under the *Medicine Act, 1991*, including therapeutic abortions, at his clinic. Among the reasons cited in the report for the “fail” was the clinic’s non-compliance with infection control standards set by the Out of Hospital Premises Standards.

5. As a result of its conclusions, the Premises Inspection Committee brought concerns to the attention of the College's Registrar regarding the standard of patient care, infection control and the overall function of the premises in relation to Dr. Sim's abortion practice. Following an investigation, the Inquiries, Complaints and Reports Committee ("ICRC") issued a decision. The ICRC agreed that Dr. Sim should undertake in writing to undergo a re-inspection of his practice, as well as a reassessment regarding record keeping and documentation. Additionally, the ICRC counseled Dr. Sim to ensure he practiced within his scope of practice.
6. On or about May 9, 2013, in accordance with terms set out in the May 9, 2012 undertaking, College compliance monitors attended at Dr. Sim's office to conduct an "infection control inspection of the office premises." Also in accordance with May 9, 2012 undertaking, a reassessment of Dr. Sim's practice took place in the summer of 2013.
7. The results of the re-assessment and infection control inspection led the Inquiries, Complaints and Reports Committee to commence a section 75(1)(a) investigation of Dr. Sim's practice in August, 2013.

***The 2013 Section 75(a) Investigation of Dr. Sim's Practice***

8. During the section 75(a) investigation of Dr. Sim's practice, the College engaged in an unannounced inspection of Dr. Sim's office on November 12, 2013.
9. As a result of this inspection, Dr. Sim agreed, among other things, to no longer perform any aspect of a surgical termination including the removal of retained products of conception following a failed medical abortion.
10. On or about January 2, 2014, the College received a report prepared by a Medical Inspector retained to investigate infection control issues pertaining to Dr. Sim. The Medical Inspector found that Dr. Sim did not meet the standard of practice in

infection control practices and instrument reprocessing. Additionally, she found that Dr. Sim's infection control and reprocessing practices may put patients at *significant* risk for harm in terms of transmission of infectious microorganisms, including antibiotic-resistant organisms and blood borne pathogens. A copy of this report is attached at Tab 2 to the Agreed Statement of Facts and Admission.

11. On or about July 9, 2013, July 10, 2013, December 4, 2013, January 22, 2014, February 7, 2014, March 14, 2014, and November 17, 2014, the College received reports from another Medical Inspector who was retained to opine on Dr. Sim's obstetrical and gynecological practice. The Medical Inspector found that Dr. Sim's practice did not meet the standard of care for the practice of the profession, and that he is still performing surgical procedures that should not be performed in an office setting. He found that Dr. Sim's "practice of medically induced therapeutic abortions is of harm and danger to the patients because he converts many of these into surgical abortions if they do not succeed initially" and "[f]or this reason, [that] Dr. Sim should cease from performing medical or surgical therapeutic abortions in an office setting." These reports are attached at Tab 3 to the Agreed Statement of Facts and Admission.

***The 2014 Practice Restriction***

12. Since May 21, 2014, the following is imposed as a term, condition and limitation on Dr. Sim's certificate of registration in accordance with an undertaking signed by him, in lieu of a section 37 order: Dr. Sim shall not perform any surgical or medical abortions and shall not engage in any aspect of surgical or medical abortions. All patients seeking termination of pregnancy shall be referred to another physician or facility where Dr. Sim does not practice. This undertaking is attached at Tab 4 to the Agreed Statement of Facts and Admission.

## **PART II - ADMISSION**

13. Dr. Sim admits the facts contained in paragraphs 1-12 of the Agreed Statement of Facts and agrees that he engaged in professional misconduct by:

- (a) Failing to maintain the standard of practice of the profession in his care of 24 patients, and in his infection control practices and instrument reprocessing;
- (b) Engaging in acts or omissions relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, including:
  - Inadequate supervision of members of his staff;
  - Improper delegation of responsibilities to his staff;
  - Inappropriate electronic communications with patients;
  - Inappropriate billing to the Ontario Health Insurance Plan;
  - and
- (c) Engaging in disgraceful, dishonourable or unprofessional conduct in his failure to refer Patient A for a second opinion.

## **FINDINGS**

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Sim's admission and found that he committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession and that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

## **PENALTY AND REASONS FOR PENALTY AND COST ORDER**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee was informed that Dr. Sim had signed an Undertaking to resign from the College effective June 30, 2015, and never reapply to practise medicine in Ontario. The Undertaking was entered into evidence (Exhibit 3). In the meantime, Dr. Sim remains bound by an earlier Undertaking, signed May 21, 2015, which requires him, amongst other things, to not perform any surgical or medical abortions and to refer all patients seeking termination of pregnancy to another physician or facility.

The Committee is aware that a joint submission should be accepted unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute. The Committee must also be satisfied that the principles governing the determination of an appropriate penalty have been properly applied. These principles are the protection of the public; the maintenance of public confidence in the ability of the profession to regulate itself in the public interest; denunciation of the misconduct; specific deterrence as it applies to the member; general deterrence as it applies to the membership as a whole; and, where appropriate, the potential for rehabilitation of the member.

The Committee considered the submissions of counsel for the College and counsel for Dr. Sim in relation to the proposed penalty. The Committee also reviewed two previous decisions of the Discipline Committee of the College of Physicians and Surgeons of Ontario pertaining to cases which bore some similarities to this case. The Committee is aware that, although previous decisions in similar cases are not binding, similar cases should generally be dealt with in a similar fashion.

The Committee also carefully considered the Agreed Statement of Facts and Admission on which the finding of professional misconduct is based.

The Committee is appalled by the conduct of Dr. Sim. The facts establish a pattern of glaring deficiencies in his practice, insensitivity to the interests of his patients, lack of knowledge in critical areas, and impaired judgment; the effect was to place his patients at serious risk of harm. Although the evidence before the Committee does not establish that



any of Dr. Sim's patients suffered actual physical harm as a result of his treatment, the risk of harm was significant.

In particular, the Committee considered the following:

- Dr. Sim fell below the standard of practice in both infection control and instrument reprocessing procedures. His hand hygiene was inadequate, the white coat which he wore while performing procedures was an infection control hazard, and his sterile gloves were ten years past expiry. The individuals in his office to whom he had delegated instrument reprocessing were neither properly trained in this area nor aware of best practices. His instrument cleaning and sterilization were inadequate. Reprocessed instruments inspected were found to have visible rust and/or debris on them. This created another infection control hazard, to which Dr. Sim and his staff appeared to have been oblivious.

The result of Dr. Sim's practice deficiencies in this area placed his patients at risk of exposure to blood-borne pathogens and antibiotic-resistant organisms.

- Dr. Sim's record keeping was totally inadequate. His notes were sketchy, disorganized, and hard to follow. A clear management plan was often not apparent. Documentation of the procedures which Dr. Sim was performing in his office was very poor. There was often no documentation that he had discussed the risks of these procedures with his patients. In several instances there was no notation whatsoever in the patient charts to correspond to OHIP billings for the services rendered. Dr. Sim's record keeping did not meet the standard of practice.
- Dr. Sim's practice of communicating with his patients by email demonstrates poor judgment. Miscommunication arising from this practice led, in the case of Patient A, to confusion and acrimony which prompted the patient to complain to the College. This could have been avoided with face-to-face communication. More concerning is Dr. Sim's habit of emailing the results of tests and investigations to his patients. This

impersonal method of communication is inadequate under the circumstances; Dr. Sim's patients would usually not be in a position to understand or interpret the significance of information communicated in this way.

- Dr. Sim was exposing his patients to unacceptable levels of risk by performing quasi-surgical abortions in his office, without emergency measures available in case of complications. Dr. Sim's practice had earlier been restricted to medical, and not surgical, abortions. Yet by the way in which he performed these "medical" procedures, specifically through the use of laminaria tents and Pratt dilators followed in some cases by suction and/or forceps evacuation of the contents of the uterine cavity, these were in effect surgical procedures. Dr. Sim's office had neither resuscitation equipment nor staff to assist with resuscitation, which would be required in the case of catastrophic complication such as uterine perforation or major hemorrhage. The type of anesthesia which Dr. Sim was using was inadequate for a surgical abortion. Monitoring equipment for patients under sedation was similarly inadequate. Dr. Sim's judgment in persisting with these procedures was seriously flawed; he should have recognized the risks to which he was exposing his patients, and referred them to a hospital or clinic setting where proper anesthesia and resuscitation capacity was available.
- Following procedures in his office, Dr. Sim was on occasion sending his patients home, on their own, in a taxi after having given them sedatives and narcotic analgesics. This is an unsafe practice and is another example of Dr. Sim having exposed his patients to potential harm. He should have taken steps to ensure that adequate supports were available to his patients under these circumstances.
- Dr. Sim's practice of providing his patients with written instructions that they remain quiet during procedures, under threat of having the procedure cancelled and being required to see another doctor, displays an egregious lack of sensitivity and, again, very poor judgment.

In summary, the Committee finds that Dr. Sim's failings were numerous. A common theme emerges; he was continuously placing his patients at risk of harm through his failure to meet the standard of care in multiple areas. He was, further, unaware of and/or unconcerned with his lack of knowledge with respect to important issues, his practice deficiencies, and his insensitivity and lack of judgment in his interactions with his patients. Dr. Sim's failures are further aggravated by the particular vulnerabilities of his patients, especially in times of emotional distress pertaining to issues of pregnancy termination.

The protection of the public is the paramount consideration of the Committee in its determination of the appropriate penalty. The Committee finds that, in light of the multiple ways in which Dr. Sim was placing his patients at risk, he cannot be permitted to continue to practise. The joint submission advocated by counsel for the College and counsel for Dr. Sim, whereby Dr. Sim has resigned from the College and undertaken never to reapply, is acceptable to the Committee for this reason. Had Dr. Sim not agreed to resign, based on the facts before the Committee, a very strong case could have been made that his certificate of registration should be revoked.

The Committee considered the two recent decisions of the Discipline Committee which were submitted by counsel; *CPSO v. Dr. Michel Prévost* and *CPSO v. Dr. Christiane Farazli*. In both of these cases, following findings of serious professional misconduct admitted by the physician, the respective panels accepted a joint submission which allowed the physician to resign and to undertake not to reapply to the College, in circumstances which otherwise would probably have resulted in revocation of the physician's certificate of registration. Although the factual findings in these earlier cases differ to some extent, the need to protect the public from physicians who expose their patients to the risk of harm is the crucial similarity between these cases and that of Dr. Sim. The Committee finds that the joint submission on penalty proposed by counsel for the College and counsel for Dr. Sim is consistent with these previous decisions.

The Committee is also satisfied that the goals of maintenance of public confidence in the ability of the profession to regulate itself, denunciation of the misconduct, and general deterrence will be satisfied by the proposed penalty. Neither specific deterrence as it applies to Dr. Sim, nor any possible potential for remediation or rehabilitation, apply under the circumstances.

The evidence before the Committee discloses that, as of December 2013, Dr. Sim was practising gynecology in Montreal two days per week. The Committee is aware that the College of Physicians and Surgeons of Ontario has no authority over the practice of physicians in other jurisdictions. Current policies of the provincial regulatory bodies ensure, however, that this decision of the Discipline Committee of the College of Physicians and Surgeons of Ontario will be communicated to other jurisdictions where Dr. Sim might be continuing to practise. It then becomes the responsibility of the regulatory authority in Quebec, or elsewhere, to investigate further if necessary.

In light of the finding of professional misconduct, the Committee is of the view that this is a suitable case in which to order Dr. Sim to pay costs to the College, at the usual tariff rate, in the amount of \$4,460.00 for one hearing day.

## **ORDER**

Therefore, having stated the findings in paragraph 1 of its written order of June 2, 2015 that Dr. Sim committed acts of professional misconduct, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Sim to appear before the panel to be reprimanded, with the fact of the reprimand to be recorded on the Register.
3. Dr. Sim to pay costs to the College in the amount of \$4,460.00 by June 30, 2015.

At the conclusion of the hearing, Dr. Sim waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v.  
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**B E T W E E N:**

**THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. WEE LIM SIM**

**PANEL MEMBERS:**

**DR. J. WATTS (CHAIR)**  
**D. DOHERTY**  
**DR. P. POLDRE**  
**J. LANGS**  
**DR. R. SHEPPARD**

<b>Hearing Date:</b>	June 2, 2015
<b>Decision Date:</b>	June 2, 2015
<b>Reprimand Date:</b>	June 2, 2015
<b>Release of Written Reasons:</b>	July 16, 2015

**PUBLICATION BAN**

**TEXT of PUBLIC REPRIMAND**  
**Delivered June 2, 2015**  
**in the case of the**  
**COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**  
**and**  
**DR. WEE LIM SIM**

Dr. Sim, it's always disheartening to see a physician appearing before this Committee at the end of a valued career. Especially so when that career has been in an area that has provided controversy, conflict, and even threats of harm to its practitioners, like yourself, and which has provided help for women at a time when they are extremely vulnerable and in distressing circumstances.

It is therefore with extreme concern and distress that we view your widespread practice failures of infection control and prevention of infection, lack of even the most basic standards of decontamination, sterilization, and cleanliness. These are derelictions that put these already distressed and vulnerable patients at significant risk of personal harm.

Furthermore, we roundly condemn your insensitive approach to communication, impersonal communication by email, your failure to understand the physical and vocal responses and needs, again, of this vulnerable, sensitive and distressed population. There is no doubt that this penalty, equivalent to revocation, is the only penalty to truly ensure that the administration of justice is upheld.

That is all. You may return.

Copies of the reprimand will be made available if necessary. If there is no further business, the Committee will retire.