NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Roland Chee Kong Wong, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that would disclose the identity of the patients whose identities are disclosed in the oral testimony and documentary record filed at the hearing 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: Wong, R. (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. ROLAND CHEE KONG WONG

PANEL MEMBERS:

DR. P. ZITER (CHAIR)
D. DOHERTY
DR. R. SHEPPARD
DR. E. ATTIA (Ph.D.)
DR. J. WATTS

Hearing Date:	**2011:** June 23 (Motion to Stay for Delay), August 24 (Motion to Call More Than Three Experts), October 3 (Motion by Intervenor), November 8, and December 6 to 9; **2012:** March 20, March 26 and April 4
Decision Date:	December 12, 2012
Release of Written Reasons:	December 12, 2012

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 in 2011 on June 23 (Motion to Stay for Delay), August 24 (Motion to Call More Than Three Experts), October 3 (Motion by Intervenor), November 8, and December 6 to 9; and in 2012 on March 20, March 26 and April 4. At the conclusion of the hearing, the Committee reserved its decision on finding.

ALLEGATIONS

The Notice of Hearing alleges that Dr. Roland Chee Kong Wong committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and
2. under paragraph 1(1) 33 of O.Reg. 856/93, in that he 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 alleges that Dr. Wong is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, ("the Code").

RESPONSE TO ALLEGATIONS

Dr. Wong denies the allegations of professional misconduct and incompetence in the Notice of Hearing.

FACTS AND EVIDENCE

A. Overview of the Allegations

The allegations of professional misconduct against Dr. Wong are made with respect to completing Special Diet Allowance forms ("SDA forms") for patients between approximately 2004 and 2009. Schedule "A" of the Notice of Hearing specifically alleges that:

a) Dr. Wong failed to maintain the standard of practice of the profession in his care and treatment of fifteen patients, between January 2008 and February 2009, including, but not limited to, his record keeping, failure to take proper histories, and failure to perform appropriate medical examinations, including diagnostic testing;

b) Dr. Wong completed and signed SDA forms between 2004 and 2009 without confirming the dietary restrictions, allergies or other medical conditions as reported by the patients. In doing so, he confirmed the presence of medical conditions that he either knew or should have known the patient did not have;

c) Dr. Wong submitted billings to OHIP for completing SDA forms, between approximately 2004 and 2009, without confirming the dietary restrictions, allergies or other medical conditions reported by the patients.

In addition, the College alleges that Dr. Wong is incompetent, as defined by subsection 52(1) of the Code, in that he displayed a lack of judgment of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

B. Background

The Special Diet Allowance is an income supplement which may be available for recipients of income support under the *Ontario Disability Support Program Act 1997*, S.O. 1997, c. 25, Schedule B ("ODSP") or under the *Ontario Works Act 1997*, S. O. 1997, c. 25, Schedule A ("Ontario Works"). Eligibility for the Special Diet Allowance is

established on the basis of an application form (the "SDA form") from the Ministry of Community and Social Services ("MCSS" or the "Ministry").

The SDA form is given to the patient by a social assistance worker. The patient takes the SDA form to a healthcare professional, who must complete the SDA form and confirm the presence of one or more of the medical conditions listed on the SDA form. The healthcare professional must sign the SDA form, which is returned to the patient. The patient then returns the completed SDA form to the appropriate social assistance office.

The only healthcare professionals approved to complete the form are physicians, nurse practitioners, registered dieticians and, in limited circumstances, registered midwives or traditional aboriginal midwives recognized by their communities.

The allegations in this case relate to SDA forms Dr. Wong completed for patients between 2004 and 2009.

Prior to 2005, the SDA form listed specific diets or nutritional products that the patient required as the result of a medical condition, and each diet was allocated a specific monetary value. The form was changed in 2005 such that the healthcare professional now has to confirm the medical conditions that require the special diet rather than the diets themselves. This was the version used in all but one of the fifteen patient files reviewed by the College.

When completing the form, a physician is required to indicate each medical condition that requires a special diet, to indicate how long the diet is required, and to confirm, first by initialling next to the condition, and second by the physician's signature at the end of the form, that the special diet is required.

A monetary value is assigned to each medical condition ranging from $10 to $240 dollars. The amounts for each condition can be added together for a maximum of $250 per month, per patient. The medical conditions on the form vary from groups of disorders

(e.g. cardiovascular disease), to specific diagnoses (e.g. diabetes) or specific laboratory findings (e.g. microcytic anaemia). These conditions also include some conditions that might more usually be called symptoms, such as chronic constipation. Minor modifications were made to some conditions listed on the SDA form in 2006 and again in 2009.

C. Investigations and Records

The College led evidence from a number of witnesses regarding Dr. Wong's practice and completion of SDA forms. The Committee was provided with the following information:

1. a review by the CPSO of fifteen of Dr. Wong's patient charts with associated SDA forms and OHIP billing;
2. a Ministry of Community and Social Services (MCSS) summary of 130 SDA forms completed by Dr. Wong;
3. a MCSS audit of all physician-completed SDA forms together with billings for completion of the forms; and
4. the OHIP records of Dr. Wong's claims for completion of SDA forms.

The CPSO Investigation

Ms X has been an investigator for the CPSO for 11 years and is responsible for collecting information on complaints for the Inquiries, Complaints and Reports Committee ("ICRC"). She randomly selected charts from the OHIP list of billings by Dr. Wong for KO55 (the OHIP billing code for completions of SDA forms) between April 2008 and May 2009. Fifteen charts were selected at random from the first two pages of the OHIP report.

Each one of the fifteen charts selected by Ms X consisted of only a single page. The single page was a form prepared by Dr. Wong and given to the patient to complete immediately before meeting with him ("Dr. Wong's SDA Questionnaire"). The first section of Dr. Wong's SDA Questionnaire required basic information, such as name, sex,

date of birth, address and health card number. The second section of Dr. Wong's SDA Questionnaire contained checkboxes for nine specific conditions (allergies to milk, eggs, wheat and soy, constipation, diabetes, high blood pressure, high cholesterol and high lipids) that qualify a patient for a Special Diet Allowance, and a tenth checkbox for other medical conditions.

The first and second sections of Dr. Wong's SDA Questionnaire were designed to be completed by the patient. The third section of Dr. Wong's SDA Questionnaire instructed patients to leave this section blank. This section was used to record any clinical assessment that may have been performed, including height, weight, body mass index, blood pressure in adults, chest, cardiac and skin examination and other physical findings.

The fifteen patient charts pulled by Ms X did not contain any information in addition to Dr. Wong's SDA Questionnaire. In evidence at the hearing, the Committee was provided with a copy of the SDA form submitted to the Ministry for each patient (signed by Dr. Wong), together with a record of the OHIP billings for each of the fifteen patients.

In all fifteen patient charts reviewed by Ms X, the boxes on Dr. Wong's SDA Questionnaire were checked off for all four allergies and chronic constipation, resulting in a total of five conditions eligible for an SDA allowance.

For 11 of these patients, Dr. Wong had noted in his own handwriting additional conditions resulting in a total of between six and ten eligible conditions for each patient. These notations consisted of one or two words such as "diabetes", "seizure", "obesity" or "thyroid."

Seven of these patients had the annotation "Fe" handwritten on Dr. Wong's SDA Questionnaire, which Dr. Wong used to indicate that the patient was on iron medication.

On one of Dr. Wong's SDA Questionnaires, the names of three drugs were recorded. The majority of Dr. Wong's SDA Questionnaires, however, had no note of the dose or nature

and effectiveness of any treatment. The prescribing or treating physician was not noted, nor was the name of a family physician, on any of Dr. Wong's SDA Questionnaires. This was true even for patients with diagnoses such as diabetes or "kidney" (which Dr. Wong explained meant renal failure).

In none of the fifteen patient charts was there a record of blood pressure, even in the three patients who were noted to have high blood pressure. Nor was there any record of test results in the case of one patient who was reported as having elevated lipids and cholesterol. There were no annotations that would indicate the performance of a physical examination, other than the patient's height and weight, and no laboratory investigations were reported.

The SDA forms for the fifteen patients submitted to the Ministry were completed in a way that mirrored the information on Dr. Wong's SDA Questionnaire. All patients, except one, had all four allergies and chronic constipation checked. The one outstanding patient had only three allergies checked, but had numerous additional conditions noted. For the seven patients who were noted to be on iron medication, microcytic anaemia was checked on each SDA form submitted to the Ministry.

MCSS Investigation

Ms Y, a Manager in the Ontario Works branch of MCSS, described concerns raised by local ODSP officers regarding Dr. Wong's completion of SDA forms. The Ministry conducted an investigation consisting of an analysis of 130 SDA forms completed by Dr. Wong. 73 of these forms were submitted from the Kitchener/Waterloo and Kingston branches of the Ministry. A further 57 forms were extracted from a random selection of 6,200 forms completed by Dr. Wong.

The 130 SDA forms represented 130 individuals from 30 families with anywhere from one to eleven members in each family. Of the 130 SDA forms, 129 identified the patients as having an allergy to egg, milk, soy and wheat as well as chronic constipation. 130 identified the patient as having soy and wheat allergy and chronic constipation. 96% of

the SDA forms verified conditions that would result in eligibility for the maximum monthly allowance of $250.

As a result of the Ministry's investigation, Ms Y drafted a letter of complaint to the CPSO.

Ms Y testified that the Ministry expected that health professionals would not simply rely on the patient's self-report. She agreed, however, that other than guidelines for the inclusion of previous as well as current weight loss, there were no specific guidelines or instructions for completion of the SDA forms by health professionals, other than the statements on the SDA forms.

Ms Y was unaware of the costs of completion and administration of the Special Diet Allowance program, but testified that 25% of all social assistance recipients received a Special Diet Allowance.

MCSS Audit

Mr. Z, the Audit Director for the MCSS, testified regarding the results of an audit of physician-completed SDA forms. This audit was requested by the Assistant Deputy Minister because of increasing expenditures in the program. In addition to reviewing physician billings for all SDA applications and a separate review of high value applications (from $200 to $250) completed by physicians, the audit also included interviews with managers and staff in Ontario Works and ten ODSP officers.

The audit showed a total 263,906 SDA applications processed between April 2006 and September 2009. Of these, 34,360 or 13% were completed by Dr. Wong; the next highest number processed by a single physician was 5,430 or 2.1%. The average number of forms completed by the top 10 physicians after Dr Wong was excluded, was 1,744 compared to an average of 18.63 applications completed by all remaining health care professionals. Of the 2,247 high value applications, 50% were completed by Dr. Wong. The next highest portion completed by an individual physician was 3.7%.

In addition to the relatively very high proportion of SDA forms completed by Dr. Wong, the auditor found that certain medical conditions were present in a significantly high proportion of SDA forms completed by Dr. Wong. 94.8% of the high value SDA forms completed by Dr. Wong included milk, wheat, soy and egg allergy and chronic constipation. Although the same conditions occurred relatively frequently in all high value forms, a comparison showed that there were significant differences between Dr. Wong and other physicians who submitted forms. For example, of the SDA forms completed by Dr. Wong 99.3% of patients had a milk allergy; in all other high value forms only 74.2% of patients had a milk allergy. In Dr. Wong's forms, 90.0% of patients had a wheat allergy, as opposed to 38.8 % of all other high value forms.

OHIP Billings

Ms Q, a senior program consultant from the Ministry of Health and Long-term Care in Kingston, testified regarding the record of OHIP billings made by Dr. Wong. Between the years 2007 to 2009, Dr. Wong billed for completing 33,102 SDA forms. On 189 of these occasions, he billed only for completion of the SDA form (K055A – value $20.00). On the remainder of occasions, he also billed an additional amount for conducting a partial assessment (A138A – value $30.60).

A partial assessment is defined in the Schedule of Benefits for OHIP as requiring a history of the presenting complaint and an appropriate physical examination. It is also the service rendered on subsequent visits for the purpose of assessing the response to treatment and/or advice provided in a previous service.

Dr. Wong's income between 2007 and 2009 derived from billing for completing SDA forms and conducting partial assessments for those patients ranged from $418,925 to $718,026 annually.

Dr. Wong's Evidence

Dr. Wong explained that he entered a Community Medicine residency after graduating from the University of Manitoba, largely because of an interest in work-related hearing loss, an interest that had developed during working on his Master's degree in audiology.

During his residency, he became increasingly interested in vulnerable populations, including alcohol abuse in aboriginal populations and the emergence of AIDS in certain vulnerable groups.

Dr. Wong came to Ontario after residency and moved to a practice in China Town in Toronto, after working at several public health clinics. In recent years, he has continued to work one day a week in occupational health clinics and rehabilitation clinics. He testified that as a result of his proximity to downtown Toronto and the fact that compensation for work-related illness and disability is frequently poor, he found himself working with an economically marginalized population and, therefore, completing an increasing number of SDA forms for patients in his primary care practice. He was approached for help by groups such as women's shelters, native groups, and poverty advocacy groups.

As a result, he decided in 2005 to operate a specialized SDA clinic. He developed a simplified form for patients to complete at the start of the visit (referred to above as the Dr. Wong SDA Questionnaire). The clinic population was composed of people who were not on-going patients and for whom he provided no continuing care. The clinics took place every day except Wednesday, when he was in his occupational health clinic, and Friday. The number of patients seen in any one SDA clinic varied, but in 2008 and 2009, this number was frequently between 70 and 90 patients a day and on occasion exceeded 100 per day. Dr. Wong agreed that he would have had only five to six minutes allotted to each patient even if he took no breaks for food or other purposes (which he said that he simply ignored).

The hours of operation of the clinics was one subject on which Dr. Wong appeared somewhat inconsistent in his evidence. He initially stated that patients were booked from 2:00 pm to 6:00 pm. He then stated that the clinic finished at 7:00 pm and he spent between 7:00 pm and 9:00 pm completing forms. He later modified this evidence, stating that the clinic frequently remained open until 9:00 pm, and that he would see patients all the time and on occasions even until midnight.

Patients who attended the clinics did not make telephone appointments (he indicated many of them did not have access to a telephone), but commonly made appointments through the internet with the help of staff from places such as shelters. Dr. Wong testified that a large proportion of his patients are refugees with limited language skills, and some had difficulty in completing even the questionnaire used by Dr. Wong. Patients were asked to complete Dr. Wong's SDA Questionnaire before seeing Dr. Wong. He testified that he would then go through the questionnaire to confirm its accuracy and to confirm the diagnosis. He admitted that he recorded very few, if any, of the questions that he asked patients. He stated that if the patient said they had a food allergy, he would ask about symptoms such as a bloated abdomen, diarrhea, improvement after cessation of a food, or a rash. No annotations were made of these questions or the responses.

It was Dr. Wong's evidence that words like "chest", "CVS" and "skin" on the form indicated that he had done an examination. He later stated that the examination consisted in large part of looking at the patient carefully while they were speaking. He said that he would ask about medications if the patient claimed to have a specific condition such as high cholesterol. It was noted, however, that most charts, though not all, where a significant diagnosis was checked-off, contained no note of medications. He stated that if a significant problem was identified which required on-going management he would do a more complete examination and provide the patient with a note for the Emergency Room or the family physician. He did not record when he had done this, nor did he keep copies of such notes.

Dr. Wong testified that he billed for completion of the SDA form (KO55) and, approximately 99% of the time, also billed for a partial assessment (A138A). Dr. Wong was aware that the OHIP Schedule of Benefits requires an appropriate physical examination as part of a partial assessment. He maintained that the measurement of height and weight constituted an appropriate partial assessment for the purposes of completing the SDA form.

In cross-examination, Dr. Wong gave answers that were, on occasion, evasive, inconsistent, and which lacked credibility. For example, with respect to constipation, Dr. Wong initially testified that he would ask patients questions as to the length of time they had had the problem with infrequency of bowel movement, as well as any difficulty straining and the presence of hard stools. He later testified, however, that if a patient reported that he had chronic constipation, he would take the patient's word alone without asking follow-up questions, since his view was that the patient's self-declaration was sufficient to meet his obligations for completion of the SDA form. He stated that although he agreed that chronic constipation could be a symptom of something more serious, he would not necessarily ask more questions, since he felt it was not his responsibility to determine whether or not it was a symptom underlying a serious disorder. He had no clear definition of what duration constituted chronic constipation except to indicate that "a few weeks" was sufficient.

Similarly, although Dr. Wong initially stated that he made a diagnosis of microcytic anaemia only when the patient gave a history of iron supplementation, he later said that it was sufficient for a patient simply to state that they had anaemia.

Dr. Wong also changed his evidence with respect to milk and wheat allergies. He initially claimed that he would ask patients about symptoms such as bloated abdomen, diarrhea and the effect of withdrawing the offending product from the diet. He later testified that he would, on occasion, accept the presence of an allergy based only on the patient's simple statement that he or she had the allergy without making further inquiry. He stated that if he thought the patient was checking off all four food allergies by rote he would be more suspicious. However, when asked whether the fact that all members of a single family claimed to have the same four allergies or that 96% of his patients had all four allergies was suspicious, he stated that he did not believe it to be so. When challenged, he agreed that dental problems were likely to be considerably more frequent in a vulnerable, extremely poor population than the presence of all four food allergies, but provided no explanation why allergies were so much more common in his patient population.

Dr. Wong stated that he knew the monetary value of each of the conditions included on the SDA form and that he also knew that the maximum amount available per month was $250. He denied, however, that he made a deliberate attempt to maximize the amount of financial assistance received by patients. In fact, when asked if it was a coincidence that in the 130 forms reviewed by the Ministry, 98% of the people qualified for the maximum financial benefit, he stated it could simply be a coincidence. On the other hand, he stated that he gave the benefit of the doubt to the patients' stories because of their poverty and also because accepting a history of multiple allergies could only be of benefit to them.

After prolonged questioning about the responsibility of a physician in completing the SDA form, Dr. Wong agreed that the Ministry expected physicians to act as gatekeepers and that a physician was expected to complete the SDA form with honesty and integrity. However, in commenting on one expert's suggestion that deception by physicians when advocating for their patients is widespread, at least in the USA, Dr. Wong's position was that some degree of misrepresentation or gaming of the system is acceptable if it benefits the patient in an otherwise unfair system.

Testimony of the Experts

a) Nutrition Expert

Professor G

Professor G was qualified as an expert on the relationship between nutrition and poverty. She provided opinion evidence regarding the context under which SDA forms are requested and completed.

Professor G has been on the faculty of the University of Toronto as a Professor of Nutrition Sciences since 1994, conducting research into the relationship between neighbourhood quality and food behaviours, both in Toronto and nationally.
Professor G defined food insecurity as the inability to obtain an adequate food intake due to financial constraints. Food insecurity is present in 7.7% of families nationally, but in 57% of households who are on social assistance. She explained that food insecurity is not

due to inadequate food selection, purchase or preparation, but arises because families on social assistance are unable to use savings or credit to buffer acute shortages in the way that other low income families can. She also gave evidence that the cost of a standardized nutritional "food basket" rose 7.4% between 2008 and 2009 and a further 13% in 2009, with minimal improvements in social benefits during this period. Professor G also addressed the relationship between poor access to healthy foods and increased rates of diabetes, obesity and cardiovascular disease.

b) Clinical Practice Experts

The Committee heard evidence from four experts in clinical practice: two of whom were called by the College and two of whom were called by Dr. Wong. All four shared similar characteristics in that they were clinicians who practised in downtown Toronto and held teaching appointments at the University of Toronto.

Dr. V

Dr. V has been in family practice in Toronto for 20 years and is an Associate Professor at the University of Toronto. He testified to having completed approximately 50 SDA forms for patients in his practice over the last five years. These were all patients with whom he had a prior doctor-patient relationship. Like the other three experts, he based his opinion predominantly on a review of the fifteen patient records from Dr. Wong that were obtained by the College.

Dr. V's opinion was that Dr. Wong failed to maintain the standard of practice. His view was that it falls below the standard of practice to rely solely on a patient's self report to complete the SDA form, without further inquiry or referral to other resources. In his view, Dr. Wong did not exercise proper diligence, such as conducting a full assessment with history and physical examination, or review former medical records, laboratory testing, or consultation notes, which would corroborate the self report, prior to completing the SDA forms. He noted that Dr. Wong, despite knowing that the patients were receiving medical care elsewhere, did not make any effort to substantiate the patients' claims by contacting those from whom they were receiving medical care, and

failed to take any responsibility for the care of the patients. He also stated that it was his understanding that these patients came to Dr. Wong because their own doctors had "turned them away" and suggested that this fact should give rise to further scrutiny.

Dr. V's view was that there was no evidence apparent in his review of the fifteen patient charts that Dr. Wong asked any questions or took any kind of history. Dr. V testified that he would not have expected Dr. Wong to run medical tests for every condition, but he would have expected that Dr. Wong engage in some sort of investigation, such as taking a history, asking questions, or looking for corroborating evidence such as medication or a consultation note, to satisfy himself that there was truth to the patient's claim prior to completing the SDA Form.

Dr. V agreed that if, after asking the patient a couple of questions, he was not sure if a patient was telling the truth as to whether he had a particular condition or not, he would give the patient the benefit of the doubt. He also agreed, with respect to allergies, that if a patient were properly questioned, filling out an SDA form could be based on the patient's own information without external collaboration.

Dr. V testified that he often gets questions from his colleagues about concerns physicians have about how they can fill out the SDA forms in the best interest of their patients yet maintain their integrity.

Dr. K

Dr. K has been in practice for 25 years in downtown Toronto and is a family physician. He is Chief of Family Medicine at Hospital A, having previously served as family physician and Chief of Family Medicine at Hospital B. He has worked as Medical Director at Hospice C, a centre for people living with HIV/AIDS, and he sits on the Board of Directors at Health Centre D, a community health centre providing healthcare services to new Canadians and uninsured persons.

Dr. K testified that in his personal practice he had filled out approximately 50 to 75 SDA forms in the past few years. He has never filled out an SDA form on behalf of a person who had not previously been his patient. He testified that if someone was interested in coming to him for the sole purpose of filling out an SDA application, he would not see the patient. If, however, the individual was interested in having an ongoing clinician providing comprehensive family care (including family physicians, nurses, dieticians, clinical pharmacists, social workers), there would be no barrier to seeing that individual.

Dr. K's opinion is that Dr. Wong failed to maintain the standard of practice. In particular, it is his opinion that Dr. Wong fell below the standard in that he failed to conduct an adequate assessment of patients prior to completing the SDA forms and relied entirely on their self-report to complete the SDA forms.

In his report, Dr. K stated the following with respect to the standard of practice:

> The standard of practice for a general practitioner/family physician is to elicit a complete history and perform a relevant physical exam for each patient complaint or concern. Such inquiry should elicit how long the patient has had this problem, the quality and quantity of the problem (e.g. abdominal cramps, diarrhea, rash etc for food allergies), aggravating and alleviating factors and any responses to previous therapy or treatment. Where appropriate, a physical exam should be performed (e.g. assessment of the patient's blood pressure) and laboratory investigation undertaken.
>
> Completion of a full, relevant assessment is required in order for a physician to sign an attestation to the patient's condition such as the application for a Special Diet Allowance. To sign such a form based on the patient's completion of a tick box form, without further assessment (history, physical examination and investigations) falls below the standard of practice reasonably expected of a competent family physician/general practitioner.

Dr. K notes that each patient chart he reviewed was comprised solely of Dr. Wong's SDA Questionnaire. There were no cumulative patient profiles, laboratory investigations or other supporting documentation in the patient charts. He noted that the patient charts did not document the patient's ongoing clinical condition in any significant way. He concluded that since there was no documentation of an appropriate history being taken or

a physical examination being performed, one must assume that Dr. Wong did not undertake such an assessment. In his view, this falls below the standard of practice expected of any physician.

Dr. K agreed in cross-examination that for some conditions, in particular allergies, taking a proper history would be a sufficient investigation. Generally, however, if someone presented for the first time with an SDA application, and he did not have any records for the person, he would require more information than could be obtained in one fifteen minute visit. He was careful to add, however, that it is difficult to be categorical. He agreed that in some circumstances he would give a patient the benefit of the doubt, but in other circumstances, such as multiple members of the same family presenting with the same conditions, he would be sceptical.

Dr. K stated, as did Dr. V, that it was his understanding that the patients were all self-referred and had come to Dr. Wong because their general practitioner or family physician had "turned them away." He noted that "all fifteen patients reported suffering from the same five clinical conditions – ones that are not readily verified in clinical investigations." He concluded that Dr. Wong demonstrated a lack of judgment in his approach to assessing these patients and subsequently completing the SDA forms, and that Dr. Wong's care fell below the standard expected of a competent family physician/general practitioner.

Dr. H

Dr. H practises community and family medicine and specializes in the care of men who are homeless in downtown Toronto. He was the first Medical Director for the largest shelter for men in the city and is also an Associate Scientist with the Centre for Research on Inner City Health at Hospital E. He testified that he has filled out several hundred SDA forms, both in the course of his work at the drop-in clinic and at the homeless shelter.

Dr. H distinguished Dr. Wong's practice from that of a general family physician. He characterized Dr. Wong's practice as a specialized clinic, directed only at the completion of SDA forms for patients with inadequate income. He explained that Dr. Wong's clinic was not for the purpose of general primary care or for the provision of continued care. Dr. H's opinion was that the standard of practice does not require that a physician have an ongoing doctor/patient relationship in order to complete an SDA form.

Dr. H drew analogies between Dr. Wong's SDA clinic and certain intermittent immunization clinics. He gave as an example the 2002 Hepatitis A vaccination clinic directed at providing prophylaxis against Hepatitis A following the exposure of individuals who shopped at a particular food outlet in Toronto. His second example was the provision of seasonal influenza vaccines by Public Health units across the province. He pointed out that in the fall of each year, such clinics provide medical interventions based purely on the self-disclosure of risk factors by patients, without any further physical assessment or investigation. In the case of the Hepatitis A clinic, patients were expected to self-report on exposure and on previous history of hepatitis. In the case of the influenza immunization clinics, patients reported the presence of an allergy to egg or an adverse reaction following a previous dose of vaccine. Answers to these questions would determine whether or not they would receive immunization.

Dr. H also pointed out that other healthcare professionals, such as dieticians who complete the SDA form, are permitted to do so without making a medical diagnosis or performing further investigations, since this would be beyond their scope of practice. Dr. H's view was that in the context of such a specialized clinic, confirmation of a diagnosis could be based purely on patient self-report. Dr. H drew an analogy between the SDA forms and forms completed for the purpose of applying for long distance travel allowance, where the information about travel comes solely from the patient. The Committee noted, however, that such forms are normally completed by a physician who has additional knowledge of the patient, such as a treating specialist or family physician.

Although Dr. H's default position is that one should generally believe a patient's self-report, Dr. H later qualified this by stating that self-report is adequate only if the physician has no concerns about the patient's level of understanding, the nature of the diagnoses claimed, and if the conditions are straightforward. He agreed that further "probing" questions would be required in situations such as a diagnosis of diabetes or renal disease, or if every patient presented with a similar list of conditions.

When asked if it was appropriate to bill OHIP for a partial assessment when seeing a patient for the primary purpose of completing an SDA form, he testified that such billing would require that at least some further questioning take place about the reported conditions.

It was Dr. H's opinion that, given the inadequacy of welfare funding and the fact that the outcome was highly beneficial to the patients, Dr. Wong's approach did not fall below the standard of practice. Dr. H concluded that Dr. Wong should be commended in meeting the needs of a particularly vulnerable population.

Dr. J

Dr. J has been Chief of the Department of Family and Community Medicine at St. Michael's Hospital since 1997. He is Associate Professor in the Faculty of Medicine at the University of Toronto and is Medical Director of the Inner City Health Program at Hospital E. He testified as to having completed hundreds of SDA forms as part of his practice.

Dr. J also characterized Dr. Wong's practice as a specialized clinic and drew analogies with other specialized clinics in which interventions were provided only on the basis of patients' self-report. The examples that he quoted included that of the H1N1 vaccination program, where influenza vaccine was given based solely on the patient completed screening questionnaire, and in the absence of any history, physical examination or investigation. He also gave the example of MRI consent forms where patients disclose

the absence or presence of metal prior to the magnetic resonance imaging (which can result in serious damage if performed on a patient with indwelling magnetic devices).

It was Dr. J's opinion that the lack of guidelines and instructions provided by the Ministry made it extremely difficult to judge the standard of practice applicable to the completion of SDA forms, other than to say that the standard required "what a minimally competent physician would do."

He stated that Dr. Wong's practice was unique, carried zero risk to patients and was not available elsewhere. Under such circumstances, his view is that confirmation of a condition for the purposes of completing an SDA form does not require the conventional elements of a complete history, physical examination and laboratory investigations. It merely requires that a physician be satisfied that the patient has the condition that is claimed. This would, however, require that the physician ask supplementary questions of clarification.

It was Dr. J's strongly held opinion that professional integrity requires the physician to act with maximum advocacy for the patient, provided that he does so without lying or engaging in deception; and that this advocacy requirement outranks any gatekeeping responsibility the physician might owe government. It was the Committee's conclusion that Dr. J's strong belief in this definition of professional integrity was a fundamental factor in his opinion that Dr. Wong's conduct did not fall below the standard of practice of the profession.

Dr. J referred to publications dealing with physician deception, manipulation or "gaming" the system." He indicated that in the United States, publications showed that some degree of misrepresentation or manipulation occurred relatively frequently and was considered acceptable by many if it was intended to benefit the patient. Dr. J did not hold the view that Dr. Wong's conduct met the threshold for misrepresentation as described in these articles. Indeed, he thought that Dr. Wong did not misrepresent any information provided to him by patients and that misrepresentation, if any, was provided by the patients

themselves. His conclusion was that Dr. Wong did not fail to maintain the standard of practice and, like Dr. H, his view was that Dr. Wong should be praised by his colleagues.

ANALYSIS AND DECISION

The Committee considered the following issues:

- What is the applicable standard of practice?
- Did Dr. Wong maintain the standard of practice, in particular with respect to his completion of SDA forms, record keeping and OHIP billing?
- Was Dr. Wong's conduct such that it would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional?
- Did Dr. Wong demonstrate a lack of judgment that meets the test for incompetence?

Background

The Committee accepted the evidence provided by Professor G, which was confirmed by all four clinical expert witnesses, that there is a crucial causative relationship between poverty, inadequate nutrition and individual patient health. The Committee also accepted that the patient population eligible for the Special Diet Allowance represents a marginalized and vulnerable population which is frequently dependent upon intermittent health services to which access may be limited or infrequent. Their care is more likely to come from walk-in and community clinics than from conventional family practices. This population is particularly likely to be found in the downtown or core areas of a city like Toronto.

The Standard of Practice

Identifying the standard of practice for a physician practising in a specialized clinic is not a simple task. Dr. Wong did not purport to provide continuing or ongoing treatment or care for the patients who attended his clinic. Although Schedule "A" to the Notice of Hearing alleged that Dr. Wong failed to maintain the standard of practice of the

profession in his "care and treatment of fifteen patients", the only form of care provided was the enabling of access to the Special Diet Allowance. The evidence accepted by this Committee was that the limited purpose of the SDA clinic was to assess patients who sought additional funding through the Special Diet Allowance program administered by the Ministry.

In its closing submissions, the College argued that Dr. Wong had failed to maintain the standard of practice of the profession with respect to: (i) his completion of the SDA forms; (ii) his record keeping; and (iii) his OHIP billing. Consequently, the Committee considered the appropriate standard of practice with respect to these three elements of Dr. Wong's practice.

(i) Standard of Practice re Completion of SDA Forms

The SDA form that Dr. Wong completed contains the following instructions:

> Instructions:
>
> 1. Complete Section III if the applicant requires a special diet as a result of a medical condition or Section IV if the applicant requires a Pregnancy/Breast-feeding Nutritional Allowance.
> 2. If completing Section III, place a check mark next to the applicant's medical condition that requires a special diet (first column), indicate the length of time the diet is required (second column) and initial to confirm that the special diet is required (third column).
> 3. Complete the information below, including your signature, to confirm that the applicant required a special diet(s) for the medical condition(s) you have indicated on the application form or for Pregnancy/Breast-feeding Nutritional Allowance.

Apart from the instructions provided on the face of the SDA form, MCSS provides no specific guidelines for completion of the form or for the circumstances in which it may be completed. Furthermore, MCSS does not provide any specific guidelines for the relationship between the healthcare worker and the patient (i.e. there is no explicit requirement for an ongoing or pre-existing doctor-patient relationship).

No evidence pertaining to widely accepted standards for the completion of SDA forms was presented to the Committee, and no published documentation of expected standards was available. In the absence of such published material, the Committee had to look to the requirements for completing the SDA form on the face of the document and the standard of practice of other physicians completing this form.

None of the clinical experts have a practice directed solely at the completion of SDA forms and no reference was made to any other physician with a similar practice or clinic to that of Dr. Wong. The experts at this hearing who had completed SDA forms virtually always did so in the context of an on-going relationship with the patient, whether as part of a practice or a service provided within an institution such as a shelter.

The SDA form was not considered onerous to complete by any of the expert witnesses. This is particularly true when compared to other forms, such as those supporting applications for ODSP and Ontario Works, both of which require additional supplementary information.

There was evidence from the Income Security Advocacy Centre, which was given intervenor status at the hearing, that the relative simplicity of the form was the consequence of an agreement between the Ministry of Health and Long Term Care and the Ontario Medical Association, aimed at reducing non-administrative demands on physicians' time.

There was much debate among counsel and the experts at to whether or not it fell below the standard of the profession to rely solely on a patient's "self-report" to complete the SDA form. The term "self-report" was used at times to refer to the patient's presenting complaint (i.e. the information provided by the patient on Dr. Wong's SDA Questionnaire), and at other times to include responses provided by a patient to inquiries made of him or her as to his or her history, symptoms, past treatment, medication etc.

Dr. J's view was that the absence of a requirement for supplementary information (unlike the ODSP application) was a fact that was consistent with Dr. Wong's reliance on patient disclosure alone. Drs. V and K disagreed, stating that the requirement of the physician's signature confirming the presence of the medical conditions meant that the form be completed with integrity, and integrity demanded further clarification by the physician. In their view, such clarification should at minimum take the form of supplementary questions to establish the patient's understanding of terms and the validity of the diagnoses, especially when significant (for example, diabetes or renal disease) or unusual (for example, multiple allergies). They agreed that it would not necessarily demand laboratory investigations or even a physical examination for conditions such as allergies or chronic constipation. Even conditions such as diabetes or renal or thyroid disease could be ascertained without further examination or testing, if they were corroborated by current prescriptions, laboratory results or physicians' notes. (They pointed out, however, that there was no record in Dr. Wong's patient charts of supplementary questions being asked, and there was no sign of any additional documented evidence).

Dr. H agreed that at the very least the physician needed to be satisfied that the patient had the medical condition that was being funded. This would require more than simply relying upon a list of boxes checked by the patient. It would require, at least, additional questions to ensure that the patient understood the term that was being used. He clarified that in his written report the use of the term "patient self-report" should be interpreted as meaning asking supplementary questions to confirm the diagnosis or getting information from the patient's own primary care physician to confirm the diagnosis. He said the physician must judge how much confirmation is reasonable and this was "part of a doctor's professional responsibility."

Dr. H also stated that he would be suspicious if a patient presented with a long list of positive check marks, or if every patient had a similar list of conditions. He stated that in these circumstances he would ask further probing questions.

Dr. J agreed that the SDA application required the physician to sign only if the physician was satisfied that the patient had the condition.

When questioned as to the likelihood of a patient presenting with allergies to wheat, milk, soy and egg, all four medical experts identified this as being an improbable circumstance. Drs. V, K and J all testified as to never having seen a soy allergy and Dr. H said it was not common. Drs. V and K stated that an egg allergy was very rare. With respect to the issue of 130 individuals presenting with all four allergies, Dr. V stated that it was highly improbable, Dr. H stated that is was suspicious, and Dr. K said "it raised scepticism to extreme heights." The experts generally agreed that these were factors that they would expect to give rise to further inquiry by the physician.

Initially in their written reports, the four clinical experts took two widely different views as to the appropriate standard. Drs. K and V contended that the standard was that of conventional general or family practice; whereas Drs. H and J used the analogy of specialized immunization clinics.

The analogy with the standard of practice in a general primary care practice fails in that it does not take account of the continuity and on-going responsibility that is inherent in conventional practice, but absent in a clinic designed to ensure accurate completion of a single form. On the other hand, the analogy with the single event immunization clinic is also deficient. Such clinics do not require professional confirmation of information derived from patients to an outside or public agency in the way that the SDA form does; in such clinics, it is the patient who confirms the presence of, for example, an egg allergy as a contraindication to immunization on signing their consent form; in such cases the patient signs the form and thereby takes responsibility. The Committee drew a clear distinction between relying on the self-report of a patient protecting themselves from risk and one who is claiming a financial benefit.

In their oral evidence, however, the experts were able to agree on a number of points that were sufficiently similar, in the view of the Committee, to describe a standard of practice by which Dr. Wong's practice can be judged.

The Committee finds that the standard of practice for completion of an SDA form does not require a pre-existing or on-going doctor-patient relationship, nor does it demand a full physical examination or laboratory investigation to confirm each medical condition, nor does it demand the degree of documentation seen in a primary care family medicine clinic. It does, however, require that the SDA form be completed with integrity and that the physician satisfy himself that the patient has the specified condition. The standard requires that the physician obtain sufficient information, either as result of a detailed self-report by the patient (such self-report consisting of more than a patient simply checking off a box or stating that he or she has a specified condition without further information) or from corroborating information (such as medical records, prescriptions, test results etc.), to satisfy the physician that the patient has the condition. The degree of inquiry (either of the patient or of third party sources) required by the physician will depend on the circumstances of each case and the nature of the conditions being claimed. The physician must satisfy himself, however, before signing, that in his professional opinion the patient has the specified condition. The nature of the necessary inquiries includes questioning a patient about surprising, unlikely, strange or inconsistent responses.

(ii) Standard of Practice for Record Keeping

The College's record keeping policy was considered by the Committee. Dr. J pointed out that the College policy on record-keeping was silent on the standards required for completion of official forms. He agreed, however, that since records generally must demonstrate that the requirements for reimbursement have been met, if billing requirements included the performance of a physical examination, the record should include evidence of this.

Dr. K testified that one's clinical record must reflect what was done during the visit. Dr. K noted that there were no cumulative patient profiles, laboratory investigations or other supporting documentation in the patient charts. He noted that the patient charts did not document the patient's ongoing clinical condition in any significant way. He concluded that there was no documentation of an appropriate history being taken or a physical examination being performed. Dr. K testified that although patient records are important

for future treatment, they are also important in circumstances where no future treatment is anticipated. He indicated that records are important for accountability purposes. He noted that even in emergency room walk-in clinics, where patients may never return, proper records must be kept.

Dr. V took a similar position to Dr. K, adding that it was the physician's responsibility to show that the diagnosis had been adequately established. He also was highly critical of Dr. Wong for failing to note the name of the treating or family physician for each patient, in particular when there were diagnoses such as renal failure, thyroid disease or diabetes.

Dr. H said a checklist (such as Dr. Wong's SDA Questionnaire) was acceptable, however, additional questions might be necessary for a physician to satisfy himself that the conditions were present, and presumably the record should reflect that these questions were asked and answered.

The Committee finds that the standard of practice requires that steps taken to confirm a condition should be documented in the patient's record. The degree of documentation in a patient's chart should reflect the degree of supporting evidence that was required for the doctor to satisfy himself that the patient had the condition reported. The Committee finds that a cumulative patient profile is not a necessary component of record keeping in a specialized clinic of this nature. The Committee agrees, however, that the standard also requires that the name of a treating physician be recorded if serious disorders such as diabetes, anaemia or renal failure are present.

(iii) Standard of Practice for OHIP Billing

In addition to billing OHIP K055 for completing the SDA Forms, Dr. Wong also billed OHIP an additional assessment fee (usually A138 or A134) in most cases.

A134 is the code a physician bills for a "Medical Specific Reassessment." The Schedule of Benefits effective July 1, 2003, defined "Medical Specific Assessment" in part as "a

service rendered by a specialist and requires a full relevant history and comprehensive physical examination of one or more systems."

Dr. Wong did not bill A134 for any of the fifteen patient charts reviewed. The OHIP records provided to the Committee indicate that Dr. Wong billed A134 on numerous occasions between April 1, 2005 and March 31, 2007. He does not appear to have billed A134 thereafter.

The Committee did not have the patient records for any of the patients for whom Dr. Wong billed A134. Consequently, we could not determine whether or not Dr. Wong had completed "a comprehensive physical examination of one or more systems" for any of those patients. The Committee has its doubts that such examinations were conducted based on the evidence it heard about Dr. Wong's general practice, but there was insufficient evidence upon which such a finding could be made.

In thirteen of the fifteen patient charts pulled by the College, Dr. Wong had billed A138, which is the code that physicians bill for completing a "partial assessment". The Schedule of Benefits in place as of October 1, 2009, states: "A partial assessment is the limited service that constitutes a history of the presenting complaint, the necessary physical examination, advice to the patient, and appropriate record."

The Schedule of Benefits effective October 1, 2006, defined "partial assessment" slightly differently. It states that a partial assessment "[r]equires a history of the presenting complaint and an appropriate physical examination. It is also the service rendered for the purpose of subsequent visits for assessing the response to treatment and/or advice provided in a previous service."

Dr. K testified that the standard required that a physician take a "reasonable history of the patient's complaint or condition" and the "necessary" "appropriate" or "relevant" physical examination, which "might be limited in scope."

Apart from Dr. K, the other experts did not provide detailed evidence about what constitutes an appropriate examination or when one is necessary for the purposes of billing for a partial assessment. Dr. V described a partial assessment as a brief encounter when you have a simple complaint which requires a "simple examination". Dr. H said that no physical examination would be necessary "in straightforward situations." He agreed, however, that a physician would have to conduct a history and gather information to bill for a partial assessment.

Drs. K and V concluded that Dr. Wong had failed to meet the standard of practice of the profession with respect to his OHIP billing on the basis that there was nothing in Dr. Wong's records upon which they could ascertain what actually occurred. In the absence of such information, they concluded that Dr. Wong had not taken a reasonable history or conducted an appropriate physical exam.

The Committee concludes that the standard of practice requires that a physician take a reasonable history of the reported condition in order to bill for a partial assessment. It may not be necessary, however, to conduct a physical examination in every case in order to bill for a partial assessment. The Committee would expect that in many situations, such as chronic constipation or allergies, one could satisfy oneself that the patient had the condition through appropriate inquiries or corroborating documentation without conducting a physical examination. In such a case, it would still be appropriate to bill for a partial assessment, even though no physical examination had taken place. The scope of any physical examination and whether or not one is appropriate will depend on the nature of the reported condition.

Did Dr. Wong Maintain the Standard of Practice?

(i) Did Dr. Wong maintain the standard of practice with respect to completion of the SDA forms?

The standard of practice requires that a physician satisfy himself that a patient has the specified condition(s) prior to endorsing the SDA form. As described above, the steps

necessary to satisfy oneself that a patient has a particular condition will depend on the nature of the condition and the information provided by the patient.

It was clear from the fifteen charts reviewed by this Committee and Dr. Wong's testimony that Dr. Wong's degree of inquiry prior to completing the SDA forms was at best variable and frequently minimal. He admitted that he usually had only five or six minutes allotted to each patient and that many of his patients had limited language skills. Although he initially testified that, if a patient said they had a food allergy, he would ask about symptoms (such as bloated abdomen, diarrhea, and the effects of withdrawing the offending product from the diet), he later admitted in cross-examination that he would, on occasion, accept the presence of an allergy based on the patient's simple statement that she or he had the allergy without making further inquiries. Despite the fact that 14 of the fifteen patient charts reviewed by the Committee contained a reported allergy to eggs and all fifteen patient charts contained reported allergies to milk, wheat and soya, none of the charts reviewed by this Committee contained any record of inquiries Dr. Wong may have made or responses that may have been provided regarding allergy symptoms. Given the limited amount of time with each patient, the absence of any notes in his records confirming that inquiries were made, the unlikely circumstance that there would be such a high level of reported allergies among these fifteen patients, and Dr. Wong's inconsistent evidence with respect to the nature of any inquiries he may have made with respect to allergies, the Committee finds that Dr. Wong failed to make the inquiries or obtain the information necessary to satisfy himself that his patients had the allergies reported on the SDA forms.

Dr. Wong initially testified that if a patient reported chronic constipation, he would ask the patient further questions. He later admitted during cross-examination that if a patient reported chronic constipation, he would simply take the patient's word without asking follow-up questions. Again, there was no indication in the fifteen patient charts reviewed by the Committee, all of which reported chronic constipation, of Dr. Wong having asked any questions about the length of time the patient had had a problem with infrequency of bowel movements, or any difficulty straining or the presence of hard stools. The

Committee finds that Dr. Wong failed to make the necessary inquiries in order to satisfy himself that the fifteen patients had chronic constipation as reported on the SDA forms. It fell below the standard simply to rely on the patient's report that he or she had chronic constipation without any follow-up inquiries.

In seven of the fifteen SDA forms reviewed (for the fifteen patients for which the Committee had patient charts), Dr. Wong reported that the patient had microcytic anaemia. He initially testified that he would only confirm such a diagnosis if the patient reported a history of iron supplementation. He later said that it was sufficient for a patient simply to report that he or she had anaemia. With the exception of the notation of "fe" in each of the patient charts for which a diagnosis of microcytic anaemia was confirmed on the SDA form, there was no notation in any of these patient charts regarding any inquiries that Dr. Wong may have made or the responses that may have been provided with respect to this condition. The Committee finds that Dr. Wong failed to make the necessary inquiries in order to satisfy himself that these seven patients had microcytic anaemia. It fell below the standard of practice simply to rely on the patient's assertion that they were on iron or that they were anaemic to confirm microcytic anaemia without any further inquiry.

In two of the fifteen patient charts reviewed, Dr. Wong confirmed a diagnosis of diabetes. Diabetes is a serious condition. With the exception of the note "diet" in one chart, there was no record in either of the two charts of any inquiries that Dr. Wong may have made prior to confirming these diagnoses, nor was there any record of any corroborating evidence of this condition in either chart (i.e. prescriptions, notes from family doctors etc). As with each of the fifteen patient charts, there was no reference to the name of a family physician. Although Dr. Wong testified that if a significant problem was identified which required ongoing management, he would do a more complete examination and provide the patient with a note for the Emergency Room or the family physician, there was no record of any examination (beyond height and weight) or follow-up in either of these charts. In the absence of any evidence confirming that the necessary inquiries were made to confirm such a diagnosis, the Committee finds that Dr. Wong failed to maintain

the standard of practice in confirming the diagnosis of diabetes without making any further inquiries of the patient.

In summary, the Committee finds that Dr. Wong did not take the necessary steps to satisfy him that the fifteen patients, whose records were before the Committee, had the conditions reported on the SDA forms.

(ii) Did Dr. Wong fail to maintain the standard of practice with respect to record-keeping?

With respect to his record keeping, Dr. Wong's level of documentation in the fifteen charts reviewed by the Committee supporting confirmation of each condition varied from minimal to non-existent. There was little to no record of the information he was provided by the patients or the nature of the inquiries he made. Beyond basic height and weight measurements, there was no documentation of any physical examinations he conducted. As noted above, Dr. Wong testified that if a significant problem was identified which required on-going management, he would do a more complete examination and provide the patient with a note for the emergency room or the family physician. He did not record when he had done this, nor did he keep copies of such notes. The Committee was not provided with any evidence to support Dr. Wong's assertion that he conducted such examinations or prepared such notes. There were no records in the patients' charts of supplementary questions being asked or responses, and there was no sign of any additional documented evidence. There was no record, in any of the fifteen charts, including those where diabetes, renal failure or anaemia were confirmed, of the name of the patient's family physician. Therefore, the Committee finds that with respect to the fifteen charts reviewed, Dr. Wong failed to maintain the standard of practice with respect to his record-keeping.

(iii) Did Dr. Wong fail to maintain the standard of practice with respect to his OHIP Billing?

Based on Dr. Wong's evidence and our review of the fifteen patient charts, the Committee concludes that Dr. Wong did not obtain sufficient information to attest to the

various medical conditions which he confirmed on the SDA forms for these fifteen patients. Consequently, the Committee finds that he did not meet the requirement of taking a reasonable history of the reported condition prior to billing OHIP for a partial assessment in the fifteen patient charts reviewed.

As indicated above, the standard of practice does not require a physician to conduct a physical examination in every case prior to billing OHIP for a partial assessment. It is a reasonable expectation, however, that Dr Wong should have taken the blood pressure for those patients for whom he confirmed a diagnosis of high blood pressure, but there is no indication on the patient records that he did so for the two patients for whom he confirmed a diagnosis of high blood pressure on the SDA forms.

(iv) Conclusion regarding Standard of Practice

The Committee finds that even though he was practising within the highly restricted environment provided by a single-purpose clinic, in which there was no expectation of providing ongoing care and treatment to patients such as one would expect in a family practice, Dr. Wong failed to maintain the standard of practice of the profession in his completion of the SDA forms, his record keeping and his OHIP billing in the case of the fifteen cases referred to the Committee.

Allegation of Disgraceful, Dishonourable and Unprofessional Conduct

Completing the SDA forms and confirming the presence of specific diagnoses or medical conditions is clearly relevant to the practice of medicine.

The Committee concluded that Dr. Wong's failure to take steps to satisfy himself that the patients had the conditions specified was a consistent aspect of his behaviour. The Committee based its conclusion on Dr. Wong's own evidence, its review of the fifteen patient charts and on the evidence regarding the SDA forms reviewed by the Ministry (with 99% having a similar diagnosis), and the number of patients seen in a relatively short time. The Committee was particularly troubled by the repetitive confirmation of four diagnoses of allergy together with chronic constipation. The inference drawn by the

Committee from this information is that there was widespread knowledge among Dr. Wong's patient population that this was a way in which the SDA allowance could be maximized. Dr. Wong, naively or deliberately, ignored the fact that the occurrence of such a collection of conditions represented an extremely unlikely reality. This is not akin to providing a patient with the benefit of the doubt.

The Committee concludes that Dr. Wong knew or certainly ought to have known that these patients did not have all of the medical conditions they reported. The Committee does not believe Dr. Wong's assertion that he believed this to be a coincidence. Dr. Wong's practice of ignoring the repetitive and extremely unlikely combination of conditions appears to have been motivated by a desire to financially benefit the patients. In so doing, however, he exhibited poor judgment and sacrificed his integrity which is essential to the practice of medicine.

Dr. Wong's conduct of confirming diagnoses on SDA forms, without first satisfying himself that the patient had the specified condition, may not have reached a level that members of the profession would necessarily consider to be dishonourable or disgraceful, given his apparent motives, but in our view it was unprofessional.

The temptation to exaggerate in order to maximize financial benefit for a patient is entirely understandable. The suggestion was made that Dr. Wong's endorsement of these claims represented advocacy for his patients. Advocacy for a patient, however, should not trump one's professional integrity. While it may well be true that additional financial assistance would provide increased health benefits to many underprivileged individuals, this does not justify failing to maintain the standard of practice, including the endorsement of a misrepresentation in order to obtain financial gain for a patient. The experts who testified for both sides (but particularly Drs. H and J) were able to demonstrate activities in their professional and personal lives that constituted advocacy for vulnerable patients that remained well within the bounds of professional integrity.

Dr. Wong's purported advocacy was limited to promoting access to additional social assistance through the Ministry of Community and Social Services. There was no evidence that Dr. Wong advocated for patients through other avenues such as promoting access to medical services, either from himself or by recommending medical clinics or physicians who might be suitable for those patients who presented with specific diagnoses and who did not have a family physician.

Consequently, the Committee finds that Dr. Wong committed an act of professional misconduct in that he engaged in conduct relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional.

Allegation of Incompetence

Dr. Wong did not appear to show any deficiency of knowledge or skill. He did demonstrate a deficiency in judgement in accepting patients' assertions of unlikely combinations of medical conditions. This was not, however, of a nature or to an extent that makes him unfit to continue to practise or that would require restriction on his practice. The Committee finds that the allegation of incompetence has not been proved.

CONCLUSION

The Committee finds that Dr. Roland Chee Kong Wong committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856 /93, in that he failed to maintain the standard of practice of the profession; and
2. under paragraph 1(1)33 of Ontario Regulation 856/93, in that he engaged in conduct relevant to the practice of medicine that, having regard to the circumstances, would reasonably be regarded by members as unprofessional.

The Committee requests that the Hearings Office of the College schedule a date for a penalty hearing.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Roland Chee Kong Wong, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that would disclose the identity of the patients whose identities are disclosed in the oral testimony and documentary record filed at the hearing 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: Wong, R. (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. ROLAND CHEE KONG WONG

PANEL MEMBERS:

DR. P. ZITER (CHAIR)
D. DOHERTY
DR. R. SHEPPARD
DR. E. ATTIA (Ph.D.)
DR. J. WATTS

Penalty Hearing Date: July 29 to 30, 2013
Penalty Decision Date: January 22, 2014
Release of Written Reasons: January 22, 2014

PUBLICATION BAN

PENALTY AND REASONS FOR PENALTY

The Discipline Committee of the College of Physician and Surgeons of Ontario (the Committee) heard this matter at Toronto in 2011 on June 23rd (motion to stay for delay) August 24th (motion to call more than three experts) October 3rd (motion by intervener) November 8th and December 6 to 9th; and in 2012 on March 20th, March 26th and April 4th. At the conclusion of the hearing, the Committee reserved its decision on finding.

On December 12, 2012, the Committee delivered its written decision and reasons which sets out the finding that Dr. Wong has committed an act of professional misconduct in that:

1) he failed to maintain the standard of practice of the profession; and
2) he engaged in conduct relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as unprofessional.

The finding of failure to maintain the standard of practice was made with respect to completion of the Special Diet Allowance forms (SDA forms), as well as with respect to Dr. Wong's record keeping and his OHIP billing. The finding of unprofessional conduct was made with respect to Dr. Wong's failure to satisfy himself that his patients suffered from the disorders that he confirmed on the SDA forms.

The Committee heard evidence and submissions on penalty and costs on July 29 and 30, 2013 and reserved its decision.

EVIDENCE AND SUBMISSIONS ON PENALTY

A . EVIDENCE

The College submitted a victim impact statement from Ms W, Director of a branch of the Ministry of Community and Social Services. The defence objected to the introduction of this document on three grounds:

1. it contained potentially disputable facts, specifically in paragraphs 6 and 9 of the letter, without providing Dr. Wong with the opportunity to cross examine the declarant;
2. the failure to produce correspondence sent from the College to the Ministry of Community and Social Services requesting the victim impact statement; and
3. the unusual nature of the victim impact statement in that it was from an institution rather than an individual patient or complainant.

The Committee reviewed the letter in order to determine whether it should be admitted. Having carefully considered the letter, the Committee determined that the bulk of the letter consisted of general statements regarding the impact of Dr. Wong's actions on public policy and on relationships of physicians, in general, with the Ministry of Community and Social Services. These statements were not contested by the defence. Of the two contested paragraphs, paragraph 6 contained substantive quantitative information which could reasonably be the subject of cross examination. The Committee ordered that if the letter were to be introduced without the opportunity for cross-examination, paragraph 6 should be redacted. Paragraph 9, on the other hand, contained information that was of a broader and more general nature and it was the Committee's decision that this paragraph was admissible as part of the victim impact statement, but that the Committee would consider the appropriate weighting of such statement, given the declarant was not subject to cross-examination.

The victim impact statement from the Ministry of Community and Social Services was introduced as evidence with the redactions that were ordered by the Committee. The letter states, in part, that physicians like Dr. Wong, who confirm the diagnosis on SDA forms without first satisfying themselves that the patient has the medical condition, have a very negative impact on the integrity of the program. It was the opinion of the Ministry that as a result of Dr. Wong's actions, the trust and reliance of the government had been eroded.

Paragraph 9 of the letter stated that an enhanced monitoring system of SDA forms had been introduced and that significant resources were associated with this activity. It was the view of the Committee that such a monitoring system would reasonably be expected of a government ministry, and the Committee therefore placed little weight on the claim that resources attributed to this activity could be considered in any assessment of penalty for Dr. Wong.

Dr. Wong also objected to the calling of both College witnesses. The College stated these witnesses were being called to testify with respect to a College investigation which had been conducted after the start of the hearing. The College submitted that it intended to lead evidence from these witnesses that would support the College's requested penalty components of supervision and audit. The College was clear that the purpose of the evidence of subsequent conduct was to justify the nature of the monitoring and supervision that it submitted was appropriate.

In support of their objection, the defence argued that unless the practitioner puts his or her character at issue or falsely suggests that the alleged conduct was an isolated instance, or unless a later finding of misconduct is made, subsequent bad conduct on the practitioner's part usually cannot be used against him or her.

The Committee found that it could consider evidence of subsequent conduct, both positive and negative, in fashioning an appropriate penalty. The Committee, in denying the objection, clearly understood that the evidence of subsequent conduct did not constitute additional evidence in relation to its findings or of additional allegations that were not before the Committee during the finding phase of this hearing. The Committee admitted the evidence of subsequent conduct for the limited purpose of determining the appropriate penalty, in particular, the need for specific deterrence. It was of assistance to elucidate Dr. Wong's attitude and whether or not he appreciated the seriousness of his earlier actions (*Del Bianco v. Alberta (Securities Commission)*, [2004] A.J. No. 1222 (C.A.); *R. v. Rolex Watch Co. Canada*, [1980] O.J. No. 770 (C.A.)). This subsequent conduct occurred after the referral to the Discipline Committee.

The Committee heard from Ms X, a College investigator. Ms X testified to having received a telephone call from the Ministry of Community and Social Services indicating that SDA forms submitted by Dr. Wong in 2012 were concerning in that a high proportion of forms confirmed that the patients in question had "chronic wounds or burns". Ms X was asked by the College to request that Dr. K, who gave expert opinion in the findings portion of the hearing, review these cases.

Although the Ministry had initially stated that of 108 SDA forms submitted in 2012, 70 had chronic wounds and burns, Ms X was able to find only 69 such charts. She was responsible for providing copies of 64 of the 69 charts (five were unavailable) to Dr. K and for forwarding his two responses on February 25 and May 10, 2013 to the Inquiries, Complaints and Reports Committee (ICRC).

In response to questions on cross-examination, Ms X testified that it was not her decision to make this investigation part of the penalty hearing. She also testified that it was common practice to request subsequent opinions from an opinion provider who had been involved earlier in the hearing. She agreed that although there might be some concern that the expert could be biased by his prior findings, she did not feel that to be the case in this instance. She further testified that Dr. Wong and his staff were extremely cooperative in obtaining the charts and copying them.

Dr. K, Family Physician-in-Chief at Hospital A, had been previously qualified as an expert in this hearing. He testified that he received 64 charts copied by Ms X. Because he was requested to provide an expedited opinion, he initially selected every third chart. These were the subject of a report dated February 25, 2013. He provided a second report on May 10, 2013, which repeated the opinions in his first report and then added information regarding the remaining 42 charts. Dr. K testified that these charts were different from those he had examined for the finding phase of the hearing, which had consisted of single page questionnaires completed by the patient and by Dr. Wong. In this instance, the charts were those of patients who had an ongoing relationship with Dr. Wong as their primary care physician and therefore consisted of multiple entries and

pages. In addition, he was provided with the relevant SDA forms. The Committee noted that the format of these forms had been modified in 2011 from the format of the forms which were the subject of the finding phase of the hearing.

In his report of February 25, 2013, Dr. K was critical of the fact that all patients in the 22 charts reviewed (i.e. 1 in 3 of the 64 charts that he received) were diagnosed as having Stage I to II chronic wounds. He said this was statistically highly improbable. However, at this stage he was unaware that the charts had been selected because the SDA forms included this diagnosis. In his second letter, he modified this statement saying that it was highly improbable that 64 patients in any family physician's office would have Stage I to II chronic wounds. Dr. K provided a definition of a Stage I wound from the National Pressure Ulcer Advisory Panel (2007) as being "intact skin with non-blanchable redness of a localized area usually over a bony prominence. The skin may be darkly pigmented and may not have visible blanching, its colour may differ from the surrounding area, and the area may be painful, firm, soft, warm or cooler as compared to the adjacent tissues. Category 1 may be difficult to detect in individuals with dark skin tones". Stage II is defined as "partial thickness, loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. It may present as an intact or open/ruptured serum-filled or sero-sanginous filled blister."

Dr. K was critical of the lack of descriptive evidence with documentation of chronic wounds on most patient charts. There was no evidence that Dr. Wong had prescribed a specific diet or had given dietary advice. He was also critical of the inclusion of this diagnosis on the SDA form because, in his view, such a condition would not be responsive to a change in the patient's diet. On the other hand, he admitted that the Ministry of Community and Social Services provided a dietary allowance for patients with Stage I or II chronic wounds.

Dr. K was also critical of the lack of information supporting the diagnosis of lactose intolerance which was present on all SDA forms reviewed. He was also critical of the fact

that patients in whom osteoporosis was indicated either had no bone densitometry measurement or the bone density was in the osteopenia (not osteoporosis) range.

Dr. K did not recall having seen a sheet of guidelines from the Ministry of Community and Social Services entitled "What healthcare professionals need to know" (about the Special Diet Allowance). These guidelines incorporated definitions of certain conditions, including diabetes and osteoporosis, and confirmed the removal of certain conditions, including egg allergy and soy allergy, from the form.

Dr. K reviewed six specific charts in some detail during his evidence. This resulted in some modification of his conclusions. In Patient 1, where he was initially critical of the diagnoses of diabetes, obesity, lactose intolerance and chronic wounds, he admitted that the chart showed a value for Hemaglobin A1C that would be recognized by the Ministry of Community and Social Services as justifying a diagnosis of diabetes. In Patient 7, he was initially critical of diagnoses of hypercholesterolemia, lactose intolerance and chronic wounds, but on cross examination noted that a high density lipoprotein value in the chart was marginally abnormal and could be considered to be hypercholesterolemia. There was also a note of "milk diarrhea" and of varicose vein stasis which would have justified the two diagnoses. Patient 13 was a 10 year-old boy who had a chronically non-healing wound. Dr. K's criticism of this was that it would have justified further investigations since it was so unusual. However, the fact that the wound was present and not healing was not contested. He remained critical of the diagnoses of lactose intolerance, soy allergy and constipation, which he felt were not justified by the notations in the chart. In patient 22, he was critical of the diagnosis of hypercholesterolemia but admitted that the LDL-cholesterol ratio and the HDL-cholesterol ratio were marginally abnormal (outside the target range). In two other patients, 40 and 45, his criticisms of nine diagnoses in one, and two in the other were not contested.

It was Dr. K's firmly held opinion that in order to justify completing the SDA form with a specific diagnosis, the physician should record the patient's specific dietary recommendations and that failure to do so fell below the standard of practice. He also felt

that it was not appropriate to complete the SDA form with a diagnosis of Stage 1 chronic wound since there was no evidence that this would benefit from dietary recommendations. It was his overall opinion that Dr. Wong continued to over-emphasize conditions in a way which would help his patients, with the result that he frequently completed the forms indicating a diagnosis for which there was minimal evidence in the chart.

The Committee found that Dr. K held Dr. Wong to a very high standard. This, on occasion, led him to be somewhat overly critical of Dr. Wong's actions when they were in fact within the boundaries set by the Ministry. At the same time, the Committee accepts that Dr. K's evidence supports that, prior to the release of the Committee's decision and reasons on finding of December 12, 2012, Dr. Wong continued to practise in a way which leaned so heavily towards advocacy for his patients that he made claims in completing the SDA forms that were not substantiated by the information in his patients' charts.

SUBMISSIONS

The College submits that the appropriate penalty is for Dr. Wong to be reprimanded and that his certificate of registration be suspended for a period of nine months. It is further submitted that following Dr. Wong's return to practice he should be subject to a preceptorship in medical record keeping and completion of special diet allowance forms; that he submit all special diet allowance forms to his preceptor who would co-sign these forms; and that his preceptor should review 10 to 15 patient charts a month until satisfied that Dr. Wong's record keeping meets the standard of care, after which a reduction in frequency may be approved by the College. The College submitted that within 12 months of completing the preceptorship, Dr. Wong undergo reassessment with regard to medical record keeping and completion of SDA forms; and that Dr. Wong's OHIP billings should be inspected at 3, 6, 9 and 12 months. The College submitted that a fine payable to the Ministry of Finance of $35,000 should be paid by Dr. Wong and that he should within 9 days pay the College costs of 12 days of hearing time at the tariff rate of $4,460/day, amounting to a total of $53,520.

Counsel for Dr. Wong submitted that an appropriate penalty was a reprimand. In the alternative, if the Committee was inclined to order a preceptorship, he argued that it should only incorporate a review of SDA forms.

The College submitted that Dr. Wong's actions were serious and far beyond the acceptable actions of his peers. The College pointed out that 51% of the "high dollar value" SDA forms submitted in the province were submitted by Dr. Wong and that this was achieved by a claim that 99% of his patients had four food allergies and chronic constipation. Ninety-six per cent of the forms submitted resulted in the payment of the maximum allowable amount for special diets. The College pointed out that Dr. Wong's actions occurred over a period of several years and certainly did not represent an isolated incident. The College argued that they increased exponentially over time and were motivated by personal gain. Dr. Wong's actions resulted in his billing for an assessment of the patient, as well as completion of the form (an activity that took only 5 to 6 minutes) and resulted in his billing between $400,000 and $700,000 annually.

It was the College's position that a relatively severe suspension was justified by the severity of the conduct and particularly by the extent of the burden on the public purse. The College also contended that Dr. Wong's behaviour was dramatically different from that of other physicians. Dr. Wong completed 34,000 SDA forms. This was 10 times more than the next largest number completed by any single physician, and was 30 times more than the average number of SDA forms completed by physicians who ranked between 2nd and 10th in the number of forms completed. The audit conducted by the Ministry of Community and Social Services determined that Dr. Wong was the sole physician who was responsible for the extreme variation in the audit. The College proposed that the preceptorship, monitoring, audit and reassessment were justified not only by the findings made by this Committee, but by Dr. Wong's continued practice of completing forms without adequate confirmation, even though he is no longer under the pressure of seeing very large numbers of patients in minimal time periods. With respect to the fine proposed, which is at the highest level allowed under the regulations, the

College pointed to the fact that Dr. Wong had not been required to make any restitution. The College argues the maximum fine was justified by the severity of the conduct as well as by the degree to which Dr. Wong had benefitted.

Counsel for Dr. Wong advised that Dr. Wong accepted the decision of the Committee and expected to live up to the standard of practice defined by the Committee. Counsel argued that there were no known standards, or guidelines, prior to the Committee's ruling and that the Ministry only produced guidelines after the hearing had taken place. Although it is the case that there were no published guidelines from the Ministry, it is not correct to say that there was no known standard of practice prior to the findings of this Committee. This Committee must identify the standard of practice of the profession (which in some cases can be challenging), but it does not impose standards of practice on the profession. It seeks to determine whether or not a physician has failed to maintain the standards of practice of the profession - such as they are. In this case, the Committee identified the standard of practice based on the evidence of the expert witnesses and made a finding that Dr. Wong failed to maintain the standard of practice of the profession.

Counsel for Dr. Wong argued that the hearing had a salutary effect on both the Ministry of Community and Social Services as well as Dr. Wong, and he pointed out the initial views of experts were modified by experts for both parties during the course of the hearing. Counsel also argued that the College had failed to prove that Dr. Wong was incompetent and the Committee had not described Dr. Wong's conduct as being disgraceful or dishonourable. Although the Committee did not find Dr. Wong to be deliberately fraudulent, counsel admitted there may have been "willful blindness" on Dr. Wong's part.

Dr. Wong has been practising for more than 30 years with no previous disciplinary findings and no problems before he began to complete the SDA forms. His counsel argued that a significant suspension would result in a seriously disadvantaged population no longer having access to his practice. He submitted the degree of supervision by the preceptor that was proposed by the College was excessive and unnecessary. Finally, he

submitted that costs for only a single day would be reasonable because of the failure of the Committee to make a finding with respect to incompetence and the specific exclusion of disgraceful and dishonourable conduct from the findings.

DECISION AND REASONS ON PENALTY

The Law and General Principles of Penalty Decisions

Having found that a member has committed an act of professional misconduct, the Committee may make any one or more of the orders permitted under section 51(2) of the Code including to require the member to pay a fine of not more than $35,000 to the Minister of Finance.

The penalty must be proportionate to the findings made. Moreover, a penalty must follow a number of established general principles that include protection of the public, maintenance of public confidence in the integrity of the profession and the College's ability to govern the profession, denunciation of the conduct, specific and general deterrence, the maintenance of public trust and, where appropriate, rehabilitation of the member.

In determining an appropriate penalty, the Committee took specific note of the decision in *Yazdanfar (Re),* [2011] O.C.P.S.C. No. 37 citing *Bolton v. Law* Society, [1994] 2 All E.R. 46 (C.A.), in which the following comments were made at page 492: "The second purpose is the most fundamental of all: to maintain the reputation of the solicitor's profession as one in which every member in whatever standing may be trusted to the ends of the earth." In our view, this is equally applicable to the medical profession. To paraphrase a further quotation from this judgment, the essential issue is the need to maintain among members of the public a well-founded confidence that any physician who they consult will be a person of unquestionable integrity, probity and trustworthiness. In applying these principles, the Committee was mindful that the phrase "members of the public" should be considered to include those political and social

institutions that represent the public, including Ministries, committees and formal structures of any order of government.

The College drew the Committee's attention to a total of ten Discipline Committee decisions regarding physicians whose conduct, it argued, bore some similarity to those of Dr. Wong. The penalties in the cases cited range from no suspension to a maximum of an effective suspension of six months (12 month suspensions reduced by 6 months by the payment of restitution in the amount of $200,000 in *Pinto,* or by the payment of a fine of $5,000 and costs to the College of $2,500 in the case of *Moore*). In two cases where the physician received no personal benefit from his fraudulent actions, either no suspension was ordered (*Kaminski*) or an effective suspension of one month was ordered (*Metcalfe*). In addition, the Committee noted that only two of the ten cases were the result of a contested hearing, in one of which (*Kumra*) a suspension of six months was ordered. The Committee took note that the very number of cases relied upon by the College only underlined the unique nature of Dr. Wong's actions.

It was the view of the Committee that the financial consequences of Dr. Wong's actions to the public at large were repetitive and of a continuing nature. This, in addition to the way in which Dr. Wong compromised his integrity, placed Dr. Wong's actions in a serious category and justifies a significant period of suspension. In addition, Dr. Wong has not been required to make restitution and was not the subject of any criminal proceedings as did some of the physicians in the cases cited (*Moore, Paikin, Pakes* and *Pinto*).

The Committee determined that a six month suspension is appropriate. The Committee did not believe that a longer suspension was justified, given its conclusions regarding both the fine and the extent of supervision and monitoring. The Committee also took into account Dr. Wong's belief, misguided though it was, that his primary purpose was helping his patients. The period of suspension is a significant sanction which should give Dr. Wong, the profession as a whole, and the public at large a clear message that maintenance of integrity and public trust is of paramount importance.

In coming to a conclusion about penalty, the Committee placed relatively little weight on the victim impact statement from the Ministry of Community and Social Services. The letter did not add to the conclusions that a reasonable person might draw from the Committee's findings regarding the impact of Dr. Wong's actions on the public and integrity of the medical profession. The Committee specifically rejected the penultimate paragraph of the letter which stated that an enhanced monitoring system of SDA application forms has been introduced as a result of Dr. Wong's actions. Indeed, it was the lack of adequate monitoring on the part of the Ministry which allowed Dr. Wong to continue in the way that he did for such a long period.

The evidence provided by Dr. K in the penalty hearing was of some value, in that it demonstrated that Dr. Wong continued to have as his primary motive the maximum provision of benefits for his patients. It also demonstrated that Dr. Wong had changed his practice and was no longer completing SDA forms for patients whom he was not seeing on an ongoing basis. Dr. Wong continued prior to the release of the Committee's decision on finding to make SDA claims with inadequate justification, which supports the need for a period of intensive monitoring of both his clinical records and his completion of SDA forms.

The Committee had found that with respect to the 50 charts reviewed in the finding phase of the hearing, Dr. Wong failed to maintain the standard of practice with respect to record keeping. Monitoring of his records with the aim of improving the standard of his record keeping was therefore a reasonable rehabilitative component of the penalty.

The Committee agrees with the preceptorship that was recommended by the College. It is important that the preceptorship be aimed at improving Dr. Wong's standard of record keeping on the one hand and the accuracy of his completion of special diet allowance forms on the other. This preceptorship shall be followed by a reassessment with respect to both his medical record keeping and his completion of special diet allowance forms. As well, the preceptorship shall also incorporate inspections of Dr. Wong's OHIP billings

and their supporting chart entries at three month intervals to be conducted by the staff of the College. Only such an intensive form of monitoring will provide a combination of appropriate rehabilitation of Dr. Wong's practices and at the same time reassurance to the public and to the profession at large that his practice is changing and is meeting the standards of the profession.

Dr. Wong has not, as far as the Committee is aware, made any form of restitution and the imposition of the maximum allowable fine represents an appropriate denunciation of his behaviour.

ORDER AND REASONS ON COST

Section 53.1 of the Code provides that in an appropriate case, the Committee may make an order requiring a member, who the Committee finds has committed an act of professional misconduct, to pay all or part of the costs associated with the hearing, including:

1. The College's legal costs and expenses.
2. The College's cost and expenses incurred in investigating the matter.
3. The College's cost and expenses incurred in conducting the hearing.

SUBMISSIONS

The College asked for $53,520 in costs. The College based this request on the cost of two days for hearing motions (the day for the hearing of the motion by an intervener was not included) plus eight days of hearing and two days of penalty hearing at the current daily tariff of the College of $4,460.

The defence did not dispute the fact that this was a suitable case for costs to be awarded. Counsel argued, however, that Dr. Wong made significant admissions at the beginning of the hearing and that Dr. Wong's decision to complete the forms in the way he did was a

consequence of lack of appropriate guidelines. He submitted that he should pay costs for a single day at the old tariff.

The Committee was referred to the decisions of this Committee in *Yazdanfar (Re), supra,* and *Lo,(Re),* [2013] O.C.P.S.D. No. 1. In *Yazdanfar,* the College requested costs for 60 hearing days (of a total of 70 days used). The Committee in *Yazdanfar* was in agreement with the College that the College was substantially successful in proving this series of allegations which related to unsafe patient care, and were of the opinion that the award of $219,000 was appropriate. On the other hand in *Lo*, the College requested costs for 13 days of hearing. This was reduced by the Committee to one day on the grounds that many of the allegations were not proven. Moreover, the length of the hearing was influenced substantially by a witness for the College of whom the Committee was severely critical.

In considering costs, it was the opinion of the Committee that the appropriate tariff to be applied was the tariff that was in force at the time of the relevant part of the hearing. The tariff that was in force at the time of the penalty hearing was $4,460 while the tariff in force during the findings portion of the hearing was $3,650. The Committee is aware that this per diem tariff does not cover the actual costs of the College of a hearing day before the Discipline Committee, and furthermore does not include investigative costs, the cost of experts, legal preparation and legal attendance, all of which may be included in determining quantum of costs. The Committee was of the opinion that there were mitigating factors with respect to Dr. Wong's responsibility for the length of the hearing. Specifically, no finding was made on the allegation of incompetence. Experts on both sides modified their position during the course of giving evidence.

Accepting that costs are inherently discretionary, and in the attempt to be fair and reasonable, the Committee allocated 100% of the time taken for debating motions (excluding the motion by an intervener), 50% of the time taken in the hearing proper and 50% of the penalty hearing, each to be calculated at the tariff in effect at the time of that part of the hearing. This amounts to two days of motions, four days of the hearing itself

and one day of penalty hearing, the latter at the higher tariff. Total costs awarded are $26,360.

ORDER

Therefore, the Discipline Committee orders and directs that:

1. The Registrar suspend Dr. Wong's certificate of registration for a period of six months, to commence fourteen (14) days after the date of this Order.

2. Dr. Wong attend before the Panel to be reprimanded.

3. The Registrar impose the following terms, conditions and limitations on Dr. Wong's certificate of registration for a period of one year from the date of Dr. Wong's return to practice, except the conditions in paragraph 3d and f, which shall remain in effect until completion:

    a. Within 30 days of his return to practice, Dr. Wong shall participate in and successfully complete a preceptorship in medical record keeping and in the completion of special diet allowance forms with a preceptor who is to be approved by the College in its sole discretion and who has signed an undertaking to the College in the form attached hereto as Schedule A (The Preceptor).

    b. Dr. Wong shall abide by all recommendations of his preceptor with respect to practice improvements and professional development. Dr. Wong shall provide 10 to 15 patient charts to his preceptor for review on a monthly basis until the preceptor is satisfied that Dr. Wong's record keeping meets the standard of care and the College approves a reduction in frequency. When the preceptor is satisfied that Dr. Wong's record keeping meets the standard of the profession and the College has approved, the preceptor shall continue the chart review every three months for the remainder of the year. All charts to be selected for the preceptor are to be selected from those patients seen in the previous month. The preceptor shall provide reports to the College at the same frequency as the chart review.

c. Dr. Wong shall retain a copy of all special diet allowance forms which he will submit to his preceptor along with the corresponding patient chart on a monthly basis. The preceptor will review and co-sign every copy of a special diet form and will report any irregularity to the College. (To clarify, the special diet forms need not be co-signed before they are given to the patient).

d. Within 12 months of completing the preceptorship required by paragraph 3a above, Dr. Wong shall undergo reassessment with regard to medical record keeping and his completion of special diet allowance forms by a College appointed assessor. Dr. Wong shall abide by all recommendations with regard to medical record keeping and the completion of special diet allowance forms made by the assessor and the results of the reassessment shall be reported to the College.

e. Dr. Wong shall cooperate with the Compliance Monitoring and Supervision Staff of the College who will conduct inspections of Dr. Wong's OHIP billings and their supporting chart entries. These reviews are to occur during the year at approximately 3, 6, 9 and 12 months from the date of Dr. Wong's return to practice and Dr. Wong shall cooperate with unannounced inspections of his practice and patient charts by a College representative for the purpose of monitoring and enforcing his compliance with the terms of this order. Monitoring this order, including the term under paragraph 3c above, shall include making enquiries of the Ministry of Community and Social Services regarding Dr. Wong's completion of special diet allowance forms.

f. Dr. Wong shall be responsible for any and all costs associated with implementing the terms of this order.

4. Dr. Wong shall within 30 days pay a fine to the Minister of Finance in the amount of $35,000 and Dr. Wong shall provide proof of this payment to the Registrar of the College.

5. Dr. Wong shall within 30 days pay the College its costs in this proceeding in the amount of $26,360.