

Indexed as: Lau, A. (Re)

**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. ALVIN WAH WING LAU

PANEL MEMBERS:

**S. DAVIS (Chair)
DR. S. KAPOOR
S. BERI
DR. R. MACKENZIE
DR. D. WALKER**

Hearing Date:	December 2, 2013
Finding Decision Date:	December 2, 2013
Penalty Decision Date:	February 5, 2014
Release of Written Reasons:	February 5, 2014

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 December 2, 2013. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and reserved its decision on penalty.

THE ALLEGATIONS

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

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has engaged in conduct or 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;

RESPONSE TO THE ALLEGATIONS

Dr. Lau admitted the allegation of professional misconduct in the Notice of Hearing that he has engaged in conduct or 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 FACTS

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

1. Dr. Alvin Wah Wing Lau (“Dr. Lau”) is 37 years old. He graduated from the University of Toronto Medical School in 2003. Thereafter, he completed two years of post-graduate training in family medicine at McMaster University. He received his designation as a specialist in family medicine from the College of Family Physicians of Canada on June 15, 2005, and has maintained that designation since that time.

The Discipline Order

2. On August 21, 2007, the Discipline Committee of the College found that Dr. Lau had committed an act of professional misconduct and failed to maintain the standard of practice of the profession, in that he failed to conduct a physical examination of four obstetrical patients and did not take a history of three of those patients, but noted on the patient record that he had done so. A copy of the Discipline Committee's Decision and Reasons for Decision dated August 21, 2007 is included at Appendix 1 [to the Agreed Statement of Facts and Admission].
3. The Discipline Committee ordered, among other things, that Dr. Lau's certificate of registration be suspended for 12 months (4 months of which suspension would itself be suspended if Dr. Lau completed College-approved courses in Ethics and Communications Skills) and that terms, conditions and limitations be placed upon Dr. Lau's certificate of registration. A copy of the Order of the Discipline Committee is attached at Appendix 2 [to the Agreed Statement of Facts and Admission]. Among the terms imposed upon Dr. Lau's certificate of registration are that:
 - a. Dr. Lau, at his own expense, shall cause a monitor to be present during his appointments with all patients at his office practice and walk-in clinic;
 - b. That monitor shall be a member of a health profession pursuant to the terms of the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18 as amended who is acceptable to the College of Physicians and Surgeons;
 - c. That monitor shall review each of Dr. Lau's chart entries to ensure that they accurately represent the appointment proceedings and will countersign the entry with Dr. Lau; and
 - d. At all times, Dr. Lau shall ensure that the monitor keeps a log of each patient seen. The log shall contain the name of the patient and the date of the encounter.
4. The terms also require that Dr. Lau shall cause a member of the College of Physicians and Surgeons who is acceptable to the College to review his patients' charts

and provide a monthly update on Dr. Lau's charts and the appropriateness of the care provided to Dr. Lau's patients. That monitoring is conducted by Dr. X. Dr. Y also provides monitoring while Dr. X is away.

Dr. Lau's Practice at the Clinic

5. Dr. Lau has practiced at the Rapids Family Health Team (the "Clinic") in Sarnia, Ontario since May 2008. The Clinic includes a team of three physicians, including other male physicians, and other health professionals, including registered nurses and registered practical nurses, who serve as Dr. Lau's monitors. There is one registered practical nurse assigned as the principal monitor for Dr. Lau (who works with him on a daily basis), who is female.

Incidents Giving Rise to the Allegations of Professional Misconduct

6. On June 4, 2012, two College investigators attended at the Clinic, for the purpose of reviewing randomly selected charts of Dr. Lau's patients, to assess compliance with the Order. Dr. Lau offered to assist the College with the review.

7. The College investigators reviewed 30 randomly selected records, all of which had been co-signed by an authorized nurse monitor.

8. In the course of an interview with College investigators, Dr. Lau's principal nurse monitor stated that there had been instances where patients being seen by Dr. Lau specifically requested that she not be present for the appointment. She stated that these are almost always male patients who wish to discuss sexual health issues such as erectile dysfunction. She stated that Dr. Lau would not say anything and she would leave the room in response to the request. She would then review Dr. Lau's notes after the appointment and co-sign them.

9. In the course of an interview with College investigators, Dr. Lau confirmed to College investigators that there had been prior instances where male patients had specifically asked that the female monitor not be present for the appointment and the monitor left the room in response to the requests. He stated that these situations occurred

rarely, with male patients who had come to speak about erectile dysfunction or other sensitive issues (such as sexually transmitted diseases, hemorrhoids, or other problems pertaining to their genitalia). Dr. Lau stated that he was concerned in these circumstances that he may not be able to obtain a full history, or the male patient may not seek treatment, if the female monitor remained in the room, and therefore he acceded to the patients' requests.

10. In response to the College investigator's request for further information, Dr. Lau subsequently provided the following additional information to the College:

- a. The process through which patients are seen in his office is that the nurse monitor will bring the patient back to the assessment room to take his or her history and conduct a brief assessment. In all instances, the nurse monitor had preliminary contact with the patient before the patient requested a private discussion with Dr. Lau;
- b. Although he could not provide a precise number of instances in which the nurse monitor was not present for the appointment, he believed that it was perhaps in the range of 10 patients a year or less; and
- c. He gave some consideration to having a male staff member present, but there are no male nurses working at the Clinic.

Admission

11. Dr. Lau admits that:

- a. he did not seek guidance or advice from the College regarding compliance with the Order of the Discipline Committee where a patient requested that the monitor not be present; and
- b. he did not apply to vary the terms of the Order of the Discipline Committee to address situations where a patient requested that the monitor not be present.

12. Dr. Lau admits that he failed to comply with the terms, conditions and limitations imposed by the Discipline Committee on his certificate of registration on August 21, 2007, in that he permitted the monitor to be absent from the room in response to specific patient requests, as described above. Dr. Lau admits that such conduct was unprofessional and thereby constitutes an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional by members of the profession, under paragraph 1(1)33 of Ontario Regulation 856/93. The parties agree that the conduct should be characterized as “unprofessional” for the purposes of paragraph 1(1)33 of Ontario Regulation 856/93.

FINDING

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. Lau’s admission and found that he committed an act of professional misconduct, in that he has engaged in conduct or 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

A further Agreed Statement of Facts was filed as an exhibit at the penalty phase of the hearing. It established the following facts:

1. On June 25, 2012, the College investigator wrote to Dr. Lau through counsel, requesting additional information from Dr. Lau.
2. Dr. Lau responded to the investigator’s questions by way of letter dated July 24, 2012.
3. Dr. Lau provided information consistent with that contained in the Agreed Statement of Facts filed during the liability hearing (the “ASF”).

4. In addition, Dr. Lau apologized to the College for not having sought specific advice from the College regarding the best way to deal with situations where male patients had requested that the nurse monitor be absent (as described in the ASF).

5. Dr. Lau also wrote that he would do whatever the College directed with respect to these situations, and that he would be grateful for the College's guidance as to how best to deal with these situations. He offered to meet directly with the Inquiries, Complaints and Reports Committee to discuss this issue further and attempt to arrive at a solution.

Counsel for the College and counsel for Dr. Lau did not agree on an appropriate penalty and did not make a joint submission on penalty. They did express agreement with the general principles to be applied in considering penalty, those being the need for public protection, general and specific deterrence, public confidence in the profession and its self-regulation, remediation and rehabilitation of the member. The parties each made submissions on what the appropriate penalty and costs order should be in the circumstances of this case.

Counsel for the College proposed that the penalty and costs order should be:

- a Reprimand
- suspension of the member's certificate of registration for three months
- continuation of the terms, conditions and limitations as described in the order of the Discipline Committee on August 21, 2007
- the posting of a sign in each clinic room where Dr. Lau sees patients stating, "Dr. Lau sees all patients in the presence of a practice monitor"; and
- payment by Dr. Lau of costs in the amount of \$4,460.

Counsel for Dr. Lau proposed that the penalty and costs order should be:

- a Reprimand
- payment by Dr. Lau of costs in the amount of \$4,460

The College's Position

Counsel for the College reviewed in her submissions the Agreed Statement of Facts and Admission and the misconduct of Dr. Lau that led to the August 2007 finding of the Discipline Committee. She referred to the expert's reports in the 2007 hearing that stated that Dr. Lau had exposed patients to risk of harm and injury. Counsel pointed out that the Discipline Committee had imposed a very significant sanction (a twelve month suspension, reduced to eight months if various conditions were met, and a strict monitoring regime with variance possible only after five years, conditional on a satisfactory practice assessment).

College counsel argued that the breach of these conditions was not minor and that it challenged the integrity of self-governance. She argued that members practising with terms, limitations and conditions imposed by the Discipline Committee may not vary them of their own accord to suit their own convenience. Counsel argued that there had been a deliberate contravention of an order, that Dr. Lau was fully aware of the purpose of the monitoring, and that the breach showed lack of respect for the authority of the College.

College counsel suggested that Dr. Lau had had alternative options. He could have called the Physician Advisory Service at the College. He could have completed the practice assessment required before applying to the Discipline Committee for a variance of the conditions. He could have referred those patients who did not wish the practice monitor in the room to another physician.

Counsel argued that the penalty to be imposed should reflect the seriousness of this breach of a condition carefully constructed by the Discipline Committee to address Dr. Lau's previous misconduct.

Dr. Lau's Position

Counsel for Dr. Lau argued that on a scale of seriousness the admitted breach was at the less serious end of the scale. He argued that Dr. Lau did not flout or disregard the conditions, but rather was respecting the wishes of a small number of male patients who

felt uncomfortable addressing their concerns in front of a female nurse. He argued that Dr. Lau had complied with all the conditions apart from these rare exceptions. He further pointed out that the monitor was present with all patients up until their request that she leave and then continued her monitoring of charting immediately after the examination was concluded. There was no suggestion from monitors that any chart entries had been inaccurate. Counsel further argued that there was no harm to patients alleged or found. He also stated that there had been no adverse reports or suggestions of inappropriate practice from practice monitors or assessing physicians over the course of over five years of monitoring.

Dr. Lau's counsel argued that deviations from the undertaking were rare, at most about ten patients per year, and that there was no evidence to contradict Dr. Lau's position (as seen in his nurse monitor's letter to the College) that these were "unusual circumstances". He pointed out that they were generated by specific patient requests in special and sensitive circumstances, not by the personal motivation of Dr. Lau, and that Dr. Lau had acceded to these requests in his patients', not his, interests.

Principles in Establishing the Penalty

In its consideration of an appropriate penalty, the Committee did so in contemplation of the following principles:

Protection of the Public

No evidence was led that Dr. Lau's breach of the conditions posed or caused a risk of harm to his patients or the public. The requirement for a monitor to be present during patient interactions was to ensure congruence between examinations performed by the doctor and the chart, not because of any egregious or abusive behaviour. The Committee noted that these conditions were stringent, comprehensive and of significant duration, and that other than the specific breach in question, had been complied with.

The Committee noted that Dr. X, the College member authorized to review all of Dr. Lau's charts for appropriateness of care on a daily basis for five years, stated in a supporting letter that "Dr. Lau has more than fulfilled his requirements for the College. I

have no concerns about his practice and believe that further monitoring of his practice is neither necessary nor appropriate”.

The Committee noted that none of Dr. Lau’s monitors had ever communicated a negative report to the College concerning his practice. Furthermore, in the few cases where patients requested the absence of the monitor, the monitor triaged and assessed each patient, brought them to Dr. Lau, and only stepped out for the requested private discussion and examination. The potential for false recording of examinations that did not occur (as was the case in Dr. Lau’s original hearing) seemed to the Committee to be very limited in these episodic, limited and rare circumstances, and certainly did not arouse the concerns of a sequence of mentors over five years.

Although any breach of conditions in a Committee’s order is serious, the Committee was not persuaded that the specific nature of the breach of conditions by Dr. Lau in the circumstances identified on the record would require a suspension of his certificate of registration as a penalty.

Deterrence

The Committee accepted that Dr. Lau has shown remorse, has cooperated with the College from the outset and has apologized for his breach of the conditions. This cooperation made a contested hearing unnecessary. The Committee concluded in the circumstances that a reprimand and costs were sufficient as a specific deterrent for Dr. Lau and as general deterrence to the profession.

Remediation/Rehabilitation

The Committee was persuaded that a suspension would not assist in rehabilitation or remediation and in fact, by suspending his certificate of registration, raised the risk of harming an otherwise successful medical practice in providing care to his community. Letters of support from six individuals, four of whom had explicit responsibilities to monitor his practice at the behest of the College, included no negative and often positive comments.

Public Interest

The Committee recognizes that the public must have confidence in the medical profession and in the authority and effectiveness of its self-regulation. This requires that the College visibly and coherently protects the interests of the public, and that terms, limitations and conditions applied to members' certificates of registration be honoured and observed.

The Committee noted that the discipline panel in August 2007 imposed a very significant sanction, a net suspension of eight months, and placed conditions on Dr. Lau's certificate of registration that were stringent, extensive and of long duration.

The Committee concluded that over the period in question Dr. Lau had complied with those extensive conditions, other than in rare circumstances at the behest of and in the interest of his patients rather than to suit his own convenience. In this breach of the conditions, his monitors were compliant and saw no reason to make negative reports to the College.

The required monitoring was not needed or designed to prevent egregious inter-personal or abusive behaviour, but was intended to ensure the appropriateness of clinical care and the veracity of charting.

Thus, it is the opinion of the Committee that while the breach of the conditions was serious and requires sanction, the breach was strictly limited, the conditions were otherwise observed over five years and that a reprimand and costs are an appropriate penalty to protect the interests of the public.

Other Committee Decisions

In assessing the seriousness of Dr. Lau's admitted misconduct, the Committee was provided with Briefs of Authorities by both counsel. The Committee considered them carefully, recognizing that while prior Committee cases provide guidance, the Committee is not bound by them.

The Committee noted from the precedents provided that where breaches of undertakings had resulted in suspensions of a certificate of registration, there had usually been deliberate disregard or outright contravention of an undertaking, often in the context of prior serious boundary violations (*Noriega*). In *Maytham* there was, again, deliberate disregard of an undertaking and evidence of lack of respect for the authority of the College (and multiple breaches and appearances before the Discipline Committee). In *Li* and *Deluco*, an undertaking to practice only with an approved monitor was breached, and the Committee noted that this was in the face of a history of boundary violations, which is not the case here.

The Committee noted greater similarity to *Franklin*, albeit in the context of a capacity matter, but one in which a longstanding condition for regular assessments of the member was breached by the physician reducing their frequency (with the compliance and agreement of the assessors). In that case, the Committee commented, “The Committee was mindful of the fact that the terms and conditions imposed on Dr. Franklin’s certificate of registration were onerous, detailed and exacting”. In that case, the only penalty for the breach was a reprimand. Counsel for Dr. Lau pointed out that in Dr. Maytham’s first discipline matter, a breach of a condition related to prescribing resulted in a reprimand and costs only.

The Committee considered the case of *Francis*, involving a breach of undertaking, where the Discipline Committee found there was a flagrant disregard by the physician of his obligations and “contempt for his patients’ welfare”, and imposed a two month suspension.

In *Gay* there were found to be regular and repeated breaches of an undertaking to cease providing primary care and repeated dishonesty with the College, resulting in a two month suspension. In *Sweet*, related to narcotics prescribing, there was a public safety issue and multiple breaches of a condition which resulted in a two month suspension.

The Committee did not find that Dr. Lau’s breach of conditions rose to the level of seriousness of *Francis* or any of the cases that resulted in suspension of the physician’s

certificate of registration. The breach, while serious, was, in the opinion of the Committee at the less serious end of the spectrum.

Thus, in the context of a variety of cases that bore some similarities to that of Dr. Lau, and in considering all the principles of a fair and appropriate penalty, the Committee concluded that a reprimand and the payments of costs was an appropriate penalty in the circumstances of this case.

Posting of a Sign

College counsel submitted that, as part of the penalty, Dr. Lau should post a sign in each room where he sees patients, which would state: “Dr. Lau sees all patients in the presence of a practice monitor”. She argued that this would assist Dr. Lau in complying with the conditions placed on his certificate of registration.

Counsel for Dr. Lau submitted that there was no evidence that supported the need to enhance the scrutiny of his practice or to strengthen the conditions already in effect, especially since Dr. Lau’s physician assessor believes he no longer needs supervision.

He also argued that such a sign might be interpreted wrongly as relating to inappropriate personal behaviours which is not the case here and which would stigmatize Dr. Lau.

The Committee was not persuaded of either the utility or necessity of a sign as described. The existing conditions which remain in effect are extensive and the Committee found no evidence that there was a need to enlarge or enhance them. Furthermore, the Committee agreed that such a sign might lead to misinterpretation by patients of the purpose of the monitoring.

In conclusion, the Committee recognized that Dr. Lau’s breach of the conditions on his certificate of registration was serious and unprofessional. However, the Committee found that the breach was motivated by his concern for the interests of his patients and not for his own convenience or benefit. There was no subterfuge in his actions; he was not flouting or wilfully disregarding the conditions, and in all other regards he was compliant with the extensive, rigorous and exacting conditions imposed on his practice. The

Committee found that Dr. Lau's actions did not incur any risk of harm to his patients and that in the over five years that these conditions have been in force there had been no negative reports from those authorized to monitor the various components of the conditions. Further, Dr. Lau's physician assessor believes he no longer requires these conditions on his practice. Dr. Lau apologized to and cooperated with the College in this matter.

ORDER

Therefore, the Discipline Committee orders and directs that:

1. Dr. Lau appear before the panel to be reprimanded;
2. Dr. Lau pay costs to the College in the amount of \$4,460 within thirty (30) days from the date of this order.

Indexed as: Lau, A. (Re)

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

S. DAVIS (Chair))	Hearing Date: December 2, 2013
DR. S. KAPOOR)	Decision Date: February 5, 2014
S. BERI)	Release of Written Reasons: February 5, 2014
DR. R. MACKENZIE)	
DR. D. WALKER)	

B E T W E E N:

DR. ALVIN WAH WING LAU

(Moving Party)

- and -

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

(Responding Party)

ORDER AND REASONS FOR ORDER

(Motion to Vary the Order of the Discipline Committee of August 21, 2007)

INTRODUCTION

On December 2, 2013, the Discipline Committee (the “Committee”) heard a motion brought by Dr. Lau for an order seeking to vary the order of the Discipline Committee of August 21, 2007, as described below. At the conclusion of the hearing, the Committee reserved its decision on the motion.

THE AUGUST 21, 2007 DISCIPLINE DECISION and ORDER

On August 21, 2007, the Discipline Committee of the College found that Dr. Lau had committed an act of professional misconduct for failing to maintain the standard of practice of the profession, in that he failed to conduct a physical examination of four obstetrical patients and did not take a history of three of those patients, but noted on the patient record that he had done so.

A copy of the Discipline Committee's Decision and Reasons for Decision dated August 21, 2007, is included at Appendix 1 to this Order.

The Discipline Committee ordered, among other things, that Dr. Lau's certificate of registration be suspended for 12 months (4 months of which suspension would itself be suspended if Dr. Lau completed College-approved courses in Ethics and Communications Skills), and that terms, conditions and limitations be placed upon Dr. Lau's certificate of registration. A copy of the Order of the Discipline Committee is attached at Appendix 2 to this Order. Among the terms imposed upon Dr. Lau's certificate of registration are that:

- a. Dr. Lau, at his own expense, shall cause a monitor to be present during his appointments with all patients at his office practice and walk-in clinic;
- b. That monitor shall be a member of a health profession pursuant to the terms of the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18 as amended, who is acceptable to the College of Physicians and Surgeons;
- c. That monitor shall review each of Dr. Lau's chart entries to ensure that they accurately represent the appointment proceedings and will countersign the entry with Dr. Lau; and
- d. At all times, Dr. Lau shall ensure that the monitor keeps a log of each patient seen. The log shall contain the name of the patient and the date of the encounter.

The terms also require that Dr. Lau shall cause a member of the College of Physicians and Surgeons, who is acceptable to the College, to review his patients' charts and provide a monthly update on Dr. Lau's charts and the appropriateness of the care provided to Dr. Lau's patients. That monitoring is conducted by Dr. X. Dr. Y also provides monitoring while Dr. X is away.

THE MOTION

The member's Notice of Motion sought an order varying paragraph 5(c) of the Order of the Discipline Committee of August 21, 2007, to include the following paragraph:

"In the event a patient, on his or her own initiative, specifically demands or directs that the monitor be absent for a portion of the attendance so that a sensitive issue can be discussed, Dr. Lau will follow the following procedure:

- (i) Dr. Lau may permit the monitor to be absent for the portion of the visit where the sensitive issue is discussed or addressed, if he is reasonably concerned that the patient will not seek treatment or provide a full history if the monitor remains in the room for the whole visit;
- (ii) Dr. Lau will, in the course of preparing his contemporaneous note of the visit, specifically note that the patient requested that the monitor be absent, the reasons for the request, and his reason for permitting the monitor to be absent;
- (iii) Dr. Lau will prepare his notes through an electronic medical record keeping system, which creates an audit trail of all entries;
- (iv) Immediately following the attendance, Dr. Lau will have a detailed discussion with the monitor, in which he will advise the monitor of all details of the patient encounter. Dr. Lau will make a note of the discussion with the monitor. The monitor will then immediately review Dr. Lau's note to ensure that it corresponds to the account received and to the monitor's understanding of the purpose of the patient's attendance; and
- (v) The monitor will also note that the patient had requested that she be absent for a portion of the visit and the reasons for the request."

AUTHORITY TO VARY AN ORDER

Rule 16.01 of the Rules of Procedure of the Discipline Committee provides that a party may make a motion to the Discipline Committee to have an order varied, suspended, or cancelled, on the grounds of facts arising or discovered after the order was made.

The Committee is guided by case law in its consideration of this motion. In *Gorman (Re)*, [2013] O.C.P.S.D. No 26, the framework for motions to vary an order made by a previous panel was described.

The Committee is aware that the onus is on Dr. Lau to make the case for such a variance and that as the moving party, he must show that it is in the public interest to vary the conditions in the prior order of the Discipline Committee.

Dr. Lau argued that he was seeking a minor variation to address specific cases; that the previous order was silent on whether the monitor could be absent for a portion of a visit; that such a variance would be respectful of a patient's wishes and was common sense. He argued that the requested variance introduced a measure of flexibility to the existing conditions while maintaining a strict regimen of supervision, and that it was a minor variation that should be made in the public interest.

Dr. Lau argued that his practice had been monitored for over five years without issues being reported, that he had insight into his actions, that he had apologized and that he was not seeking to vary any other conditions.

Counsel for the College argued that the original order described a practice assessment as a precondition for a motion to vary the conditions in that order and presented uncontradicted evidence that no practice assessment had been either requested or performed. The Committee does not consider it is bound by this pre-condition, but is of the opinion that it is an appropriate pre-condition to this motion for variance, in the circumstances of this case.

Counsel for the College drew to the attention of the Committee the statement in the August 2007 Decision and Reasons that there had been no explanation for Dr. Lau's behaviour and that "any potential variance of the order in the future should address this issue". Counsel suggested that varying the order coincident with a finding of misconduct for breaching same order could be seen as rewarding bad behaviour.

College counsel referred to *Doyle (Re)*, [2012] O.C.P.S.O. No 2, at paragraph 11, in which *CPSO vs Wesley (2008)* was used in example where the test was stated as follows:

"Counsel for both parties agreed that the onus was on Dr. Wesley to show that a change in circumstances had occurred such that it is in the public interest for the terms, conditions and limitations to be removed. The burden of proof to be met is the civil standard or a balance of probabilities."

Counsel for the College submitted that there had been no change in circumstances, only a breach of the order, and that the College would like to see strict compliance and a full assessment before contemplation by the Discipline Committee of any variance.

DECISION AND REASONS FOR DECISION

It is the decision of the Committee that Dr. Lau has not met the burden of proof required for the Committee to vary the existing conditions placed on his certificate of registration.

There was no evidence provided of a significant change in circumstances. The order of August 2007 clearly delineates the process that the Panel believes should occur before any consideration of variance, namely that there be a practice assessment. The 2007 Order states that this might occur after five years, a period that has now expired. However, Dr. Lau has neither requested nor undergone a practice assessment, which he could have done before making a request for a variance.

The Committee noted the concern of the previous panel that any consideration of a variance should address the issue of Dr. Lau's lack of explanation for his previous behaviour, and further noted that no such explanation was offered then, or on the hearing of this motion

Furthermore, the Committee finds that there are workable alternatives in the rare circumstances upon which the request is made that would satisfy the existing conditions, such as having another physician attend upon the patient.

The Committee is also concerned at the possibility that increasing numbers of patients may request the monitor be absent, diluting the effectiveness of the conditions in protecting the public, if this variance is granted.

In the final analysis, the Committee took into account that the original order was carefully thought out and that insufficient evidence was put forward that it was in the public interest to justify the variance requested.

ORDER

Therefore, the Discipline Committee denies the motion to vary the existing terms, conditions and limitations imposed on Dr. Lau's certificate of registration by the Committee's order of August 21, 2007.