

**Indexed as: Lau (Re)**

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

**IN THE MATTER OF** a Hearing directed  
by the Executive Committee of  
the College of Physicians and Surgeons of Ontario  
pursuant to Section 36(1) of the **Health Professions Procedural Code** ("the 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:**

**DR. O. KOFFMAN (CHAIR)**  
**E. COLLINS**  
**DR. S. YOUNG**  
**E. ATTIA (Ph.D.)**  
**DR. K. GUPTA**

**Hearing Date:** August 21, 2007  
**Decision Date:** August 21, 2007  
**Release of Written Reasons Date:** October 12, 2007

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the “Committee”) heard this matter at Toronto on August 21, 2007. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its order as to penalty and costs with written reasons to follow.

### **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 acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and
2. under paragraph 1(1)2 of O. Reg. 856/93 in that he has failed to maintain the standard of practice of the profession;

### **RESPONSE TO THE ALLEGATIONS**

Dr. Lau admitted to the allegation in the Notice of Hearing that he committed an act of professional misconduct, in that he engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and that he failed to maintain the standard of practice of the profession.

### **FACTS AND EVIDENCE**

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

1. Dr. Lau is a family physician practitioner currently practising in Sarnia.

2. In July to September, 2005, when the events described below took place, Dr. Lau was a family physician at a General Hospital in northern Ontario.

Patient 'A'

3. In the summer of 2005, Dr. Lau saw Patient 'A' for a prenatal appointment. Patient 'A' was in her twenties and approximately 16 weeks into her pregnancy. Dr. Lau completed the Antenatal Record 1 ("ANR1"), indicating that a history had been taken and a physical examination performed. He checked off all physical items on the ANR1 as negative/normal. In fact, Dr. Lau did not take a medical history or family history, did not weigh Patient 'A' and did not conduct a PAP test nor any other physical examination on Patient 'A'.
4. During the course of the appointment, Patient 'A' asked to hear the baby's heartbeat and was told this was not necessary. In addition, Patient 'A' asked Dr. Lau whether the cramping she had been experiencing was normal. She alleges that he replied "I wouldn't know; I'm not a woman". Patient 'A' asked whether she would be able to determine the sex of the baby from the ultrasound. She alleges that Dr. Lau responded "I wouldn't know; I've never been pregnant".
5. Patient 'A' saw a different physician for her next pre-natal appointment after the summer appointment with Dr. Lau. As a result of tests ordered by that physician, Patient 'A' was diagnosed with a condition unrelated to her pregnancy.

Patient 'B'

6. Patient 'B' saw Dr. Lau for two prenatal appointments, in August, 2005 and September, 2005. She was in her twenties, and, at her August appointment, approximately 8 weeks pregnant. At her August appointment, Patient 'B' asked to have blood work to confirm her pregnancy. Dr. Lau deferred ordering blood

testing without an explanation. At the September, 2005 appointment, Dr. Lau recorded a complete history on the ANR1, as well as a physical examination and a discussion of Maternal Serum Screening (“MSS”). However, Dr. Lau actually performed no physical examinations, took no medical history and did not discuss MSS with her at either appointment. Patient ‘B’ indicates that the only question Dr. Lau asked her was whether, if she was pregnant, she would be keeping the baby.

#### Patient ‘C’

7. Dr. Lau saw Patient ‘C’ in September, 2005 for a prenatal appointment. At the time, Patient ‘C’ was in her thirties and approximately 13 weeks pregnant. Dr. Lau documented on the ANR1 that he had conducted a complete history and physical examination and that he had discussed MSS with Patient ‘C’. In fact, Dr. Lau did not ask any medical history or family history questions of Patient ‘C’, did not conduct any physical examination and did not offer or discuss MSS with Patient ‘C’.

#### Patient ‘D’

8. Dr. Lau saw Patient ‘D’ for three prenatal appointments, twice in August and once in September, 2005. Patient ‘D’ was in her forties and approximately 6 weeks pregnant at her first appointment in August, 2005. On the first August, 2005 appointment, Dr. Lau ordered a confirmatory pregnancy test. When Patient ‘D’ returned later in August, 2005, Dr. Lau deferred a dating ultrasound until mid-September. Dr. Lau did not conduct Patient ‘D’s’ first prenatal appointment until September, 2005. At that appointment, he documented in the ANR1 that he had conducted a complete physical examination and that he had discussed MSS with Patient ‘D’.
9. The ultrasound taken in September, 2005 indicated that Patient ‘D’ was 11 weeks

pregnant. She would have been required to attend at the latest within four weeks from this date for blood to be drawn for MSS. In fact, in September, 2005, Dr. Lau did not perform any physical examination on Patient 'D' other than taking her blood pressure. He did not perform a pelvic examination or PAP test and he neither discussed nor offered MSS to her. Accordingly, Patient 'D' did not receive her MSS within the required time frame.

#### Expert Reports

10. The College obtained two expert reports from Dr. Z. Dr. Z's curriculum vitae is attached to the Agreed Statement of Facts entered as Exhibit "A".
11. Dr. Z's first report, dated May 22, 2006, is attached as Exhibit "B" [to the Agreed Statement of Facts]. In it, Dr. Z states that in his opinion Dr. Lau did not meet the minimum standards of practice in the above-noted cases and has exposed these patients to harm and injury.
12. Dr. Z's second report, dated July 17, 2006, is attached as Exhibit "C" [to the Agreed Statement of Facts]. In it, Dr. Z states that it appears Dr. Lau has committed fraud in his charting. He also states that Dr. Lau's charting conceals omissions which can reasonably be expected to result in poor health outcomes for the four patients involved.

#### Section 37 Order

13. Dr. Lau's license is currently restricted by virtue of a Section 37 Order imposed on August 8, 2006, a copy of which is attached as Exhibit "D" [to the Agreed Statement of Facts]. Since that date, as required by the Order, Dr. Lau has had a nurse monitor in attendance at all of his patient encounters. The nurse also reviews all of Dr. Lau's chart entries. In addition, as required by the Order, a physician monitor reviews Dr. Lau's patient charts on a daily basis. Since the

imposition of this Order over a year ago, Dr. Lau has been compliant with all aspects of this Order. There have been no concerns expressed by either of Dr. Lau's monitors concerning his record keeping or the quality of his care.

### Admissions

14. Dr. Lau admits the facts set out in paragraphs 1 to 13 above.
15. Dr. Lau admits that he has committed acts of professional misconduct as provided by Ontario Regulation 856/93 made under the *Medicine Act, 1991* in that:
  - (A) he engaged in conduct, set out above, which would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and
  - (B) by the conduct set out above he failed to meet the standards of practice of the profession.

### **FINDINGS**

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Lau's admission and found that he committed an act of professional misconduct under paragraph 1(1)33 of O. Reg. 856/93, in that he engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and under paragraph 1(1)2 of O. Reg. 856/93, in that he failed to maintain the standard of practice of the profession.

### **PENALTY SUBMISSIONS**

Counsel for the College and counsel for the member made a joint submission as to penalty and costs. Both made oral submissions in support of the proposed penalty.

College counsel submitted that the proposed penalty should be accepted by the Committee in that it reflected the profession's abhorrence for the misconduct of Dr. Lau and for the reason that it would meet the need to protect the public from any such future misconduct. Counsel for the College also indicated that Dr. Lau's admission to the allegation of professional misconduct should be taken into account as a mitigating factor in the imposition of penalty.

College counsel presented to the Committee four cases which she submitted were considered in assessing an appropriate penalty. The range of penalty in these cases included, in two cases, a two to six month suspension at one end of the spectrum for false charting, to a 12 month suspension and revocation in the other cases at the most serious end of the spectrum involving incompetence. Counsel submitted, and the Committee accepted, that the cases presented were not sufficiently similar to apply the principle that "like cases should be treated alike". The facts of the subject case were more important in the determination of the appropriate penalty to be imposed in the circumstances of this case. The cases did provide examples of the range and kind of penalties available in serious cases.

College counsel submitted that the proposed penalty was appropriately tailored to the seriousness of the findings in this case. Not only was there a significant suspension, but after the suspension it was proposed that there be a strict monitoring of Dr. Lau's practice. If Dr. Lau wished a variance of the order, he could apply but only after five years and the onus would be on him to satisfy the Committee that the order should be varied. Furthermore, the proposed order provided for a practice assessment of Dr. Lau's practice, acceptable to the College, as a condition of an application to vary. It was submitted that these measures will be sufficient to protect the public.

Defense counsel supported the submission made by College counsel. In addition, she submitted that Dr. Lau was showing remorse by admitting to the misconduct. That and the fact that witnesses were spared the difficulty of testifying are mitigating factors in her submission.

She further submitted that the principles of general and specific deterrence, as well as protection of the public, are being satisfied by the proposed stringent minimum five-year monitoring. The monitoring covers patients both in Dr. Lau's private office and in the walk-in clinic in which he works. One level of scrutiny by a nurse sees to the veracity of the charts and another level of scrutiny by a physician assesses patient care. She submitted that Dr. Lau, for the past year, has been under a s. 37 monitoring order, with no complaints and that this should give the Committee comfort. Moreover, the monitoring does not end automatically after five years: first, there will be a practice assessment; and second, Dr. Lau will have to apply to the College and persuade the Committee to vary or lift the restrictions. She submitted that the public is further protected by the fact that Dr. Lau no longer does pre-natal care. She submitted that his hospital duties are limited and subject to hospital supervision, and hence, they constitute a reasonable exclusion from the monitoring provisions.

In addition to the protection provided by feedback to the College from the monitors, defense counsel further submitted that the educational components of the proposed penalty adequately address rehabilitation.

Defense counsel concluded her submissions by stating that the joint submission is in the public interest and would not bring the administration of justice into disrepute. Dr. Lau will have an opportunity to learn from the events and to re-enter the profession. She submitted that the proposal is fair and should be accepted.

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

The Committee accepted the joint submission for the reasons provided by counsel in support of it. The Committee did wish to express its concern that there was no information given to it (both counsel said that they had no such facts) to help it understand the behaviour of Dr. Lau, a new medical graduate at the time of the misconduct. The Committee took into account this fact as well as the facts agreed upon. In the view of the panel, any potential variance of the order in the future should address this issue. The Committee further accepted that, where a joint submission is made by the



parties, the law requires that the Committee accept the proposed penalty, unless it concluded that it was not in the public interest to do so and the proposed penalty would bring the administration of justice into disrepute. The Committee concluded that the proposed penalty does not do this, and in the view of the Committee it should provide the protection for the public that is required given the facts of this case.

The Committee further agreed that the proposed suspension and the strict monitoring on the resumption of practice will serve as a specific deterrent to Dr. Lau and the proposed ethics and communication courses should help in the rehabilitation process.

### **ORDER**

Therefore, the Discipline Committee ordered and directed that:

1. Dr. Lau appear before the panel to be reprimanded.
2. The Registrar suspend Dr. Lau's certificate of registration for a period of twelve (12) months. The suspension shall commence at 12:01 am on September 1, 2007.
3. Four (4) months of the suspension referred to in paragraph 2 shall be suspended provided Dr. Lau meets the following conditions:
  - (a) Dr. Lau will successfully complete, at his own expense, a Medical Ethics Course organized through the College's Quality Management Division;
  - (b) Dr. Lau will successfully complete, at his own expense, the Physician-Patient Communication Skills Course offered by the College or, in the alternative, a comparable course organized through the College; and
  - (c) Dr. Lau will continue to abide by the following terms, conditions and limitations, which are set out in the s. 37 Order dated August 8, 2006:

- i. 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;
- ii. 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 (the “College”);
- iii. 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;
- iv. 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;
- v. Dr. Lau shall ensure that the monitor provides to the College a copy of the log during the previous month, by facsimile on the 1<sup>st</sup> of each and every month;
- vi. Dr. Lau, at his own expense, shall cause a member of the College of Physicians and Surgeons, who is acceptable to the College, to review his patient charts on a daily basis (the “Chart Review”);
- vii. The physician conducting the Chart Review shall provide to the College a monthly update on Dr. Lau’s charts and the appropriateness of the care provided to Dr. Lau’s patients by Dr. Lau as indicated in the charts;
- viii. Dr. Lau shall co-operate with the monitor and the physician conducting the Chart Review and not interfere with their abilities to perform their respective functions, including allowing them free access to his charts;
- ix. Both the monitor and physician conducting the Chart Review shall report to the Registrar of the College immediately any and all irregularities they may encounter;
- x. Dr. Lau shall provide a signed consent allowing the College to have access

to his OHIP billings; and,

xi. Dr. Lau shall co-operate with, unannounced inspections of his office(s) and practices(s) and patient charts by a College representative for the purposes of monitoring and enforcing his compliance with the terms of this Order.

4. The Registrar impose the terms, conditions and limitations set out in paragraph 3(c) above on Dr. Lau's certificate of registration. Dr. Lau may apply for the terms of this Order to be varied as of August 21, 2012. If Dr. Lau makes such an application, he will provide the results of a practice assessment arranged by and acceptable to the College to be completed at Dr. Lau's expense. Dr. Lau may request such a practice assessment any time after February 21, 2012 and the College agrees to make reasonable efforts to arrange and complete the practice assessment within the six month period after Dr. Lau initiates the request.
5. Dr. Lau pay to the College costs in the amount of \$2,500.00 within thirty (30) days of the date of this Order.
6. The results of this proceeding be included in the register.

Dr. Lau waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.