

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Billing, 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. Billing,  
2017 ONCPSD 30**

**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. KULBIR SINGH BILLING**

**PANEL MEMBERS:**

**DR. M. GABEL  
MR. P. PIELSTICKER  
DR. C. CLAPPERTON  
DR. R. SHEPPARD**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:**

**MS E. WIDNER  
MS E. GRAHAM**

**COUNSEL FOR DR. BILLING:**

**MR. D. PORTER  
MR. H. M. ROSENBERG (except January 16)  
MR. J. KATZ (January 16)  
MS C. WADSWORTH (January 16)**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MS J. McALEER**

<b>Hearing Date:</b>	November 21, 2016
<b>Finding Decision Date:</b>	November 21, 2016
<b>Penalty Hearing Dates:</b>	January 16 and 17, 2017
<b>Penalty Decision Date:</b>	June 22, 2017

**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 November 21, 2016 and January 16 and 17, 2017. On November 21, 2016, the Committee stated its finding that Dr. Billing committed an act of professional misconduct.

The Committee heard evidence and submissions on penalty on January 16 and 17, 2017, and reserved its decision on penalty.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Kulbir Singh Billing committed an act of professional misconduct:

1. in that he has failed to maintain the standard of practice of the profession; under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), and
2. under paragraph 1(1)33 of 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.

The Notice of Hearing also alleged that Dr. Billing is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the “Code”).

### **RESPONSE TO THE ALLEGATIONS**

Dr. Billing entered a plea of no contest to the first allegation in the Notice of Hearing, that he failed to maintain the standard of practice of the profession. Counsel for the College withdrew the second allegation and the allegation of incompetence.

## THE FACTS

The following facts were set out in a Statement of Uncontested Facts on Liability which was filed as an exhibit:

### Background

1. Dr. Billing is a 65-year-old anaesthesiologist who received his certificate of independent practice in 1980 and his specialist qualification in anesthesiology in 1988.
2. Dr. Billing practises in the area of chronic pain management as the sole physician at his clinic in Kitchener, Ontario. Dr. Billing's practice is primarily devoted to injection therapies for chronic pain, including nerve blocks, paravertebral blocks, epidural injections and trigger point injections.

### Overview of the Case

3. After receiving information from the Ministry of Health and Long-Term Care ("MOHLTC") in 2011, the College commenced an investigation into Dr. Billing's clinical practice pursuant to s.75(1)(a) of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991* ("the Code").
4. As part of its investigation, the College obtained independent opinions from Dr. Katherine Ower, anesthesiologist, St. Joseph's Health Care, London, Ontario, and Dr. James Watson, anesthesiologist, St. Joseph's Health Care, London, Ontario. Dr. Ower reviewed twenty-six (26) patient charts and observed Dr. Billing's care of twenty-nine (29) patients. Dr. Watson reviewed fifty-six (56) patient charts.
5. Dr. Billing obtained independent opinions from Dr. Norman Buckley, anesthesiologist, McMaster University, Hamilton, Ontario, and Dr. Paul Westacott, anesthesiologist, Cambridge Memorial Hospital, Cambridge, Ontario. Dr. Buckley reviewed the same patient charts that were reviewed by Dr. Watson and observed Dr. Billing's care of patients. Dr. Westacott reviewed the same patient charts that were reviewed by Dr. Ower and observed Dr. Billing's care of patients.

## **PART II – FAILURE TO MAINTAIN THE STANDARD OF PRACTICE OF THE PROFESSION**

### **A. Record Keeping**

6. The expert opinion concerning Dr. Billing’s documentation in his patient charts concluded that the following deficiencies are present:

- (a) Initial patient histories are not always present. When present, the patients’ histories often lack, or record an incomplete, past medical and medication history;
- (b) Previous treatments for chronic pain are not always well-documented;
- (c) The effect or efficacy of blocks administered to patients is not always well documented;
- (d) Changes in treatment plans or injection therapies, when recorded, are not explained in the chart;
- (e) Changes in patients’ diagnoses do not always reflect a change in treatment plans and no explanation is provided;
- (f) The correlation between physical diagnoses or findings and the treatment provided is often not documented;
- (g) Dr. Billing uses template-style reporting, or note-stamping, i.e. he “cuts and pastes” from patients’ previous clinical notes, carrying over grammatical and spelling errors;
- (h) Although Dr. Billing documents a review of the complications that may arise from nerve blocks in general, he does not document a discussion of the specific and unique complications that may arise when obtaining consent to a new kind of nerve block;
- (i) Patient consent to procedures is often poorly documented; and
- (j) There is often a failure to document changes, or lack of changes, in functionality or activities of daily living of patients.

### **B. Insufficient evidence of individualized treatment plans**

7. Information regarding Dr. Billing’s claims submitted to the Ontario Health Insurance Plan (“OHIP”), received from the MOHLTC, indicates that for the period between 2006 and

2013, Dr. Billing billed the maximum number of nerve blocks allowed under the Schedule of Benefits, namely eight (8) blocks per patient per service date for many of his patients.

8. Information regarding Dr. Billing's claims submitted to OHIP also indicates that for the period between April 2010 and March 2014, Dr. Billing submitted claims to OHIP for an average of 10 to 11 injections per patient per service day.

9. The expert opinion revealed the following deficiencies in this area:

- (a) The records do not always indicate an attempt to create individualized treatment plans;
- (b) Many patients receive more blocks than the maximum eight (8) paid by OHIP. The rationale for providing patients with the maximum or greater than the maximum number of blocks is not always sufficiently documented;
- (c) Many patients are given the same or similar sets of nerve blocks and trigger point injections without a documented rationale;
- (d) Although Dr. Billing uses patient feedback to determine which blocks work best, this feedback approach is not always clearly reflected in his clinical notes;
- (e) It is difficult to determine the effect or benefit of any particular block, given Dr. Billing's practice of routinely initiating multiple blocks simultaneously and his failure to record patients' responses to various blocks;
- (f) In several instances, Dr. Billing did not adjust his treatment based on new evidence when new findings or diagnostic results, such as imaging became available, and/or he failed to record any adjustments to treatment based on new findings or diagnostic results; and
- (g) When a patient notes a new area of pain, Dr. Billing often performs nerve blocks without documenting investigations to confirm the diagnosis.

### **C. Infection control**

10. Due to their proximity to the epidural space, paravertebral blocks must be done using appropriate sterile technique due to the rare, but potentially severe consequences of infection in this area, including epidural abscess and paralysis. (A paravertebral block is a block of the spinal nerve where local anesthetic is injected in the paravertebral space.)

11. “Sterile technique” means that everything used in the injection must be sterile, including:
  - (a) The target area on the patient’s skin for the injection must be cleaned in a sterile fashion;
  - (b) The syringe, the needle, and the solution in the syringe must all be sterile; and
  - (c) Sterile gloves must be worn.
12. The expert opinions revealed the following deficiencies with respect to the sterile technique used by Dr. Billing in administering paravertebral blocks:
  - (a) He only used only alcohol swabs to sterilize the general block area, not the stronger chlorhexidine spray. According to Dr. Billing, he began to use chlorhexidine spray when this issue was drawn to his attention by Dr. Ower;
  - (b) He administered injections to individual patients using the same needle that had already been used to perform occipital nerve blocks through the patients’ scalps. The scalp area is notoriously difficult to sterilize;
  - (c) He did not appropriately maintain the sterility of his gloves, in that although he started with sterile gloves, while he was administering injections, he used gloves that had touched unsterilized areas of the patients, including their scalps.

### **PART III – PLEA OF NO CONTEST**

13. Dr. Billing does not contest the facts specified above and he does not contest that, based on these facts, he engaged in professional misconduct, in that:

- (a) He has failed to maintain the standard of practice of the profession, under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”).

### **FINDING**

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts on Liability. Having regard to these facts, the Committee accepted Dr. Billing’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.

## **SUBMISSIONS ON PENALTY**

The College sought a penalty consisting of a suspension of Dr. Billing's certificate of registration for a period of two (2) months, a requirement that Dr. Billing practise chronic pain management under the supervision of a Clinical Supervisor for a period of twelve (12) months to be followed by a reassessment of his practice, and a public reprimand. The College also sought costs.

Counsel for Dr. Billing took the position that an appropriate order should include a public reprimand, a twelve (12) month period of clinical supervision, followed by a reassessment of Dr. Billing's practice, and the payment costs. Counsel for Dr. Billing suggested that a suspension of Dr. Billing's certificate of registration was not warranted and requested some variations in the terms of Dr. Billing's clinical supervision which had been proposed by the College.

## **EVIDENCE ON PENALTY**

The Committee heard the testimony of a number of witnesses called by Dr. Billing: three physicians who refer patients to Dr. Billing, and five patients of Dr. Billing. Dr. Billing also entered into evidence a brief of supportive letters (exhibit 6) from 18 physicians who refer patients to him and 36 of his patients. Dr. Billing entered additional exhibits consisting of certificates of membership in the Canadian Academy of Pain Management and the American Board of Anesthesiology, with a certified sub-specialty in Pain Management and Pain Medicine; and a certificate of completion of the Medical Record Keeping course at the University of Toronto, Faculty of Medicine.

While the College emphasized the limitations of this evidence in terms of its potential to assist the Committee, there was no dispute about its admissibility. Similar evidence has been accepted by the Discipline Committee in many previous cases, some of which were referred to by counsel for Dr. Billing [*CPSO v. Vaidyanathan* (2006), *CPSO v. Sharma* (2004), *CPSO v. Yeung* (2012)]. The Committee accepted that the testimony of and letters from Dr. Billing's patients and of physicians who refer patients to him was admissible.



## **PENALTY DECISION AND REASONS**

The principles guiding the imposition of penalty are well-established. The protection of the public is the foremost consideration. Other principles are maintenance of public confidence in the integrity of the profession and in its ability to govern itself effectively in the public interest, denunciation of wrongful conduct, specific deterrence as it applies to the member, general deterrence in relation to the membership as a whole and, where appropriate, the member's potential for remediation. The task of the Committee is to give suitable expression to these principles in light of the particular facts and circumstances of the case, in arriving at a penalty which is fair, reasonable, and appropriate. Aggravating and mitigating factors specific to the case will be considered. It is clear that the Committee is not required to impose the "least restrictive" penalty which would be consistent with its objectives. Although this is an accepted principle of sentencing in criminal law, it does not apply to proceedings of the Discipline Committee, as recently affirmed by the Divisional Court in *CPSO v. McIntyre* (2017).

The Committee carefully reviewed the Statement of Uncontested Facts which is the basis of its finding that Dr. Billing committed professional misconduct. The Committee found that Dr. Billing had failed to maintain the standard of practice of the profession. Dr. Billing's deficiencies are in two broad categories: his record keeping, including in relation to individualized patient treatment plans; and, his sterile technique. It is apparent from the Statement of Uncontested Facts on Liability that difficulties in these areas were not limited to one or two isolated incidents; rather, they were a pervasive feature of Dr. Billing's practice in relation to multiple patients over extended periods of time. Dr. Billing's multiple failures to meet the standard of care were attested to by four experts who had conducted thorough assessments of Dr. Billing's practice through chart reviews and patient observation. A total of 82 charts were reviewed by the experts, and Dr. Billing's care of multiple patients was directly observed.

The Committee finds that Dr. Billing's failures to maintain the standard of practice in his treatment of his patients are matters of serious concern. Although the Committee heard no evidence to suggest that patients were actually harmed, there is no doubt that they were exposed to the risk of harm. Complete and accurate records containing individualized treatment plans are

a crucial component of quality patient care. The Statement of Uncontested Facts on Liability documents the many inadequacies of Dr. Billing's record keeping procedures. The lack of individualized patient treatment plans resulted in there being no documented rationale on the records for providing patients with the maximum, or greater than the maximum, number of blocks paid by OHIP, and no clear method of determining the efficacy of these multiple blocks, amongst other deficiencies in the records. There can be no confidence that patients were not exposed to risk through multiple treatments, the rationale for which is not documented. Dr. Billing's lack of sterile technique is equally concerning; the risk of serious complications with potentially disastrous consequences is increased.

The Committee considered the evidence of mitigation submitted on Dr. Billing's behalf.

A number of consistent themes emerge from the evidence of Dr. Billing's patients and of physicians who refer to him. The patients of Dr. Billing were without exception very satisfied with the care they received from him. Many spoke positively about Dr. Billing's professionalism and empathy. All had experienced significant reductions in their levels of pain as a result of Dr. Billing's treatments, leading in many cases to multiple benefits in different areas of their lives. None had experienced significant complications attributable to Dr. Billing's treatments. The physicians who had, and continued to, refer patients to Dr. Billing found him professional and accessible and, in general, felt that he performed a valuable service to the community by practising both in underserved rural areas and in the relatively underserved domain of pain management, often with improved patient outcomes. Several physicians stated that Dr. Billing provided timely and complete consultation notes.

All the patients and referring physicians who provided evidence in support of Dr. Billing had been made aware of the current College proceedings. They had been provided with and had read the Statement of Uncontested Facts on Liability. Counsel for Dr. Billing, in soliciting their evidence by letter (exhibits 4 and 5), had drawn their attention to these matters. Nevertheless, all spoke positively about their experiences with Dr. Billing.

Other mitigating factors are that Dr. Billing has no prior disciplinary history with the College, and that by pleading no contest to the allegations, he obviated the need for a full hearing and took responsibility for having failed to maintain the standard of practice of the profession.

The testimonials of both Dr. Billing's patients and of physicians who refer to him were impressive. There is no doubt that Dr. Billing is highly regarded by the patients and colleagues who provided this evidence. By its nature, however, this does not diminish the significance of the findings of professional misconduct made by the Committee. Dr. Billing's failures to maintain the standard of practice of the profession are clear from the Statement of Uncontested Facts on Liability and are founded on expert opinions, which address broad standard of care issues. Although the patients and colleagues who provided evidence in support of Dr. Billing had been made aware of the issues before the Committee, their evidence of necessity pertained only to their individual experiences with Dr. Billing. They clearly cannot provide opinion evidence with respect to standard of practice issues and they cannot have any personal knowledge of the systemic deficiencies in Dr. Billing's practice, which were found by the experts who assessed him. The evidence of support of patients and colleagues, while it does provide useful insight into some aspects of Dr. Billing's practice, does not negate or diminish the findings of professional misconduct made by the Committee.

The objectives of penalty are multiple. Remediation is an important goal and the Committee finds that, based on the evidence heard, Dr. Billing's prospects in this regard are favourable. The Committee is encouraged by his willingness to take responsibility for his deficiencies, by voluntarily completing a record keeping course, and by, according to his counsel, improving his sterile technique in response to suggestions by the experts who assessed his practice. These steps are commendable and speak to Dr. Billing's insight and commitment to remediation. Other issues separate and apart from Dr. Billing's remediation, however, require expression in the Committee's penalty.

Dr. Billing's patients were placed at risk of harm by his substandard care. Misconduct of this nature is significant and serious. Dr. Billing, and the membership as a whole, must understand that it will not be condoned or tolerated. In the view of the Committee, the interests of

deterrence, both specific and general, merit a significant sanction. A suspension of Dr. Billing's certificate of registration for a period of two (2) months will be imposed for this reason. Public confidence in the effective self-governance of the profession is maintained through the imposition of significant penalties for professional misconduct of this nature.

The remaining elements of the penalty order are largely agreed to by the parties.

A public reprimand is essential, and serves to express the profession's disapproval of wrongful conduct.

Although Dr. Billing has, on his own, taken initial steps to improve his practice, there is no evidence that previous deficiencies have now been corrected. Accordingly, a twelve (12) month period of clinical supervision, with varying levels of supervision in response to the findings of the clinical supervisor, will ensure that the identified deficiencies in Dr. Billing's practice will be addressed, and that the public will be protected as a result.

Counsel for Dr. Billing agrees that a clinical supervision order is appropriate in this case. However, he submits that the terms of the supervision order suggested by the College are inappropriate. In particular, he argues there is no basis to include the various reports prepared by the College and defence experts in the materials to be considered by the supervisor. These reports have not been admitted as evidence in these proceedings. Many of the opinions of the College's experts were not accepted by the defence experts. He states that to the extent that there was consensus about deficiencies in Dr. Billing's practice, those views are already set out in the Statement of Uncontested Facts on Liability. He argues it would therefore be prejudicial to Dr. Billing to force him to address, through the clinical supervision order, unproven opinions in the reports of the College's experts which the defence experts rejected.

The Committee agrees and finds that it is not appropriate for Dr. Billing's clinical supervisor to have access to the expert reports prepared by the parties for these proceedings. These reports are not in evidence and their reliability has therefore not been determined.

A reassessment of Dr. Billing's practice within three (3) months after the completion of clinical supervision will determine whether Dr. Billing can safely resume unsupervised practice.

Information from patients and/or staff can be utilized in the interests of a complete and thorough assessment. Unannounced inspections of Dr. Billing's chronic pain management practice by a College representative will ensure that he remains compliant with the terms of this Order.

Finally, the Committee concludes that this is a suitable case in which to order costs, and does so in accordance with the tariff rate of \$5,000.00 per day.

In recognition of Dr. Billing's busy practice, the level of need of his patients and the underserved areas and domain in which he practises, this Order will come into effect thirty (30) days from the date it is issued. This will hopefully minimize disruption to patient care as much as possible.

The Committee considered the previous decisions of the Discipline Committee submitted by the parties which bore some similarity to the facts in Dr. Billing's case. The Committee accepts that similar cases should generally be dealt with in a similar fashion. The Committee, however, is not bound by its own previous decisions. The recently released decision of the Divisional Court in *CPSO v. Peirovy* (2017) clearly states the drawbacks of strict adherence to previous similar cases. The facts and circumstances of each case are unique, and public tolerance for physician misconduct can change. After reviewing the cases submitted, the Committee is satisfied that the penalty imposed on Dr. Billing is reasonable and proportionate given the particular facts of this case.

## **ORDER**

Accordingly, the Discipline Committee orders and directs that:

1. The Registrar suspend Dr. Billing's Certificate of Registration for a two (2) month period effective thirty (30) days from the date of this Order.

2. The Registrar impose the following terms, conditions and limitations on Dr. Billing's certificate of registration:

1. **Clinical Supervision**

- (a) Within twenty (20) days of this Order, Dr. Billing shall retain a College-approved Clinical Supervisor or supervisors (the "Clinical Supervisor") with respect to his chronic pain management practice, who will sign an undertaking in the form attached hereto as Schedule "A".
- (b) For a period of twelve (12) months commencing on the date that the Clinical Supervision is approved by the College, Dr. Billing may practise chronic pain management only under the supervision of the Clinical Supervisor ("Clinical Supervision"). Clinical Supervision of Dr. Billing's practice will end after a period of twelve (12) months.
- (c) Clinical Supervision of Dr. Billing's chronic pain management practice shall contain the following elements:

**Moderate-Level Supervision**

- (a) For an initial period of four (4) months, the Clinical Supervisor will engage in a period of moderate-level supervision, during which time the Clinical Supervisor will meet with Dr. Billing every two weeks and will at minimum:
  - i. review a minimum of fifteen (15) of Dr. Billing's patient records, to be selected at the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Billing;
  - ii. directly observe Dr. Billing's treatment of patients, including patient consultations and his administration of injections, for a minimum of three (3) hours per visit;
  - iii. discuss with Dr. Billing any concerns the Clinical Supervisor may have arising from the chart reviews or the direct observations;
  - iv. make recommendations to Dr. Billing for practice improvements and ongoing professional development, and inquire into Dr. Billing's compliance with the recommendations; and
  - v. keep a log of all patient charts reviewed along with patient identifiers.

- (b) The Clinical Supervisor shall consider the need for moderate supervision after the first four (4) months of Dr. Billing's Clinical Supervision, and at the beginning of every month thereafter for as long as the period of moderate supervision continues. If the Clinical Supervisor believes that Dr. Billing is ready to practise under low supervision, he/she shall provide the College with a report addressing the practice concerns raised in the Statement of Uncontested Facts on Liability.
- (c) The College must agree to the transition to the next phase, based on the reports of the Clinical Supervisor.

### **Low-Level Supervision**

- (a) If the transition is approved by the College, for a period of a further eight (8) months, the Clinical Supervisor will engage in a period of low-level supervision, during which time the Clinical Supervisor will meet with Dr. Billing on a monthly basis and will:
  - i. review a minimum of ten (10) of Dr. Billing's patient records, to be selected at the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Billing;
  - ii. directly observe Dr. Billing's treatment of patients, including his patient consultations and his administration of injections, for a minimum of three (3) hours per visit;
  - iii. discuss any concerns the Clinical Supervisor may have arising from the chart reviews or the direct observations;
  - iv. make recommendations to Dr. Billing for practice improvements and ongoing professional development and inquire into Dr. Billing's compliance with the recommendations; and
  - v. keep a log of all patient charts reviewed along with patient identifiers.

### **Other Elements of Clinical Supervision**

- (a) Throughout the period of Clinical Supervision, Dr. Billing shall abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to patient care, record keeping, infection control, practice improvements, and ongoing professional development.

- (b) The Clinical Supervisor shall submit written reports to the College at least once every month, or more frequently if the Clinical Supervisor has concerns about Dr. Billing's standard of practice.
- (c) If the person who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its provisions, Dr. Billing shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.
- (d) If Dr. Billing is unable to obtain a Clinical Supervisor as set out in this Order, he will cease practising medicine until such time as he has obtained a Clinical Supervisor acceptable to the College.
- (e) If Dr. Billing is required to cease practise as a result of section (5)(d) above, this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the public register.

## 2. **Re-Assessment of Practice**

- (a) Approximately three (3) months after the completion of Clinical Supervision, Dr. Billing shall undergo a reassessment of his chronic pain management practice by a College-appointed assessor (the "Assessor"). The assessment shall include a review of Dr. Billing's patient charts and direct observation of patient care. The assessment may also include interviews with staff and/or patients. The results of the assessment shall be reported to the College.
- (b) Dr. Billing shall consent to sharing of information among the Assessor, the Clinical Supervisor, and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

## 3. **Monitoring**

- (a) Dr. Billing shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this



Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

- (b) Dr. Billing shall cooperate with unannounced inspections of his chronic pain management practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
  - (c) Dr. Billing shall consent to the College's making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
  - (d) Dr. Billing shall be responsible for any and all costs associated with implementing the terms of this Order.
3. Dr. Billing appear before the panel to be reprimanded within 30 days of the date this Order becomes final.
  4. Dr. Billing pay costs to the College for a one (1) day hearing in the amount of \$5,000 within 30 days of the date of this Order becomes final.

**APPENDIX “A”****UNDERTAKING OF DR. \_\_\_\_\_ TO THE COLLEGE**

1. I am a practising member of The College of Physicians and Surgeons of Ontario (the “College”), certificate number \_\_\_\_\_.
2. I have read the Order of the Discipline Committee of the College dated \_\_\_\_\_ (the “Order”) regarding Dr. Kulbir Singh Billing (“Dr. Billing”), and have read the Statement of Uncontested Facts on Liability.
3. I understand the terms, conditions and limitations that the Discipline Committee directed the Registrar of the College to impose upon Dr. Billing’s certificate of registration in the Order, and I understand the concerns regarding Dr. Billing’s standard of practice. I will review as soon as practicable any additional materials provided to me by the College, including the College’s Guidelines for College-Directed Supervision.
4. I agree that commencing from the date I sign this undertaking, I shall act as Clinical Supervisor for Dr. Billing’s chronic pain management practice, for the duration of at least twelve (12) months. My obligations as Clinical Supervisor shall include, at a minimum:
  - (a) Moderate-Level Supervision: For an initial period of four (4) months, I will engage in a period of moderate supervision, during which time I will meet with Dr. Billing every two weeks and will, at minimum:
    - i. review a minimum of fifteen (15) of Dr. Billing’s patient records, to be chosen solely by me independent of Dr. Billing’s participation, and discuss any issues or concerns arising therefrom;
    - ii. directly observe Dr. Billing’s treatment of patients, including his patient consultations and his administration of injections, for a minimum of three (3) hours per visit;
    - iii. discuss with Dr. Billing any concerns that I may have arising from the chart reviews or the direct observations;
    - iv. make recommendations to Dr. Billing for practice improvements and ongoing professional development and inquire into Dr. Billing’s compliance with recommendations;

- v. I shall keep a log of all patient charts reviewed along with patient identifiers; and
  - vi. I shall reconsider the need for moderate supervision after the first four (4) months of Dr. Billing's Clinical Supervision, and at the beginning of every month thereafter for so long as the period of moderate supervision continues. If I believe that Dr. Billing is ready to practise under low-level supervision, I shall provide the College with a report addressing the practise concerns raised in the Statement of Uncontested Facts on Liability.
- (b) Low-Level Supervision: Upon receiving express approval from the College to transition to low-level supervision, for a period of a further eight (8) months, I will engage in a period of low-level supervision, during which time I will meet with Dr. Billing on a monthly basis to:
- i. review a minimum of ten (10) of Dr. Billing's patient records, to be chosen solely by me independent of Dr. Billing's participation, and discuss any issues or concerns arising therefrom with Dr. Billing;
  - ii. directly observe Dr. Billing's treatment of patients, including his patient consultations and his administration of injections, for a minimum of three (3) hours per visit;
  - iii. discuss with Dr. Billing any concerns I may have arising from the chart reviews or the direct observations;
  - iv. make recommendations to Dr. Billing for practice improvements and ongoing professional development and inquire into Dr. Billing's compliance with recommendations; and
  - v. I shall keep a log of all patient charts reviewed along with patient identifiers.

#### Other Elements of Clinical Supervision

5. I undertake to submit written reports to the College at least once every month, or more frequently if I have concerns about Dr. Billing's standard of practice. Such reports must be in reasonable detail and contain all information I believe might assist the College in evaluating Dr. Billing's standard of practice and compliance with the Order, including but

not limited to a list of all charts reviewed and procedures observed with patient identifiers, review of charts and procedures discussed and concerns identified, a summary of the topics that we have reviewed and Dr. Billing's success in implementing changes into his practice.

6. I undertake to notify the College immediately if I am concerned that Dr. Billing's practice may fall below the standard of practice of the profession, that Dr. Billing may not be in compliance with the Order, and/or that his patients may be exposed to risk of harm or injury.

7. I acknowledge that Dr. Billing has consented to my disclosure to the College and all other Clinical Supervisors and Assessors of all information relevant:

(a) to the Order;

(b) to the provisions of this, my Clinical Supervisor's undertaking;

(c) any Reassessment of Dr. Billing's practice; and

(d) for the purposes of monitoring Dr. Billing's compliance with the Order.

8. I acknowledge that all information of which I become aware in the course of my duties as Dr. Billing's Clinical Supervisor is confidential information and that I am prohibited, both during and after the period of Clinical Supervision, from communicating it in any form and by any means except in the limited circumstances set out in sections 36(1)(a) through 36(1)(j) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "RHPA").

9. I undertake to notify the College and Dr. Billing in advance wherever possible, but in any case immediately following, any communication of information under section 36(1) of the RHPA.

10. I undertake to immediately inform the College in writing if Dr. Billing and I have terminated our Clinical Supervision relationship, or if I otherwise cannot fulfill the provisions of my undertaking.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 2017.

\_\_\_\_\_  
Dr.

\_\_\_\_\_  
Witness signature