SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)

(Information is available about the complaints process here and about the Committee here)

Dr. David Dung Mai (CPSO #72641)

INTRODUCTION

The College received information raising concerns about Dr. Mai. In particular, Dr. Mai was performing out-of-hospital premises (OHP) procedures (specifically, nerve blocks) without following the proper notification process; Dr. Mai was performing epidural injections under the Out-of-Hospital Premises Inspection Program (OHPIP) from 2013 to 2017; and an unannounced inspection at his clinic revealed significant deficiencies, and the facility received a "Fail" grade. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Mai's practice.

COMMITTEE'S DECISION

The Committee considered this matter at its meeting of September 19, 2019. The Committee required Dr. Mai to attend at the College to be cautioned in person with respect to failing to meet office infection control standards when doing injections, for performing Level 2 OHP procedures in an unapproved facility, and for performing procedures which would require change of scope of practice. The Committee also requested that Dr. Mai complete a written report with respect to this matter.

COMMITTEE'S ANALYSIS

The facility inspection found multiple serious deficiencies, particularly with respect to infection control and quality management. These went beyond the specific procedures that initiated the investigation. For instance, the inspection found the lack of a sharps container, the use of multidose vials, an inappropriate medication preparation area, and insufficient cleaning.

Dr. Mai's apparent lack of awareness of general clinic infection control and prevention (IPAC) practices is in and of itself a serious concern. These standards and guidelines are easily available and accessible, and physicians have a responsibility to be aware of them. The shortcomings identified were serious breaches of basic IPAC practices, which are as important in his existing clinical practice as when he was performing OHP procedures, given that Dr. Mai continues to perform a variety of injections.

The Committee was not satisfied, based on the information Dr. Mai provided, that Dr. Mai had adequate training to perform these injections. In the Committee's view, these injections were quite invasive and required a change of scope.

Given these concerns, the Committee required Dr. Mai to be cautioned, as described above.