

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 names and any information that could disclose the identity of patients referred to orally or in the exhibits 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: Wu, H. (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. HOWARD WU

PANEL MEMBERS:

**DR. J. WATTS
D. DOHERTY
DR. M. DAVIE
P. GIROUX
DR. B. LENT**

Hearing Date:	April 29, 2013
Decision Date:	April 29, 2013
Release of Written Reasons:	May 31, 2013

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 29, 2013. At the conclusion of the hearing, the Committee delivered a written order stating its finding that the member committed acts of professional misconduct and is incompetent, and delivered its penalty and costs order, with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Wu 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 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 is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the “Code”), which is schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Wu admitted the allegations of professional misconduct and the allegation of incompetence.

FACTS AND EVIDENCE

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

1. Dr. Wu graduated from Queen's University medical school in 1994. He completed a family medicine residency program with the University of Toronto from 1994 to 1997.
2. In 1999 Dr. Wu established Smart Health Medical Clinic in Markham.
3. Dr. Wu is a trilingual Chinese Canadian, who speaks Cantonese, Mandarin and English. Approximately 85% of Dr. Wu's patients are of Chinese origin. Approximately 60% of his patients do not speak English fluently. According to Dr. Wu, these patients prefer to receive their medical care in their native language.
4. During the period of time that Dr. Wu's practice was investigated, as set out below, approximately 98% of his practice was dedicated to primary care and 2% to chronic pain.

Investigations into Dr. Wu's Clinical Care

S. 75(a) Investigation dated May 13, 2009

5. In response to a complaint from a family member of one of Dr. Wu's patients made on or about March 20, 2009, a request was made to the Registrar for an appointment of investigator under s.75(a) of the *Health Professions Procedural Code* ("HPPC").
6. By s.75(a) notice of investigation dated May 13, 2009, and subsequently amended, the College appointed Dr. X as medical inspector to conduct an investigation into Dr. Wu's practice.

7. Following a review of 30 patient charts and after conducting four interviews with Dr. Wu, Dr. X provided an opinion dated May 23, 2010, and an addendum report dated October 23, 2010 (delivered January 2011), which are attached at Schedules 1 and 2 [to the Agreed Statement of Facts and Admission].
8. In response to Dr. X's report, Dr. Wu delivered the report of Dr. Y dated September 15, 2010, and a letter from counsel dated March 10, 2011. In his reports, Dr. Y responded to and generally disagreed with Dr. X's opinion that Dr. Wu's medical management did not meet the expected standard of practice.

S.75(1)(a) Investigation dated July 5, 2010

9. In response to a letter from the Ontario College of Pharmacists dated March 18, 2010, a request was made to the Registrar for an appointment of investigator under s.75(1)(a) of the *HPPC*.
10. By s.75(1)(a) notice of investigation dated July 5, 2010, and subsequently amended, the College appointed Dr. Z as medical inspector to conduct an investigation into Dr. Wu's chronic pain practice.
11. Following a review of 25 patient charts, Dr. Z provided a report dated November 16, 2010, and an addendum report dated March 14, 2011, which are attached at Schedules 3 and 4 [to the Agreed Statement of Facts and Admission].
12. In response to Dr. Z's reports, Dr. Wu delivered the report of Dr. Y dated May 9, 2011. In his report, Dr. Y responded to and generally disagreed with Dr. Z's opinion that Dr. Wu's medical management did not meet the expected standard of practice.

Patient "A"

13. By letter dated August 17, 2011, the College received a complaint from Patient "A".
14. Dr. Wu filed a response dated October 3, 2011.

15. The College retained Dr. Z to review the complaint, and Dr. Z provided a report dated November 2011, attached as Schedule 5 [to the Agreed Statement of Facts and Admission].

Patient “B”

16. By letter dated November 22, 2011, the College received a complaint from Patient “B”.
17. Dr. Wu filed a response dated April 4, 2012.
18. The College retained Dr. Z once again to review the complaint, and Dr. Z provided a report dated May 14, 2012, attached as Schedule 6 [to the Agreed Statement of Facts and Admission].

Patient “C”

19. In response to contact from Patient “C”’s family physician on August 9, 2011, and a letter from Hospital Q emergency physicians dated August 25, 2011, a request was made to the Associate Registrar for an appointment of an investigator under s.75(1)(a) of the *HPPC*.
20. By s.75(1)(a) notice of investigation dated September 28, 2011, the College appointed Dr. Z as medical inspector to review these matters. Dr. Z provided opinions dated December 20, 2011 and March 8, 2012, attached as Schedule 7 [to the Agreed Statement of Facts and Admission].
21. The complaints of patients “A”, “B” and “C” followed the signing of Dr. Wu’s Undertaking dated July 27, 2011, as referenced in paragraph 24 of this Agreed Statement of Facts.

Notice of Hearing dated July 6, 2011 and September 5, 2012

22. As a result of these five investigations, the Inquiries, Complaints and Reports Committee (the “ICRC”) referred to the Discipline Committee allegations that Dr. Wu is incompetent and engaged in professional misconduct by failing to maintain

the standard of practice of the profession. Additionally, with respect to his improper delegation of care and treatment of patients, the ICRC referred to the Discipline Committee the allegation that Dr. Wu 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.

Undertaking dated July 27, 2011

23. On July 6, 2011, the ICRC delivered its notice of intent to make an interim order pursuant to s.37 of the *HPPC*.
24. Rather than require a s.37 order, Dr. Wu signed an Undertaking not to prescribe narcotics or other controlled substances (“Restricted Substances”), subject to the engagement of a College-approved Clinical Supervisor. The July 27, 2011 Undertaking is attached at Schedule 8 [to the Agreed Statement of Facts and Admission] (the “Undertaking”).

Clinical Supervisor Pursuant to Undertaking

25. On June 13, 2012, Dr. V agreed to act as Dr. Wu’s “Clinical Supervisor” as provided for in Schedule “D” to the Undertaking. Dr. V practised in the field of chronic pain management prior to his retirement from full-time private practice in 2011, and Dr. V was approved by the College to act as Dr. Wu’s Clinical Supervisor.
26. Dr. V travelled to Dr. Wu’s office to attend all appointments for chronic pain patients and provided reports to the College dated September 17, November 19 and December 15, 2012, and January 17 and February 20, 2013.
27. Dr. Wu incurred personal costs exceeding \$25,000 to engage the assistance of Dr. V as his Clinical Supervisor.

Investigation into Dr. Wu's Compliance with the Undertaking

28. Following a visit to determine compliance with the Undertaking, a request was made to the Registrar for an appointment of investigator under s.75(1)(a) of the *HPPC*.
29. By notice dated March 12, 2013, the College commenced an investigation into Dr. Wu's compliance with the Undertaking.

Notice of Hearing dated April 4, 2013

30. By notice of hearing dated April 4, 2013, the ICRC referred to the Discipline Committee the allegation that Dr. Wu 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 by breaching his Undertaking.

B. ADMISSIONS

31. Dr. Wu admits the following:
 - (a) That he engaged in acts of professional misconduct by failing to maintain the standard of practice of the profession and is incompetent in his chronic pain practice as detailed in Dr. X and Dr. Z's reports in relation to the following chart numbers:

Reviewed by Dr. X (Chart #)

1.	***	Pain
2.	***	Pain
4.	***	Pain/Family/Delegation
5.	***	Pain/Employee
6.	***	Pain
7.	***	Pain
8.	***	Pain
11.	***	Pain/Family/Delegation
18.	***	Pain
19.	***	Pain
20.	***	Pain
25.	***	Pain

Reviewed by Dr. Z (Chart #)

1.	***	Pain
2.	***	Pain
3.	***	Pain
4.	***	Pain
5.	***	Pain
6.	***	Pain
7.	***	Pain
8.	***	Pain

9.	***	Pain
10.	***	Pain
11.	***	Pain
12.	***	Pain
13.	***	Pain
14.	***	Pain
15.	***	Pain
16.	***	Pain
17.	***	Pain
18.	***	Pain
19.	***	Pain
20.	***	Pain
21.	***	Pain
22.	***	Pain
23.	***	Pain
24.	***	Pain
25.	***	Pain
1.	“A” - ***	Pain
2.	“B” - ***	Pain
3.	“C” - ***	Pain

- (b) That he engaged in acts of professional misconduct by failing to maintain the standard of practice of the profession in his family practice as detailed in Dr. X’s reports in relation to the following chart numbers:

Reviewed by Dr. X

3.	***	Family/Record Keeping
4.	***	Pain/Family/Delegation
5.	***	Pain/Employee
11.	***	Pain/Family/Delegation
23.	***	Family/Record Keeping

- (c) That he engaged in acts of professional misconduct by failing to maintain the standard of practice of the profession and engaging 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 with respect to his delegation of controlled acts as detailed in Dr. X's reports in relation to the following chart numbers:

Reviewed by Dr. X

4.	***	Pain/Family/Delegation
5.	***	Pain/Employee
11.	***	Pain/Family/Delegation

- (d) That he engaged in acts professional misconduct by engaging 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 by breaching his Undertaking as set out below:

- (i) Failing to comply with section B1(a) of his Undertaking by issuing a prescription for Testosterone on August 10, 2011 before engaging a Clinical Supervisor acceptable to the College;

- (ii) Failing to comply with section B2(a)(i) of his Undertaking between June 2012 until October/November 2012 by failing to ensure his Clinical Supervisor co-signed patient charts to indicate he approved of the prescription for each and every Restricted Substance prescription issued by Dr. Wu;
- (iii) Failing to comply with section B(2)(a)(i) of his Undertaking by failing to ensure the charts co-signed by his Clinical Supervisor for patients *** and *** on December 4, 2012, accurately reflected the prescriptions issued to the patients; and
- (iv) Failing to comply with section B2(a)(iv) of his Undertaking by failing to include the following information in his log of all prescriptions for Restricted Substances:
 - (A) For Patient *** the prescriptions:
 - (I) Hydromorph Contin 24 mg and Hydromorph Contin 3mg, both issued on August 3, 2012;
 - (B) For Patient *** the prescriptions:
 - (I) Fentanyl Citrate 100 mcg and Statex 25 mg, both issued on August 3, 2012;
 - (C) For Patient *** the prescription:
 - (I) Hydromorph Contin 12 mg issue on August 17, 2012;
 - (D) For Patient *** the prescriptions:
 - (I) Statex 5 mg, Kadian 10 mg, and Kadian 20 mg, all issued on July 17, 2012; and
 - (E) For Patient *** the prescription Oxycodone 80 mg issued on January 29, 2013.

FINDING

The Committee accepted as true all of the facts as set out in the Agreed Statement of Facts and Admissions. Having regard to these facts, the Committee accepted Dr. Wu's admission and found that he committed acts of professional misconduct, in that he has failed to maintain the standard of practice of the profession; and 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 Committee also found that Dr. Wu is incompetent under subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or 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.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee is mindful of the guiding principles that the Courts have determined to be relevant in imposing a penalty. The law is very clear regarding the test to apply in accepting a joint proposal from the parties. A proposed penalty should only be rejected if it is contrary to the public interest and would bring the administration of justice into disrepute.

The Committee accepts the jointly proposed penalty as appropriate in this case.

A penalty must express the Committee's abhorrence of the physician's misconduct and serve as a deterrent to the membership at large as well as the member specifically against such misconduct. A penalty must uphold the reputation of the profession and instill confidence in the public that the profession is capable of self-governance. A penalty must ensure that the public is protected from the potential of harm. Additionally, a penalty should serve to rehabilitate the physician to the extent possible. No two cases are exactly alike and a penalty needs to be tailored to the specifics of the misconduct. Comparable

cases can be helpful for the Committee to consider, but the penalty imposed in any case must be specific to the case as well as fair, reasonable and appropriate.

The Committee was dismayed to learn of the long list of significant inadequacies in Dr. Wu's pain practice, as outlined in the expert report of Dr. Z, including incomplete charting, lack of the use of interdisciplinary pain protocols, and overprescribing. Dr. Wu admitted that he failed to maintain the standard of the profession in this area of his practice, and that he is incompetent in his management of chronic pain patients, which constitute about 2% of his practice.

With respect to the larger portion of his medical practice, his family practice, Dr. Wu is also woefully lacking. The majority of cases reviewed were found by the expert to have serious deficits. Some of the charts reviewed were found to meet the standard of practice of the profession, but most of the charts reviewed by the expert, Dr. X, revealed scant documentation, boundary violations with one patient who was also an employee, diabetes management inadequacies in a couple of the patients, the failure to have written opioid prescribing agreements with all patients, many unnecessary laboratory tests, scant history and physical examinations, no clear or accurate diagnoses documented, inadequate progress notes, and generally poor documentation overall.

Of particular concern to the Committee was Dr. Wu's inappropriate delegation of controlled acts to individuals not qualified to perform those acts.

Finally, Dr. Wu, even after being apprised of his shortcomings and entering into an undertaking with the College, breached that undertaking in the area of prescribing, supervision and charting.

Of great concern to the Committee is the fact that this is not the first time Dr. Wu has been before the Discipline Committee for breaching an undertaking. Physicians must take their undertakings with this College seriously and to breach an agreement shows a blatant disregard for the authority of the College and a lack of respect for the profession.

In mitigation, the Committee is aware of Dr. Wu's admission and cooperation with the College on these present matters but, none the less, finds that the public will be protected

only if Dr. Wu is completely prohibited from prescribing controlled substances in the future, does not delegate to any person any controlled act and that, after a lengthy suspension, he be assessed by a College appointed assessor and that he abide by any and all recommendations of the assessor arising out of that assessment. Dr. Wu must also be deterred from any further breach of his undertakings with the College. The Committee concluded that a long suspension is necessary to make it clear to Dr. Wu that his misconduct is very serious and repeated misconduct of this nature will not be tolerated. Any further breach of undertaking or failure to comply with the Committee's order will raise the fundamental issue of Dr. Wu's governability as a member of the profession.

The Committee has discretion to award costs in cases it deems appropriate. The Committee finds that this is such a case and orders that Dr. Wu should pay the tariff rate for the one day hearing that took place.

ORDER

Therefore, having stated its findings of professional misconduct and incompetence in paragraphs 1 and 2 of its written order of April 29, 2013, the Committee ordered and directed, on the matter of penalty and costs, that:

3. The Registrar suspend Dr. Wu's certificate of registration for a period of six (6) months commencing June 1, 2013.
4. The Registrar place the following terms, conditions and limitations on Dr. Wu's certificate of registration:
 - (a) Dr. Wu shall not issue new prescriptions or renew existing prescriptions for any of the following substances:
 - (i) Narcotic Drugs (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
 - (ii) Narcotic Preparations (from the Narcotic Control Regulations

made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);

- (iii) Controlled Drugs (from Schedule G of the Regulations under the *Food and Drugs Act*, S.C., 1985, c. F-27); and
- (iv) Benzodiazepines/Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19)

(collectively referred to as the “Restricted Substances”)

(A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached to the Order as Schedule “A”; and the current regulatory lists are attached to the Order as Schedule “B”)

- (b) Dr. Wu shall post a clearly visible sign in his waiting room in the form set out at Schedule “C” [to the Order]. For further clarity, this sign shall state as follows: “Dr. Wu cannot prescribe Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances.” A sign reflecting this restriction will also be posted in Chinese.
- (c) Dr. Wu shall not delegate to any other person any Controlled Act as that term is defined in the *Regulated Health Professions Act, 1991*.
- (d) Approximately one month after the completion of the suspension required by paragraph 3 of this Order, Dr. Wu shall undergo an assessment of his family practice by a College-appointed assessor (the “Assessor(s)”) at his expense. The Assessor(s) shall report the results of the assessment to the College. Dr. Wu shall abide by any recommendations of the Assessor(s).
- (e) Dr. Wu shall consent to the sharing of information between the

Assessor(s) and the College as any of them deem necessary or desirable in order to fulfill their respective obligations.

- (f) Dr. Wu shall co-operate with unannounced inspections of his office practice and patient charts by the College for the purpose of monitoring and enforcing his compliance with the terms of this Order and will make his OHIP billings accessible to the College for this purpose.
- 3. Dr. Wu appear before the panel to be reprimanded.
 - 4. Dr. Wu pay costs to the College in the amount of \$3,650 within thirty (30) days from the date of this Order.

At the conclusion of the hearing, Dr. Wu waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.