

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Howard Wu, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

Every person who contravenes an order made under ... section 45 or 47... is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. WU,
2020 ONCPSD 1**

**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:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. HOWARD WU

PANEL MEMBERS:

**DR. PAUL GARFINKEL
MS. CHRISTINE TEBBUTT
DR. DEBORAH HELLYER
MR. J. PAUL MALETTE, Q.C.
DR. STEPHEN HUCKER**

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. MORGANA KELLYTHORNE

COUNSEL FOR DR. WU:

**MS. ANNE POSNO
MS. KELLY HAYDEN**

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. JENNIFER McALEER

Hearing dates:	October 1, 15 and 17, 2019
Decision date:	October 17, 2019, 2019
Release of Reasons Date:	January 8, 2020

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario (the “College”) heard this matter at Toronto on October 1, 15 and 17, 2019. On October 17, 2019, the Committee released a written order stating its finding that the member had committed an act of professional misconduct and was incompetent, and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Wu committed acts 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;
2. under clause 51(1)(a) of the *Health Professions Procedural Code* (the “Code”), Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 in that he has been found guilty of an offence that is relevant to his suitability to practise;
3. under paragraph 1(1)5 of O. Reg. 856/93, in having a conflict of interest; and
4. under paragraph 1(1)33 of O. Reg. 856/93 in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Wu was incompetent as defined in subsection 52(1) of the Code.

RESPONSE TO THE ALLEGATIONS

Dr. Wu admitted that he committed acts of professional misconduct:

- (a) under paragraph 1(1)2 of O. Reg. 856/93 made under the Medicine Act, 1991 in that he failed to maintain the standard of practice of the profession;
- (b) under clause 51(1)(a) of the *Code*, in that he has been found guilty of offences relevant to his suitability to practice, namely dangerous operation of a motor vehicle under section 249(1)(a) of the *Criminal Code of Canada*, (the "*Criminal Code*") operating a motor vehicle without insurance under the *Compulsory Automobile Insurance Act*, and driving while disqualified under section 259 of the *Criminal Code*;
- (c) under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in 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.

Dr. Wu also admitted that he was incompetent in respect of his care and treatment of: Patient A; the 22 patients whose care was reviewed by Dr. Nijhawan, a medical inspector retained by the College; and the patient identified in Dr. Lam's report as "Chart #1."

Dr. Wu pled no contest to the allegation of professional misconduct on the basis of having a conflict of interest. He also pled no contest to the allegation of disgraceful, dishonourable or unprofessional conduct with respect to his financial relationship with the medical devices supplier.

THE FACTS

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

BACKGROUND

1. Dr. Howard Wu ("Dr. Wu") is a 50 year-old family physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") in June 1997. He completed his medical degree at Queen's University in 1994, and his postgraduate training in family medicine through the University of Toronto in 1997.
2. At the relevant time, Dr. Wu practised family medicine in Markham, Ontario at the Smart Health Medical Clinic.

FACTS

Registrar's Investigation re Death of Patient A

3. On June 3, 2016, the College received a letter from Dr. Dirk Huyer, the Chief Coroner for Ontario, describing his concerns about the care and treatment that Dr. Wu provided to Patient A in November and December 2015, specifically regarding Dr. Wu's approach to medical assessment and care of a febrile neonate (a newborn with a fever). Patient A died on December 3, 2015 in hospital of *E.coli* sepsis due to meningitis. He was 19 days old. Dr. Huyer's letter, enclosing a copy of the Coroner's Investigation Statement and Paediatric Death Review Committee report, is attached at Tab 1 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.

4. The College appointed investigators on June 23, 2016. Dr. Mark Nassim was retained as a medical inspector to provide an independent opinion regarding Dr. Wu's care of Patient A. Dr. Nassim interviewed Dr. Wu, and reviewed Dr. Wu's office chart, as well as hospital and ER records.
5. Dr. Wu's office chart for Patient A is attached at Tab 2 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.
6. In his report dated September 28, 2016, which is attached at Tab 3 and forms part of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts, Dr. Nassim opined that the care Dr. Wu provided to Patient A did not meet the standard of practice of the profession and displayed a lack of knowledge, skill, and judgment. Dr. Nassim was concerned regarding Dr. Wu's chart note that he recommended the patient, a newborn, be given water and vitamin C-rich juice when he saw him on November 25, 2015. The infant's elevated temperature reported in the subjective notes on that date was concerning and Dr. Wu should have recommended the mother bring her son to hospital immediately. On a subsequent visit two days later, the temperature was still elevated at 37.4°C and the inappropriate recommendation to add water was repeated in the chart. Dr. Wu also used an infrared thermometer to measure body temperature in the context of evaluating a potentially critical illness, which is not recommended. Dr. Nassim further opined that Dr. Wu's clinical practice, behaviour or conduct exposed or was likely to expose newborn patients to harm or injury.
7. Dr. Wu failed to maintain the standard of practice of the profession and was incompetent in respect of his care and treatment of Patient A.

Registrar's Investigation re Medical Devices

8. Sun Life Assurance Company of Canada ("Sun Life") wrote to the College expressing concern regarding Dr. Wu's completion of medical supply claims. Sun Life had received a "very high quantity of medical supply claims bearing referrals" from Dr. Wu, and, because it suspected there was no medical necessity underlying the claims, Sun Life had requested medical notes from the patients. Upon review, as noted by a Sun Life medical consultant, the clinical notes were all in the same format and cited similar complaints, stated that investigation had been refused by the patient, and contained identical treatment plans. There was no medical support for prescription of the devices. Sun Life also noted connections between Dr. Wu and the medical supplier, Health A. Smart Wellness Centre (also known as 'Health Aid'), namely that Dr. Wu's administrator was a director of the wellness centre. The email from Sun Life representative Melissa Haig to the College dated December 19, 2013, with attachments, is attached at Tab 4 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.

9. College investigators were appointed as a result, and Dr. Beryl Moore was retained as a medical inspector. She reviewed patient charts from Dr. Wu's office and corresponding information from Sun Life, and interviewed Dr. Wu.

10. Dr. Wu does not admit, but does not contest that, as he stated in his interview with Dr. Moore, he received financial compensation, in respect of the patients to whom he prescribed the medical devices, from the wellness centre that supplied the devices:
 - the proprietor of the wellness centre, April Chan, had access to Dr. Wu's computer system;
 - the wellness centre would schedule patients for Dr. Wu to see;

- he prescribed those patients braces and other medical devices;
- this took place between 2011 and 2015;
- he was paid \$100 per patient per year for every patient to whom he prescribed medical devices and referred to the wellness centre next door.

11. Dr. Moore's report, received July 15, 2016, is attached at Tab 5 and forms part of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts. As Dr. Moore found, Dr. Wu failed to maintain the standard of practice of the profession in his care and treatment of 19 patients (i.e., all of the patient charts reviewed by Dr. Moore) presenting with musculoskeletal complaints who were referred to him from the wellness centre next door; for example, in the use of multiple bracing at a single visit or over several visits in a short period of time, lack of investigations, and lack of follow-up. While Dr. Moore did not find that Dr. Wu's behaviour or conduct exposed the 19 patients whose care she reviewed to harm or injury, she did find that his care displayed a lack of knowledge, skill and judgment.

12. The College investigator sought more information and documentation from Dr. Wu regarding his financial relationship with the wellness centre. The College investigator's letter to Dr. Wu's counsel dated February 1, 2018 is attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 6. However, Dr. Wu advised that he was unable to provide the information requested, by letter dated April 12, 2018, which is attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 7.

13. In a prior investigation in 2013-2014, Dr. Wu provided responses to the College asserting that he had no financial interest in the sale of braces/medical devices which were sold by the same wellness centre next to his clinic, and that there was no conflict of interest in relation to Dr. Wu's prescription of braces and the

payment for these devices to the wellness centre. Dr. Wu does not admit but does not contest that the information Dr. Wu provided to the College at that time was untrue. Dr. Wu's assertions to the College are contained in prior correspondence dated October 8, 2013, October 24, 2013, November 25, 2013, and January 15, 2014, attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 8. The Inquiries, Complaints and Reports Committee (ICRC) decision dated July 23, 2014 is attached at Tab 9 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.

14. Dr. Wu admits that he failed to maintain the standard of practice of the profession with respect to the 19 patients whose care was reviewed by Dr. Moore. Dr. Wu does not contest that he had a conflict of interest and engaged in disgraceful, dishonourable or unprofessional conduct with respect to his financial relationship with the medical devices supplier. Dr. Wu does not contest that he also engaged in disgraceful, dishonourable or unprofessional conduct in failing to disclose this financial relationship to the College in a prior investigation and in providing untruthful information to the College about it.

Registrar's Investigation regarding Eye Examinations

15. On April 2, 2015, the College received information from an investigator at Sun Life raising concern regarding claims submitted for eye examinations by Dr. Wu. Sun Life had received approximately eight hundred eye examination claims for services rendered by Dr. Wu between January 3, 2012 and March 20, 2015. To determine whether eye examinations were within Dr. Wu's scope of practice, Sun Life had sought to contact Dr. Wu on four occasions, but he had failed to respond. The email from the Sun Life investigator is attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 10. Dr. Wu apologized for failing to respond to the email from Sun Life in a letter

to the College investigator on June 7, 2018.

16. The College initiated an investigation. It faced challenges in obtaining Dr. Wu's patient records for review during the course of its investigation, as outlined in the investigator's memorandum to file and supporting documentation attached at Tab 11 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts. The College began to seek the records in the summer of 2015. Dr. Wu advised in November 2015 that none of the 25 individuals whose records were sought (based on claims having been submitted to Sun Life for eye examinations he conducted) were "patients of his clinic," but instead were "customers of Fuji Optical Company." Between November 2015 and September 2016, the College attempted to retrieve Dr. Wu's medical records in respect of these patients from Fuji Optical, eventually being provided with eight two-page patient charts in September 2016. Dr. Wu advised he had no document, file, record, or other material in relation to any of the listed individuals.
17. The College retained Dr. Navdeep Nijhawan as medical inspector to provide an independent opinion regarding Dr. Wu's care and treatment of patients based on seven patient charts that were able to be retrieved from Fuji Optical as well as 15 other patient records regarding eye care obtained from Dr. Wu's office in 2017. Dr. Nijhawan also interviewed Dr. Wu.
18. Dr. Nijhawan's report received on April 4, 2017 and addendum received on April 11, 2017 are attached at Tab 12 and form part of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts. As Dr. Nijhawan concluded, Dr. Wu did not meet the standard of practice of the profession in the care and treatment of the 22 patients whose charts were reviewed. The refractions he performed were incomplete with key elements not being performed. Major elements of the exam were missing in periodic oculo-visual assessments. Dr. Wu lacked both knowledge and judgment, for example having trouble in the interview

describing basic instruments used for refraction or articulating the basic steps of refracting a patient. Dr. Wu had advised Dr. Nijhawan in his interview that he was no longer performing refractions or complete eye examinations. Dr. Nijhawan opined that if Dr. Wu were to continue to perform refractions or complete eye examinations, there would be significant risks to patients, with risk to children and older patients in particular.

19. As Dr. Nijhawan observed in his report, Dr. Wu submitted claims to the Ontario Health Insurance Plan (OHIP) for periodic oculo-visual examinations performed in his office, without performing the minimum elements required by the Schedule of Benefits.

20. Dr. Wu provided a response to Dr. Nijhawan's report. Upon reviewing it, Dr. Nijhawan provided the College with a further report containing his reply, dated November 12, 2017, attached at Tab 13, which forms part of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts. Dr. Nijhawan remained concerned that Dr. Wu had gaps in his knowledge of the basic technique of refracting and had trouble identifying basic equipment. Some charts did not identify pre-op vision and none identified post-op vision. Nor was Dr. Nijhawan confident that Dr. Wu was in a position to identify issues that required directing the patient to a doctor for a proper examination. There continued to be concerns regarding Dr. Wu's in-office examinations and the specific charts reviewed.

21. Dr. Wu admits that he failed to maintain the standard of practice of the profession in his care and treatment of the 22 patients whose charts were reviewed by Dr. Nijhawan and that he was incompetent in respect of his care and treatment of these patients. Dr. Wu admits that he engaged in disgraceful, dishonourable or unprofessional conduct in respect of his failure to respond to Sun Life's inquiries, in submitting claims to OHIP that were not appropriately

supported by his records, and failing to ensure appropriate storage and maintenance of his medical records.

Reassessment of Family Practice

22. On March 8, 2016, Dr. Wu entered into an undertaking which required him to complete professional education, including clinical supervision, and to undergo a reassessment. Dr. Wu's undertaking of March 8, 2016 (the "2016 Undertaking") is attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 14.
23. Dr. Wu had entered into the 2016 Undertaking as a result of a prior unsatisfactory reassessment of his family practice, performed in March 2015 by Dr. Irene Cohen, who had found that Dr. Wu had failed to maintain the standard of practice of the profession and showed a lack of judgment in his care of four patients and in maintaining proper hygiene. Dr. Cohen's report of March 2015 is attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 15.
24. As required by the 2016 Undertaking, Dr. Wu completed a medical record-keeping course offered by the University of Toronto and completed summaries regarding his review of a number of policies, guidelines, and clinical issues. The summaries which Dr. Wu submitted to the College are attached at Tab 16 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts. Dr. Wu also completed a period of supervision from March 2016 to July 2017. The supervisor reports of Dr. Henry Wu dated March to May 2016 and the supervisor reports of Dr. Ken Ng dated June 2016 to July 2017 are attached at Tab 17 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.
25. Dr. Andrew Lam was retained by the College to reassess Dr. Wu's practice under

the terms of his 2016 Undertaking. Dr. Lam reviewed 20 of Dr. Wu's patient charts, observed Dr. Wu's encounters with six patients on November 29, 2018, performed an infection control office inspection, and interviewed Dr. Wu.

26. Dr. Lam's reassessment report received January 8, 2019 and his addendum report received January 21, 2019 are attached at Tab 18 and form part of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts. As Dr. Lam found, Dr. Wu failed to maintain the standard of practice of the profession and displayed a lack of judgment in his care of three patients, placing them at risk of harm.

27. Dr. Wu admits that he failed to maintain the standard of practice of the profession in his care and treatment of the three patients identified by Dr. Lam. Dr. Wu admits that he was incompetent in his care and treatment of one patient whose care was reviewed by Dr. Lam in what he identified in his report as Chart #1. In that case, Dr. Wu failed to conduct a pertinent history and investigation in managing a patient with suspected angina.

Registrar's Investigation regarding Offences

28. On August 24, 2017, the College received an anonymous letter alleging that Dr. Wu "was suspended from driving and again recently for Criminal Code violation," and that the information was not contained on the College's Public Register, which should be remedied. The anonymous letter is attached at Tab 19 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.

29. The College initiated an investigation. It obtained Dr. Wu's criminal record and driver's licence history from the Ontario Provincial Police ("OPP") on August 31, 2017, which are attached at Tab 20 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts. As they indicate, on September

10, 2015, Dr. Wu was convicted of dangerous driving under the *Criminal Code*, and on January 9, 2017, Dr. Wu was convicted of driving while disqualified under the *Criminal Code*.

30. Additional information obtained from the OPP on January 4, 2018, attached at Tab 21, which forms part of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts, demonstrates that on August 4, 2014, Dr. Wu was arrested on Highway 407 by the OPP and charged under the *Criminal Code* with dangerous operation of a motor vehicle, flight while pursued by a police officer, and assault with intent to resist arrest, as well as offences under the *Compulsory Automobile Insurance Act* and the *Highway Traffic Act*.

31. As a member of the College, Dr. Wu was required to complete an annual renewal report. On May 20, 2015, Dr. Wu completed his Annual Renewal Report to the College, attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 22. In it, he answered “no” to the question, “Since April 1, 2014, have you been charged with any offence in Canada or elsewhere?” This was untrue.

32. On September 10, 2015, Dr. Wu attended court in Newmarket, Ontario, where he pleaded guilty to the charge of dangerous operation of a motor vehicle under the *Criminal Code* (s. 249(1(a))) and received an absolute discharge for the dangerous driving charge. He was prohibited from driving for one year under the *Criminal Code*. He also pleaded guilty to operating a motor vehicle without insurance under the *Compulsory Automobile Insurance Act* (s. 2(1)(a)) and was fined. This is reflected in the documents received from the OPP above at Tab 20 as well as in the court transcript of the proceedings and reasons for sentence dated September 10, 2015, attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 23.

33. Nonetheless, on May 20, 2016, Dr. Wu answered “no” to the following question on his Annual Renewal Report to the College, which is attached to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts at Tab 24: “Since April 1, 2015, have you been charged with and/or found guilty of, any offence in Canada or elsewhere? (Include all offences under the *Criminal Code of Canada*, the *Controlled Drugs and Substances Act*, the *Food and Drugs Act*, the *Health Insurance Act*, and/or related legislation in any Province or jurisdiction. In addition, include any other offences related to the practice of medicine.”). Dr. Wu’s response was untrue.
34. On September 5, 2016, Dr. Wu was arrested by the York Regional Police and charged with driving while disqualified under the *Criminal Code* and operating a motor vehicle without insurance under the *Compulsory Automobile Insurance Act*. Materials received from York Regional Police on December 11, 2017 in this regard are attached at Tab 25 and form part of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.
35. On January 9, 2017, Dr. Wu pleaded guilty to driving while disqualified under the *Criminal Code*, receiving a fine and a prohibition from driving for one year. The transcript of proceedings is attached at Tab 26 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.
36. Nonetheless, on May 15, 2017, Dr. Wu answered “no” to the following question on his Annual Renewal Report to the College, which is attached at Tab 27 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts: “Since April 1, 2016, have you been charged with, and/or found guilty of, any offence in Canada or elsewhere? (Include all offences under the *Criminal Code of Canada*, the *Controlled Drugs and Substances Act*, the *Food and Drugs Act*, the *Health Insurance Act*, and/or related legislation in any province or jurisdiction. In addition, include any other offences related to the practice of medicine.).”

37. On October 18, 2017, after having been contacted by the College investigator in August regarding this matter, Dr. Wu emailed the College's "Membership" email address, stating, "I am writing to correct one of the mistake [sic] I might have made on the renewal of membership last time. I was convicted criminally because [sic] driving disqualify. Please correct the mistake I might have made filling out the questionnaire." Dr. Wu's email of October 18, 2017 is attached at Tab 28 to the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.

38. Dr. Wu admits that he engaged in disgraceful, dishonourable, or unprofessional conduct with respect to his failure to disclose to the College, as required, the information relating to having been charged with and found guilty of offences. Dr. Wu admits that he has also been found guilty of offences relevant to his suitability to practice.

ADMISSION AND PLEA OF NO CONTEST

39. Dr. Wu admits the facts specified above, with the exception of those facts set out at paras. 10, 13, and 14 which he is specified not to contest. Based on the facts he has admitted, Dr. Wu admits that he committed acts of professional misconduct:

- (a) under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that Dr. Wu failed to maintain the standard of practice of the profession;
- (b) under clause 51(1)(a) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "Code"), in that Dr. Wu has been found guilty of offences relevant to his suitability to practice, namely

dangerous operation of a motor vehicle under section 249(1)(a) of the *Criminal Code of Canada*, operating a motor vehicle without insurance under the, and driving while disqualified under section 259 of the *Criminal Code of Canada*;

- (c) under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in 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.

Dr. Wu also admits that he was incompetent in respect of his care and treatment of: Patient A, the 22 patients whose care was reviewed by Dr. Nijhawan, and the patient whose care was reviewed by Dr. Lam and whose chart was identified in Dr. Lam's report as "Chart #1."

Dr. Wu does not contest the facts specified at paras. 10, 13, and the second and third sentence of paragraph 14 for the purposes of this proceeding, nor does he contest that these facts constitute professional misconduct:

- (a) under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in 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; and
- (b) under paragraph 1(1)5 of O. Reg. 856/93, in having a conflict of interest.

RULE 3.02 – PLEA OF NO CONTEST

Dr. Wu has pleaded no contest to the third allegation in the Notice of Hearing, i.e., that he had engaged in professional misconduct as a result of a conflict of interest. He also pleaded no contest with respect to the allegation of disgraceful, dishonourable or unprofessional conduct on the basis of the uncontested facts in paragraphs 10 and 13,

and the second and third sentence of paragraph 14 of the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.

Rule 3.02 of the Rules of Procedure of the Discipline Committee regarding a plea of no contest states as follows:

3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:

- a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
- b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
- c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

FINDINGS

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission and Statement of Uncontested Facts.

Having regard to these facts, and Dr. Wu's admissions (and plea of no contest to the facts set out at paragraphs 10 and 13, and the second and third sentence of paragraph 14), the Committee found that Dr. Wu committed acts of professional misconduct as follows:

- (a) under paragraph 1(1)2 of O. Reg. 856/93 made under the *Medicine Act*, 1991, in that Dr. Wu failed to maintain the standard of practice of the profession in

respect to: (i) his care and treatment of Patient A; (ii) his care and treatment of the three patients identified by Dr. Lam; (iii) in his care and treatment of 19 patients (i.e., all of the patient charts reviewed by Dr. Moore) presenting with musculoskeletal complaints who were referred to him from the wellness centre next door; and (iv) in his care and treatment of the 22 patients whose charts were reviewed by Dr. Nijhawan.

(b) under clause 51(1)(a) of the *Code*, in that Dr. Wu has been found guilty of offences relevant to his suitability to practice, namely (i) dangerous operation of a motor vehicle under section 249(1)(a) of the *Criminal Code of Canada*, (ii) operating a motor vehicle without insurance under the *Compulsory Automobile Insurance Act*, and (iii) driving while disqualified under section 259 of the *Criminal Code of Canada*;

(c) under paragraph 1(1)5 of O. Reg. 856/93, in having a conflict of interest with respect to his financial relationship with the medical devices supplier;

(d) under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in 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, in particular on the basis that: (i) he engaged in disgraceful, dishonourable or unprofessional conduct with respect to his financial relationship with the medical devices supplier; (ii) he engaged in disgraceful, dishonourable or unprofessional conduct in failing to disclose this financial relationship to the College in a prior investigation and in providing untruthful information; (iii) he engaged in disgraceful, dishonourable or unprofessional conduct in respect of his failure to respond to Sun Life's inquiries, in submitting claims to OHIP that were not appropriately supported by his records, and failing to ensure appropriate storage and maintenance of his medical records; (iv) he engaged in disgraceful, dishonourable, or unprofessional conduct with respect to his failure to disclose to the College, as required, the information relating to having been charged with and found guilty of offences.

Further, the Committee also finds that Dr. Wu is incompetent in respect of his care and treatment of: Patient A, the 22 patients whose care was reviewed by Dr. Nijhawan, and the patient identified in Dr. Lam's report as "Chart #1."

PENALTY AND REASONS FOR PENALTY

Positions on Penalty

This was a contested penalty hearing. The College's position on penalty was that the Committee should revoke Dr. Wu's certificate of registration and order a reprimand. The College also sought costs in the amount of \$31,110.00, payable within 30 days of the date of the Committee's Order.

Dr. Wu agreed that the penalty order should include an order for a reprimand and costs in the amount sought by the College, but took the position that instead of revocation, his certificate of registration should be suspended for a period of 15 months, and that his return to practice be conditional on successfully completing a practice assessment by a College-approved assessor. If approved to return to practice, he would then be subject to supervision every two weeks for 12 months, consisting of alternating observation of ten patients with charts one week, and a review of 15 charts the following week. He would then be subject to a further reassessment within six months of the end of the 12-month period of supervision.

Evidence on Penalty

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

Discipline History with the College

1. In 2009, the Discipline Committee of the College found Dr. Wu to have contravened a term, condition and limitation on his certificate of registration and to have engaged in disgraceful, dishonourable or unprofessional conduct by breaching an April 2002 undertaking to not perform any nerve blocks in his practice of medicine. Dr. Wu had performed 30 nerve blocks on seven patients.

Dr. Wu's certificate of registration was suspended for six months, two months of which was to be suspended upon his successful completion of a course on medical ethics and informed consent. He was reprimanded and ordered to pay costs. The Discipline Committee imposed terms, conditions and limitations on Dr. Wu's certificate of registration prohibiting him from performing nerve blocks and requiring monitoring of his chronic pain practice. The Discipline Committee's decision, dated April 24, 2009, is attached at Tab 1 to the Agreed Statement of Facts Regarding Penalty.

2. In 2013, following five investigations into his practice, the Discipline Committee found Dr. Wu to have failed to maintain the standard of practice of the profession, to be incompetent, and to have engaged in disgraceful, dishonourable, or unprofessional conduct. The findings regarding Dr. Wu's clinical care related to both his family practice and his chronic pain practice, and to delegation of controlled acts. The findings regarding disgraceful, dishonourable or unprofessional conduct related to breaching an interim undertaking to the College that Dr. Wu entered into pending the hearing, restricting him from prescribing narcotics and other controlled substances subject to engagement of and co-signing of prescriptions by a College-approved clinical supervisor. Dr. Wu's penalty included a six-month suspension; a restriction prohibiting him from prescribing narcotic drugs and preparations, controlled drugs, benzodiazepines and other targeted substances; a prohibition on delegating controlled acts; a reprimand, an assessment of Dr. Wu's family practice following his return to practice; and costs. The Discipline Committee's decision, dated May 31, 2013, is attached at Tab 2 to the Agreed Statement of Facts Regarding Penalty.

***Past Inquiries, Complaints and Reports Committee and Complaints Committee
Decisions***

3. Attached at Tab 3 to the Agreed Statement of Facts Regarding Penalty is a January 2004 decision of the College's Complaints Committee in which the Committee concluded that it was not satisfied that Dr. Wu's management of the complainant's chronic pain care demonstrated sufficient knowledge on his part regarding how to approach the challenges in that area of practice. The Complaints Committee directed the matter to the attention of the College's Quality Assurance Committee.
4. Attached at Tab 4 to the Agreed Statement of Facts Regarding Penalty is a July 23, 2014 decision of the College's ICRC in which the Committee issued advice to Dr. Wu to reconsider the rationale for expensive devices in cases where simpler options or more extensive use of physiotherapy are warranted.
5. Attached at Tab 5 to the Agreed Statement of Facts Regarding Penalty is a March 28, 2019 ICRC decision cautioning Dr. Wu regarding infection prevention and control deficiencies, and a conflict of interest related to Dr. Wu's involvement in sales of supplements to patients through his office.

Compliance Monitoring

6. As set out above, in its decision of April 2009 attached at Tab 1 to the Agreed Statement of Facts Regarding Penalty, the Discipline Committee ordered Dr. Wu not to perform any nerve blocks. The College has not identified any subsequent breaches of this term by Dr. Wu.
7. As set out above, in its decision of May 2013 attached at Tab 2 to the Agreed Statement of Facts Regarding Penalty, the Discipline Committee ordered Dr. Wu

not to prescribe narcotic drugs and preparations, controlled drugs, benzodiazepines and other targeted substances. The College has not identified any subsequent breaches of this term by Dr. Wu.

8. On February 2, 2016, Dr. Wu entered into an additional undertaking to the College not to prescribe other monitored drugs. Dr. Wu's undertaking of February 2, 2016 is attached at Tab 6 to the Agreed Statement of Facts Regarding Penalty. The College has not identified any subsequent breaches of this undertaking by Dr. Wu.
9. Following the referral of allegations at issue in this proceeding to the Discipline Committee, Dr. Wu entered into an interim undertaking in lieu of the ICRC making an interim order under section 25.4 of the *Health Professions Procedural Code* (the "Code"). Dr. Wu's undertaking of July 23, 2018 is attached at Tab 7 to the Agreed Statement of Facts Regarding Penalty. It requires Dr. Wu to not perform any periodic oculo-visual assessments or major eye examinations; and to refer any patient who is an infant under three months of age who presents with a history of fever to an emergency department or a pediatrician on an urgent basis. The College has not identified any subsequent breaches of this undertaking by Dr. Wu.
10. Following the referral of additional allegations at issue in this proceeding to the Discipline Committee, Dr. Wu entered into a further interim undertaking in lieu of the ICRC making an interim order under section 25.4 of the *Code*. Dr. Wu's undertaking of August 20, 2019, requiring clinical supervision of his practice, is attached at Tab 8 to the Agreed Statement of Facts Regarding Penalty. The clinical supervision reports received from Dr. Wu's clinical supervisor, Dr. Kimberly Wintemute, are attached at Tab 9, and form part of, the Agreed Statement of Facts Regarding Penalty.

In addition to the above, the following additional facts were set out in a Further Agreed Statement of Facts Regarding Penalty, which was filed as an exhibit and presented to the Committee:

1. On October 10, 2019, a College Compliance Case Manager advised Dr. Wu through his counsel that she would be reporting to the ICRC the following day, in view of concerns about protecting patients from harm raised by reports and information received from Dr. Wu's clinical supervisor, Dr. Kimberly Wintemute. The letter from the Compliance Case Manager to Dr. Wu's counsel dated October 10, 2019 is attached at Tab 1 to the Further Agreed Statement of Facts Regarding Penalty.
2. Dr. Wu subsequently offered through his counsel to cease to practise medicine pending completion of these proceedings. Dr. Wu's interim undertaking, dated October 11, 2019, to cease to practise medicine as of 12:01 a.m. on October 12, 2019, is attached at Tab 2 to the Further Agreed Statement of Facts Regarding Penalty and was accepted by the ICRC on October 11, 2019 in lieu of making an interim order under section 25.4 of the *Code*.

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts Regarding Penalty and the Further Agreed Statement of Facts Regarding Penalty.

The Evidence of Dr. Wu

Dr. Wu testified before the Discipline Committee during the penalty phase of the hearing.

In her examination-in-chief Dr. Wu's counsel asked whether he had read the expert report of Dr. Nassim from 2016 regarding the death of a 19-day-old baby in his care, and what he understood to be the problems raised in the expert report about his practice. Dr. Wu answered that he did not have the knowledge to recognize that a baby with a fever can be much sicker than it may appear and that such a case requires urgent care.

As a result of the College's concern about Dr. Wu's treatment of very young patients, he entered into an undertaking requiring him to urgently refer to an emergency department or a pediatrician any patient who was an infant under three months of age who presents with a history of fever. As well, he was to keep a log of all patients under the age of three months and to document any patient, whether or not they had a fever, and send the log to the College monthly. Dr. Wu indicated that he had sent such a log to the College, as required.

Dr. Wu indicated that he attended a course at McGill University on managing babies and said he now has a better understanding of this area. He mentioned that later Dr. Wintermute had suggested an urgent online course, and he also obtained more basic knowledge about the types of investigation that would be necessary, although he indicated that he would defer to the opinion of an experienced pediatrician. He added that he fully accepted responsibility and apologized for his lack of relevant knowledge.

Dr. Wu's counsel asked about the medical device referrals that he had accepted from the wellness clinic adjacent to his office. He agreed that he had provided prescriptions for medical devices between 2011 and 2015. He explained his understanding of the concerns that Dr. Moore raised in her report, acknowledging that he did not take a detailed history, list differential diagnoses and possible investigations, and formulate a treatment plan including follow-up of the patients. He added that he thought his record-keeping was somewhat inadequate.

Dr. Wu also addressed the concern which was raised about his corresponding with Sun Life Assurance Company when the company contacted his office and he did not get back to them. He explained that his usual practice was to respond to such requests, and suggested a miscommunication was responsible. Nonetheless, he said he accepted that he should have replied promptly.

Dr. Wu described his relationship with the wellness clinic adjacent to his office. They would refer patients to him and he would assess the patient and make recommendations on braces or stockings. He charged a block fee of \$100 a year to cover the cost of writing a letter to the insurance company. He clarified that the block fee money came to him from the wellness centre, but acknowledged that the money would originally have come from the patients themselves.

When asked what he learned from this experience and the advice of Dr. Moore, Dr. Wu answered that he now understood and accepts that there was a conflict of interest, adding that he has not had any business relationship with the wellness clinic since 2015. He said he accepted responsibility for the breaches of standard as reported by Dr. Moore and as found by the Discipline Committee.

Dr. Wu's counsel asked him about the eye examinations that he was performing at Fuji Optical and also those that he was performing at his own office. Dr. Wu estimated that he was working at Fuji Optical from 2012 to 2015, but said he had not done any work for them since then.

He also said he no longer performed eye examinations and that he has had an optometrist working at his office since 2014.

Dr. Wu confirmed that he had read the material in the Agreed Statement of Facts relating to his referral to Discipline and had read the two expert reports of Dr. Nijhawan. Dr. Wu acknowledged that he did not have sufficient training to conduct refractions and did not understand what was required for a full eye examination, which provides an opportunity to determine any other possible eye diseases, especially in children and elderly patients.

With respect to assessments he was doing for Fuji Optical, Dr. Wu said concerns were raised because of poor record-keeping, lack of a comprehensive assessment of the

patient, and lack of follow up to ensure that the patient's vision improved. He said that the record-keeping was poor because he thought it was a "non-OHIP type of assessment" that did not require him to keep thorough records.

Dr. Wu entered into an undertaking when the College raised concerns about the safety of patients, and he agreed not to perform any periodic oculo-visual assessments or major eye examinations, as defined in the OHIP Schedule of Benefits, or any refractions. He said he had complied with this undertaking.

Dr. Wu stated that he accepts responsibility for the findings made by the Committee.

Dr. Wu indicated that he understood the concerns expressed by various experts and supervisors about his clinical care. He explained what he has done in an attempt to ensure that these problems would not occur in the future. He explicitly stated that he accepted responsibility and apologized for his misconduct, adding that he felt ashamed.

With regard to his not reporting correct information to the College in his Annual Renewal forms, Dr. Wu again said that he felt ashamed about the convictions, adding that in his ethnic culture, one is expected to keep matters about which one is ashamed within the family. He said, nevertheless, that he had no excuse for what he did, He accepted responsibility and stated that he has been compliant with the College's reporting requirements since.

Counsel asked him about the findings of Dr. Cohen and Dr. Henry Wu who had supervised him for almost two years. Dr. Wu stated that he had met with Dr. Henry Wu regularly and that Dr. Henry Wu also conducted chart reviews and observed him with patients.

Dr. Cohen raised concerns in 2015. Dr. Cohen expressed general concerns about Dr. Wu's clinical practice and in particular noted issues with his delegation of duties,

infection control, management of certain patients, use of antibiotics and proper assessment and management of an obstetric patient with bleeding. Dr. Wu acknowledged that he needed to be more vigilant and careful in his clinical work and stated that he has taken the medical record-keeping course, which improved his record-keeping.

However, the assessment by Dr. Lam in the fall of 2018 found further inadequacies in his record-keeping. Dr. Wu pointed out that his most recent supervisor, Dr. Wintermute, had said that his record-keeping had improved.

Dr. Wu explained that, as a result of the reviews of his practice, he proposed to implement some remedial strategies during the suspension and supervision period that he was proposing. He said that going back to medical school was not feasible, but explained that he has identified a weekly lecture series intended for fourth year medical students and indicated that he had purchased the large manual that accompanies these lectures. He also mentioned that he has purchased some books that have been recommended on aspects of his practice. He said he is enrolled in the American Academy of Family Physicians (AAFP) urgent care and emergency care online courses, as well as a review course for family physicians. Finally, he acknowledged that he needs to do more than reading and courses and that he requires someone to coach him. He said he has identified Dr. Tran, a family physician who also practices emergency care. He stated that he was impressed with Dr. Tran, whom he said has been a College assessor. He indicated that Dr. Tran had committed to assist him five hours a week, with four hours of observation and the rest to “explain things to me, teach me, coach me, quiz me” from the lectures he had attended and topics that Dr. Tran thinks he should explore further. He stated that Dr. Tran had agreed to coach him in this way, but provided no further details.

Dr. Wu said that there may be a College-approved assessment at the end of the proposed year-long period of supervision but he added that he thought that was

insufficient and that he would explore a similar arrangement that he had with the College in the past and have someone, he hopes Dr. Tran, supervise his practice for one to two years until the College is satisfied that he can practice independently again.

Dr. Wu's counsel asked him whether, if the Committee accepts the proposed 15-month suspension, he agrees to be subject to a further College assessment and approval before entering into practice, and he strongly affirmed his agreement.

Counsel asked Dr. Wu if he accepts responsibility for failing to maintain the standard of practice and incompetence with respect to his clinical practice, and he affirmed that he did.

Dr. Wu's counsel referred him to the Committee's prior decision dated May 31, 2013, and the breach of undertaking. He explained that he had learned from those prior proceedings that such violations are a serious matter and that he must make every effort to comply with undertakings. He stated that he believes he has learned his lesson and was confident that he would not breach any undertaking in the future. Dr. Wu's counsel pointed out that he had given an undertaking previously in relation to not prescribing narcotics. He explained his understanding of this and stated that he has a notice in his office regarding this restriction. Dr. Wu added that he does not do nerve blocks, and these notices are posted in the waiting area for all to see.

Following the concerns raised in Dr. Lam's report about his practice in the spring of 2019, Dr. Wu undertook supervision with Dr. Wintermute. She raised concerns about patient safety and he said that he immediately called a patient for whom he had recommended over-the-counter medication because it put the patient at risk for urinary retention. He offered that he uses electronic medical records to check for medication interactions but asserted that there are limitations with the software and that possible interactions between prescribed and over-the-counter medications are not always identified.

Dr. Wu also stated that in light of Dr. Wintermute's reports, he decided to stop seeing patients. He confirmed that he fully accepts responsibility for the issues raised by Dr. Wintermute.

Dr. Wu was asked why the Committee should give him another chance. He has been through discipline proceedings previously and has had periods of supervision. A number of physicians have raised concerns with his clinical practice and competence. In response, Dr. Wu said he was very proud to be a family physician and feels privileged to serve his patients. He enjoys the work and is passionate about serving his patient population, which is predominantly of Chinese origin. He said that he could have accepted revocation and given up medicine but he does not want to do so because he loves the work and does not want to be a bad example to his child. He said that if he makes mistakes and admits his misconduct, he goes back to learn. He made it clear that he understands that this will require a great deal of work, but he believes that he can achieve what is required of him. He added that he did not think Dr. Tran believed that he was not remediable; otherwise, Dr. Tran would not waste time on him.

Following the examination-in-chief, counsel for the College reviewed Dr. Wu's previous interactions with the College, and attempts at remediation. Dr. Wu acknowledged 13 past investigations, three of which resulted in referrals to discipline. Each time, Dr. Wu stated that he agreed with the findings, accepted responsibility, and apologized for his deficiencies. He always readily agreed to remediation, including supervision and feedback about his practice. However, he agreed that he has consistently been found, in successive investigations, to have serious, often newly-identified, shortcomings.

Dr. Wu conceded to College counsel that when he testified as a witness in the 2009 Discipline hearing, he had expressed remorse for his breach of an undertaking, was sorry for it, explained to the Committee that he had learned from his mistakes,

described his commitment to patient care, and testified that he intended to comply with his professional obligations in the future.

In 2013, Dr. Wu was again before the Discipline Committee. At that hearing, he said that he would meet his professional obligations in the future and maintain the standard of practice of the profession. Dr. Wu agreed that the 2013 Discipline hearing, and related investigation, revealed that the deficits in his family practice were wide-ranging. He further agreed that this was the finding of the expert evaluator and the Discipline Committee. He submitted an Agreed Statement of Facts in that proceeding, admitted his conduct and accepted that his deficits were extensive. He acknowledged that part of his penalty was that he would undergo an assessment of his family practice. He understood that the assessment was intended to ensure that he had resolved the broad deficits that had been identified and that it was his responsibility to ensure that he met the standard of practice.

Dr. Cohen's assessment was performed in March 2015. College counsel noted, and Dr. Wu agreed, that this was because the Discipline Committee had given him the opportunity to show via reassessment that his practice met the standard of practice. However, he also agreed that Dr. Cohen found that was not the case.

As a result of his failures, Dr. Wu entered into a further undertaking in 2016. This undertaking included both observation of his practice and chart reviews. He undertook to take a medical record-keeping program and he did so. He acknowledged that this was the third time he had taken such a course, the most recent being the month prior to the current hearing. He agreed that the aim of the 2016 undertaking was to give him a further opportunity to show on reassessment that he could consistently meet the standard of practice. He underwent supervision for a significant period of time. The first supervisor was Dr. Henry Wu. He understood that once the supervision was completed he would undergo reassessment under the 2016 undertaking, and that this was another opportunity for him to show he had consistently maintained the standard of practice.

Dr. Lam conducted the reassessment. He indicated significant concerns about Dr. Wu's clinical management and his lack of judgment. In response to Dr. Lam's report, Dr. Wu acknowledged that he had put patients at risk of harm and said that he had already made changes, and would take a medical record-keeping course again.

Dr. Wintermute started to supervise Dr. Wu from the end of August 2019, pursuant to a new undertaking that he entered into because of the ICRC's concerns about patient safety. Dr. Wintermute provided several reports which included numerous recommendations. She had several concerns about his medical record-keeping. Dr. Wu agreed that some of his record-keeping practices were not satisfactory. She submitted her final report dated October 8, 2019 in which she expressed concern that Dr. Wu's patients were exposed to potential harm. She also expressed concern that several practice deficiencies remained apparent, that had been observed previously during supervision, assessment or reassessment. In fact, she specifically was concerned that through all of those processes Dr. Wu received feedback, yet the issues were still present. Dr. Wu agreed with this summary.

College Counsel also noted that Dr. Wintermute was worried that even with her supervision it may not be enough to protect Dr. Wu's patients. Dr. Wu said that he did not realize this before Dr. Wintermute reported her concern. Dr. Wu agreed not to practice and accepted that that was necessary to protect patients from harm.

College Counsel referred Dr. Wu to Dr. Cohen's report dated March 18, 2015, which identified hygiene issues including office cleanliness and lack of handwashing between patients. The College sent investigators to Dr. Wu's office beginning in December 2015. The investigators reported many deficiencies, and at a follow-up visit in February 2016, investigators reported that although there been some improvement, there were some outstanding concerns. College Counsel reminded Dr. Wu that Dr. Henry Wu also had concerns about his lack of handwashing routine.

College Counsel finally asked Dr. Wu about his failure to report his criminal convictions to the College on his annual renewal form as well as other omissions regarding conflict of interest situations. He acknowledged these deficiencies, reiterating that he would not make excuses but apologized again, saying he was aware that these issues were serious.

Jurisdiction on Penalty

Having found that Dr. Wu committed acts of professional misconduct and having found Dr. Wu to be incompetent, the Committee may order any one or more of the orders set out under sections 51 (2) and 52(2) of the Code.

Penalty Principles

The Committee recognizes that its penalty should be guided by and reflect the following penalty principles: public protection; maintaining the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest; specific deterrence; general deterrence; and where applicable or appropriate, rehabilitation. Other principles include denunciation of the misconduct and proportionality.

Aggravating Factors

The nature and scope of Dr. Wu's misconduct and incompetence in the present case is an aggravating factor. The Committee has found that he failed to maintain the standard of practice with multiple patients in varying situations. He has demonstrated serious clinical deficiencies that put his patients at risk. The outcome for Patient A and his family is heartbreaking. Although the expert opinion did not go so far as to conclude that Dr. Wu's conduct resulted in the infant's death, Dr. Wu's failure to maintain the

standard of practice of the profession meant that this child, the most vulnerable of patients, did not get the care that he urgently needed.

Further, the misconduct that resulted in the multiple findings of disgraceful, dishonourable or unprofessional misconduct was also widespread. In some circumstances, the misconduct caused the Committee to question Dr. Wu's honesty and integrity. In particular, Dr. Wu omitted or misrepresented facts to the College on several occasions. He failed to disclose his charges (dangerous operation of a motor vehicle, flight while pursued by a police officer, and assault with intent to resist arrest under the *Criminal Code*, as well as offences under the *Compulsory Automobile Insurance Act* and the *Highway Traffic Act*) on his 2015 annual renewal application. He also failed to report the subsequent findings of guilt under the *Criminal Code* and *Compulsory Automobile Insurance Act* in his 2016 annual renewal application. On January 9, 2017, Dr. Wu pleaded guilty to driving while disqualified under the *Criminal Code*, yet he failed to disclose conviction to the College on his 2017 annual renewal form. Dr. Wu's evidence that he felt ashamed was not a reasonable explanation or justification for misleading his regulator.

While under investigation by the College, Dr. Wu also advised the College that he had no financial interest in the sale of the braces/medical devices sold by the wellness centre next to his clinic, and that there was no conflict of interest in relation to Dr. Wu's prescription of braces and the payment for these devices to the wellness centre. The Committee has found that the information Dr. Wu provided to the College at that time was untrue.

In the Committee's view, these omissions and misrepresentations extend beyond simple poor judgment and reflect a propensity to mislead the College, which causes the Committee significant concern with respect to Dr. Wu's governability. This is an aggravating factor.

Another significant aggravating factor is Dr. Wu's extensive history with the College. Concerns about his practice have resulted in no less than 13 investigations and this is the third time Dr. Wu has been before the Discipline Committee. Dr. Wu has had several opportunities to improve both his clinical skills and his conduct, yet he continues to engage in acts of professional misconduct and has been found to be incompetent. The fact that this is his third discipline hearing is an aggravating factor.

Mitigating Factors

Dr. Wu's admissions and plea of no contest in this proceeding are mitigating factors. His plea saved the College much time and expense and meant that many witnesses did not have to be called to testify. For the reasons expressed below, however, the Committee was not persuaded that Dr. Wu has any true remorse or insight into his failings and did not find insight or remorse to be mitigating factors in this case.

Prior Cases

Although prior Committee decisions are not binding on the Committee, the Committee has accepted as a principle of fairness that, generally, like cases should be treated alike. Several prior cases were submitted to the Committee for consideration. Review of prior Committee decisions also assists the Committee to determine a penalty that falls within a reasonable range of orders taking into account the particular circumstances of the case.

With regard to the penalty principles, generally, College counsel referred the Committee to *Ontario (College of Physicians and Surgeons of Ontario) v. Patel*, 2015 ONCPSD 22 (CanLII) ("*Patel*") in which the Committee states:

"In determining the appropriate penalty, the Committee considered the seriousness of Dr. Patel's misconduct, and the finding of incompetence, together with both aggravating and mitigating factors. The Committee took into account

penalties imposed in somewhat similar cases while recognizing that cases are rarely identical and that each case must be considered on its own specific facts. The Committee also considered the principles that are well established in considering an appropriate penalty: the protection of the public, specific deterrence of the member, general deterrence of members of the profession, maintenance of the integrity of the profession, and the College's ability to govern itself in the public interest; maintenance of the public trust and, where possible, rehabilitation of the member."

With respect to maintaining the integrity of the profession and the College's ability to govern the profession in the public interest, counsel for the College drew attention to two cases involving members of the legal profession.

In *Adams v. Law Society of Alberta*, 2000 ABCA 240 (CanLII), the Court stated at paragraph 6:

"Professional bodies are those to whom the government has seen fit to grant monopoly status. With this monopolistic right comes certain responsibilities and obligations. Chief amongst them is self-regulation...."

"...A professional misconduct hearing involves not only the individual and all the factors that relate to that individual, both favourably and unfavourably, but also the effect of the individual's misconduct on both the individual client and generally on the profession in question. This public dimension is of critical significance to the mandate of professional disciplinary bodies."

In *Bolton v Law Society*, [1993] EWCA 32, the England and Wales Court of Appeal articulated the same principle, stating:

"It is important that there should be full understanding of the reasons why the Tribunal makes orders which might otherwise seem harsh. There is, in some of these orders, a punitive element: a penalty may be visited on a solicitor who has fallen below the standards required of his profession in order to punish him for what he has done and to deter any other solicitor tempted to behave in the same way. Those are traditional objects of punishment. But often the order is not punitive in intention. Particularly is this so where a criminal penalty has been imposed and satisfied. The solicitor has paid his debt to society. There is no

need, and it would be unjust, to punish him again. In most cases the order of the Tribunal will be primarily directed to one or other or both of two other purposes. One is to be sure that the offender does not have the opportunity to repeat the offence [...] The second purpose is the most fundamental of all: to maintain the reputation of the solicitor's profession as one in which every member, of whatever standing, may be trusted to the ends of the earth. To maintain this reputation and sustain public confidence in the integrity of the profession it is often necessary that those guilty of serious lapses are not only expelled but denied re-admission. [...] A profession's most valuable asset is its collective reputation and the confidence which that inspires."

The College also relied on the decision in *Ontario (College of Physicians and Surgeons of Ontario) v. Doyle*, 2018 ONCPSD 41 (CanLII) ("*Doyle*"), upheld by the Divisional Court decision 2019 ONSC 3905 (CanLII). In that case, Dr. Doyle admitted the allegations of professional misconduct on the basis of failing to maintain the standard of practice of the profession and also on the basis of disgraceful, dishonourable or unprofessional conduct. He also admitted the allegation of incompetence. There was a contested penalty hearing, as the College sought revocation and Dr. Doyle submitted that the Committee should issue a remedial order, allowing him to continue to practice psychiatry under supervision and with terms, conditions or limitations on his certificate. The Committee ordered revocation of Dr. Doyle's certificate of registration, a reprimand and costs to the College. Unlike Dr. Wu, Dr. Doyle did not testify at the discipline hearing, but presented expert evidence in support of his proposed penalty. The Committee found that Dr. Doyle had not implemented some expert recommendations, questioning whether he truly had the insight that he claimed to have. The Committee found in that case that a remedial order would not protect the public. Dr. Doyle submitted, on appeal, that the Committee had failed to take into account the many educational courses that he had taken, as well as his insight as testified to by an expert. In dismissing the appeal, the Divisional Court stated at paragraph 16:

"...The Discipline Committee was charged with assessing whether the public could be protected by Dr. Doyle's assurance of his insight when he had failed for

over a decade, to adequately address issues that were identified to him and which he had represented he was addressing.”

The Divisional Court upheld the penalty of revocation. As to Dr. Doyle’s submissions that the penalty was disproportionate and that he had taken a lot of courses and understood the issues, the Court indicated at paragraphs 25 and 26:

“...The Discipline Committee held that the same assurance given some time ago for the same or similar issues have not been borne out. Moreover, while Dr. Doyle’s assurances were being relied upon while he was undergoing therapy and subject to supervision and license restrictions, many more patients have been subjected to unprofessional and/or incompetent treatment.

Dr. Doyle simply has no answer to the finding of the Discipline Committee that I repeated here for convenience.”

The Court’s decision refers to the numerous chances for remediation that Dr. Doyle was given, and, his continued struggle and the risk of harm to patients. Though Dr. Doyle practiced psychiatry, and Dr. Wu has practiced as a family physician, and there were some differences in terms of the particulars of the professional misconduct, Dr. Doyle’s case is similar to that of Dr. Wu in that both had repeated failings, despite opportunities to rehabilitate. The Committee in that case also found that Dr. Doyle had practiced under supervision for a lengthy period which proved ineffective. The same may be said with respect to Dr. Wu.

In *Kamermans v. The College of Physicians and Surgeons*, 2018 ONSC 529, the Discipline Committee had revoked Dr. Kamermans’ certificate of registration after finding that he had failed to maintain the standard of practice of the profession and was incompetent. The Discipline Committee findings related to Dr. Kamermans’ emergency practice - in particular, the Committee found that documentation in nine patient charts was inadequate and incomplete and that Dr. Kamermans displayed a lack of knowledge, skill or judgement in the treatment of six emergency room patients. The Committee found that the deficits were of the kind that would also be seen in his broader family practice

and in the result ordered that his certificate of registration be revoked. The Divisional Court found that the Discipline Committee's decision to revoke was reasonable, based on a number of factors including that there were many serious failures to maintain records, and some failures to properly diagnose; these were long-standing and serious deficiencies; and despite many opportunities, Dr. Kamermans was unable or unwilling to correct the deficiencies to any significant extent. This is also true of Dr. Wu, who has a wide range of deficiencies, has been provided with many opportunities to correct the deficiencies and has failed to do so to any significant effect.

The Divisional Court also accepted that the errors were common problems seen in Dr. Kamermans' practice areas:

“The fact that no serious harm was suffered by a patient is not a measure of the severity of the deficiencies; the proper measure, concomitant with the mandate to protect the public, is the potential risk of harm to patients.”

The Committee notes that in the present case, serious harm did befall Patient A, who succumbed to his illness after Dr. Wu failed to maintain the standard of practice with respect to his treatment of this infant.

The Committee was also referred to the 2018 case of Dr. Martin, an obstetrician/gynecologist, [*Ontario (College of Physicians and Surgeons of Ontario) v. Martin*, 2018 ONCPSD 61 (CanLII) (“*Martin*”)]. In that case, Dr. Martin had already resigned from the College and the penalty therefore consisted only of a reprimand and costs. The Committee noted that if Dr. Martin had not resigned and undertaken to never reapply for his certificate of registration, it would have revoked his certificate of registration. Dr. Martin was found to have failed to maintain the standard of practice and to be incompetent in his care of two young transgender patients. He also had a past (2014) discipline finding regarding his fertility practice. The Committee noted with respect to Dr. Martin's prior history:

“Although the clinical failings at issue in 2014 [at a prior Discipline proceeding] differ from those in the present case, the Committee expected that Dr. Martin

would have been become particularly vigilant in his attention to practice standards in his chosen area of medicine.”

The Committee would have expected the same of Dr. Wu, given the numerous prior investigations and two past discipline proceedings, yet rather than becoming particularly vigilant to practice standards, Dr. Wu has failed to maintain the standard of practice and has been found to be incompetent with respect to numerous patients in various aspects of his practice.

In the *Patel* case, cited above, the doctor was a general practitioner and at all relevant times he maintained a solo practice, providing family physician services, including walk-in services. Dr. Patel admitted that he engaged in professional misconduct by having failed to maintain the standard of practice of the profession in his care of 25 patients, and that he had engaged in 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. Dr. Patel’s conduct included inadequate supervision of staff; improper delegation of controlled acts; improperly prescribing and/or directing staff to prescribe to patients; inappropriately having staff care for and treat patients in his absence; inappropriate billing to OHIP; and breaching his undertaking with the College. Dr. Patel also admitted that he was incompetent in that his professional care of 25 patients displayed a lack of knowledge, skill or judgment that was of such a nature or to such an extent that his practice should be restricted or that he is unfit to continue to practise. Dr. Patel also did not contest additional facts or that those facts constitute professional misconduct as a failure to maintain the standard of practice of the profession, and as disgraceful, dishonourable and unprofessional conduct on his part. Dr. Patel had two prior discipline findings. Both of those prior findings concerned deficits in the care of a single patient. The Committee revoked his certificate of registration. After a lengthy discussion of his past history, the Committee concluded:

“The cumulative impact of the breadth and the pervasiveness of Dr. Patel’s clinical misconduct, and its extent, together with his failure to respond to the recommendations of his College appointed supervisor, provided evidence of

ungovernability, and constitutes professional misconduct that, in the view of the Discipline Committee, deserves the most serious sanction, that of revocation of his certificate of registration.”

The Committee found both the scope of the misconduct and the past discipline history in Dr. Patel’s case to be similar to that in Dr. Wu’s case. The Committee was particularly struck by the breadth and pervasiveness of the clinical deficiencies in Dr. Wu’s case.

Three other cases were brought to the Committee’s attention and are briefly discussed below.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Prévost*, 2015 ONCPSD 14 (CanLII), an obstetrician/gynecologist who failed to maintain the standard of practice with respect to the medical termination of pregnancy for many patients, voluntarily resigned his certificate of registration and agreed not to reapply. The Committee noted that, given the sheer volume and repetitive nature of the misconduct, and the fact that Dr. Prévost had not learned from his experiences, the Committee would have revoked his certificate of registration.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Shum, A. S.*, 2013 ONCPSD 40 (CanLII), a family physician whose practice centred on urology had broad clinical shortcomings. The Committee accepted a joint submission on penalty which included revocation of Dr. Shum’s certificate of registration. Dr. Shum had no prior discipline history, but the Committee noted that the doctor’s deficiencies were not only fundamental and profound but that they had been repeated.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Sweet*, 2017 ONCPSD 40 (CanLII), the Committee found that a family physician had failed to maintain the standard of practice and had engaged in disgraceful, dishonourable or unprofessional conduct. Dr. Sweet had four previous disciplinary findings and extensive, but unsuccessful, past remediation attempts. Each time, he had acknowledged his misconduct and cooperated with investigations, demonstrating that admission of

wrongdoing and cooperation are insufficient in themselves and do not predict whether remediation will be successful.

Counsel for Dr. Wu submitted that the Discipline Committee should distinguish Dr. Wu's case from those in which the physician did not testify. She noted that Dr. Wu had testified before the Committee and not through an expert or other witnesses and as such the Committee could rely on the fact that he took responsibility for his actions, had insight into his failings and had a plan for rehabilitation.

Analysis re Appropriate Penalty

Dr. Wu articulated shame, remorse, and accountability, but he has expressed these sentiments on previous occasions before the Committee and yet has engaged in further extensive misconduct and has been found to be incompetent. The Committee is not reassured by Dr. Wu's acceptance of responsibility for his misconduct and clinical deficiencies. Based on his record, acceptance of responsibility for past failings has not dissuaded him from engaging in further misconduct.

The Committee also places no weight on his plans for remediation in light of his repeated past and current transgressions. Dr Wu states that he is motivated to remediate and referred to some options that he had explored about remediation. However, he put forward a plan that was imprecise and offers strategies no more robust than those that have been attempted many times before. Dr. Wu's history is a litany of missed opportunities to remediate in a timely fashion.

Dr. Wu's lack of deeper insight is also illustrated by his failure to recognize just how casual his approach to changing his behaviour was when it came to infection prevention and control.

Dr. Wu's insight and his remediation attempts have been incomplete, have not been timely, and have been unreliable.

Independent evaluators and experts have repeatedly found that Dr. Wu displays lack of knowledge, skill, and judgment. These deficiencies are fundamental to the work of family physicians who must be able to apply knowledge, skill and judgment in identifying when a referral, especially an urgent one, is required.

Dr. Wu's record-keeping has consistently been found inadequate and his lack of hygiene has been noted twice during evaluations of his practice.

While given numerous opportunities to remediate, Dr. Wu has been unable to demonstrate significant improvement. This does not support the prospect of remedial success in the future.

In addition to his deficits in knowledge, skill and clinical judgment, Dr. Wu's nonclinical misconduct includes being found guilty of an offence relevant to his suitability to practice, failing to declare charges and findings of guilt on his annual renewal forms three years in a row, having a conflict of interest, not disclosing information to the College in a previous investigation, not responding to queries from an insurer, and billing irregularities. All of these findings indicate that Dr. Wu's poor judgment extends to several different areas and show that he is a member upon whom the College and the public cannot rely.

The Committee considered very carefully the evidence presented at the hearing, including Dr. Wu's testimony. Based on the scope of the misconduct and extent of Dr. Wu's incompetence, the Committee concluded that revocation of his certificate of registration is the only appropriate penalty that will protect the public and maintain the integrity of the profession. The Committee found that the legal cases provided by counsel support a finding that revocation falls within a reasonable range of penalties for

misconduct and incompetence of this nature, in particular taking into account the broad scope and repeated nature of the misconduct. The deficiencies are serious and put patients at risk. Past attempts to rehabilitate Dr. Wu, including supervision to ensure that he maintains the standard of practice of the profession, have failed. Equally concerning are the numerous acts of disgraceful, dishonest or unprofessional conduct which reflect very poorly on Dr. Wu's professional integrity and his governability.

The order of revocation and the reprimand should also serve as a general deterrent and maintain public confidence in the College's ability to regulate in the public interest, as it should indicate to the public and members of the profession that the College takes such professional misconduct and incompetence seriously and will respond appropriately in order to protect the public.

The reprimand will also serve to denunciate Dr. Wu's misconduct and express this Committee's view on Dr. Wu's woefully inadequate responses to prior disciplinary and remedial interventions. True insight and the ability to benefit from remedial interventions require more than repeated apologies and the apparent expectation of indefinite opportunities for corrective action. The practice of medicine is a privilege; not a right. It is a privilege which should be taken seriously and never for granted.

COSTS

The Committee has the power pursuant to section 53.1 of the Code to award costs. Costs are always in the discretion of the Committee. Any costs order must be reasonable, and based on the costs actually incurred or pursuant to Tariff A.

Under Rule 14.04(3) of the Committee's Rules of Procedure, where the request for costs or expenses includes the cost or expense to the College of conducting a day of hearing, no evidence of the cost or expense of a day of hearing is needed if the request is equal

to or less than the amount set out in Tariff A. Tariff A currently provides that the costs and expenses of a day of hearing is \$10,370.00.

The Committee agrees that \$31,110.00 in costs is an appropriate order to make, given that the hearing took three days. The amount sought is equal to the Tariff rate for three days and the amount is agreed to by Dr. Wu.

ORDER

The Committee stated its findings in paragraphs 1 and 2 of its written order of October 17, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Wu attend before the panel to be reprimanded;
4. The Discipline Committee directs the Registrar to revoke Dr. Wu's certificate of registration, effective immediately;
5. Dr. Wu to pay costs to the College in the amount of \$31,110.00 within thirty (30) days of the date of this Order.