

## 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 the identity and any information that would disclose the identity of patients whose names are disclosed at the hearing, or in any documents 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, in relevant part:

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 (Re)**

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

**IN THE MATTER OF** a Hearing directed  
by the Executive Committee of  
the College of Physicians and Surgeons of Ontario  
pursuant to Section 36(1) of the **Health Professions Procedural Code**  
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. C. CLAPPERTON  
DR. E. ATTIA (Ph.D.)  
DR. P. CHART  
DR. P. TADROS**

<b>Hearing Dates:</b>	January 12-14, 2009
<b>Decision Release Date:</b>	April 24, 2009
<b>Release of Written Reasons:</b>	April 24, 2009

**PUBLICATION BAN**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the “Committee”) heard this matter at Toronto on January 12-14, 2009. At the conclusion of the hearing, the Committee stated its finding that the member engaged in an act of professional misconduct and reserved its finding on penalty.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Wu committed an act of professional misconduct:

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has engaged in conduct or an act or 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
2. under paragraph 1(1)1 of O. Reg. 856/93, in that he contravened a term, condition or limitation on his certificate of registration.

### **RESPONSE TO THE ALLEGATIONS**

Dr. Wu admitted all the allegations as set out in the Notice of Hearing.

### **OVERVIEW OF THE ISSUES**

This case is about a breach of an Undertaking made to the Executive Committee of the College of Physicians and Surgeons of Ontario and signed by Dr. Wu on April 5, 2002. At that time Dr. Wu was a family physician with a special interest in the management of pain. In the Undertaking Dr. Wu acknowledged and undertook not to perform any nerve blocks in his practice of medicine. Between April, 2002 and December, 2005, Dr. Wu performed 30 nerve blocks on seven patients. The case proceeded by means of an Agreed Statement of Fact to the allegations as set forth in the Notice of Hearing. The parties did not agree, however, as to the appropriate penalty, specifically to the length of the

suspension, costs, and the terms, conditions and limitations to be imposed. The Committee heard testimony from four witnesses including Dr. Wu, received documentary evidence and reviewed the position of the parties and the case law cited on the aspects of the penalty which were at issue.

The question before the Committee is: What penalty represents an appropriate censure in this matter?

## **FACTS AND EVIDENCE**

The following Agreed Statement of Facts was filed as an exhibit and presented to the Committee:

### **PART I – FACTS**

#### **A. Dr. Wu**

1. Dr. Howard Wu (“Dr. Wu”) is a member of the College of Physicians and Surgeons of Ontario (the “College”) who received a certificate of registration authorizing independent practice in Ontario in 1997. He is a member of the College of Family Physicians.
2. Dr. Wu is currently practising family medicine and pain medicine with a special interest in smoking cessation, chronic pain and palliative care.

#### **B. The Undertaking**

##### **i. Terms of the Undertaking**

3. On or about April 5, 2002, Dr. Wu entered into an Undertaking with the College (the “Undertaking”). A term of this Undertaking prohibits Dr. Wu from performing any nerve blocks in his practice of medicine. A copy of this Undertaking is attached as Schedule 1 [to the Agreed Statement of Facts].

## **ii. Breach of the Undertaking**

4. On or about April 3, 2006, the College's Compliance Monitor wrote to Dr. Wu asking him to complete a Consent and Direction for the Release of Billing Information in order to monitor Dr. Wu's compliance with the Undertaking through OHIP billing data.

5. On or about January 2, 2007, Dr. Wu provided the College with the requested Consent and Direction for the Release of Billing Information. It was also at this time that Dr. Wu admitted to having performed several nerve blocks since April, 2002.

6. After reviewing OHIP records and patient charts, the College confirmed that Dr. Wu performed 30 nerve blocks on seven patients on the following occasions:

- (a) Patient 1 on or about April, 2002;
- (b) Patient 2 on or about July, 2003;
- (c) Patient 3 on or about August, 2003 and November, 2003;
- (d) Patient 4 on or about December, 2003;
- (e) Patient 5 on or about December, 2003;
- (f) Patient 6 on or about December, 2003 [on two occasions]; and
- (g) Patient 7 on or about December, 2005.

## **PART II – ADMISSION**

7. Dr. Wu admits to the facts contained in paragraphs 1-6 above and admits to the allegations contained in the Notice of Hearing that he committed acts of professional misconduct under paragraphs 1(1)33 and 1(1)1 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional and in that he contravened a term, condition or limitation on his certificate of registration.

## **FINDINGS**

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Wu's admission and found that he committed an act of professional misconduct as set out in the Notice of Hearing in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded as disgraceful, dishonourable or unprofessional, and in that he contravened a term, condition or limitation on his certificate of registration.

In regard to allegation #1, the Committee noted that Dr. Wu not only specifically breached his Undertaking with the College, which was clear and which he understood, but he did so shortly after signing the Undertaking, and again on a number of occasions with different patients.

With respect to allegation #2, the legislation specifically defines professional misconduct under 1(1) of O. Reg 856/93 as contravention of a term, condition or limitation on his certificate of registration. The Undertaking signed by Dr. Wu constitutes such a restriction.

## **PENALTY AND REASONS FOR PENALTY**

The Committee set out their determination of the appropriate penalty as follows:

- I) Circumstances of the misconduct;
- II) General principles and relevant legislation;
- III) Submissions of the parties;
- IV) Overview of the evidence; and
- V) Reasons for the decision.

## *I) CIRCUMSTANCES OF THE MISCONDUCT*

The material circumstances in this matter relate to a breach of an Undertaking made to the Executive Committee of the College. This Undertaking was signed by Dr. Wu at a time when he had been served with a Notice of Hearing (exhibit #5) related to allegations of failure to meet the standard of care and incompetence which arose out of a College investigation of his practice. The Notice of Hearing was withdrawn on the basis of the Undertaking.

The current matter resulted from a subsequent breach of this Undertaking. Findings made on both of the allegations relate to the same events – namely, 30 nerve blocks performed on seven patients, and done subsequent to the Undertaking. When Dr. Wu was notified that the College wanted to have access to his OHIP records to monitor compliance with the Undertaking, he agreed to the College's request and admitted that he had breached the Undertaking. Dr. Wu has been cooperative in the investigation that followed. The Executive Committee of the College then issued a s. 37 Order (exhibit #10), directing that Dr. Wu must have a monitor present when seeing patients and that he pay related costs. Dr. Wu has complied completely.

## *II) GENERAL PRINCIPLES AND RELEVANT LEGISLATION*

The Committee is empowered under s. 51(2) of the *Regulated Health Professions Act* to order a broad range of penalty options.

The Committee believes that an Undertaking made by a member to the College is serious. The expectation is that it will be followed, and if breached, a serious penalty must follow.

Terms, conditions and limitations need to be fully justified and purposeful. Costs, when judged to be appropriate, should generally relate to College expenses, but other relevant factors may be considered.

In the matter at hand, the penalty principles are first and foremost protection of the public, followed by a clear denunciation of the conduct. Specific deterrence, general

deterrence and maintenance of the integrity of the profession and confidence in the College to govern the profession are also relevant. Overall the penalty should be fair, reasonable and rational in respect of the findings made.

### *III) SUBMISSIONS OF THE PARTIES*

#### Submissions of the College

The College asked for a 12-month suspension of Dr. Wu's certificate of registration, three months of which shall be suspended upon successful completion of the College's Medical Ethics and Informed Consent Course at his own expense.

The College sought an order prohibiting Dr. Wu from doing any nerve blocks until he has permission of the College to do so after he has undergone a College-approved fellowship in pain management at his own expense.

The College requested an order to consent to OHIP billing review by the College and unannounced practice inspections with no time duration.

The College sought an extensive monitoring and reporting program requiring a monitor for all patient encounters with costs to be paid by Dr. Wu.

Furthermore, the College sought a reprimand and for the results of the proceedings to be included in the register.

Costs in the amount of \$16,643.87 were requested.

#### Submissions of the Member

Dr. Wu suggested a six-month suspension of his certificate of registration, commencing April 1, 2009 (or within 60 days of the order), two months of which shall be suspended



upon Dr. Wu's successful completion at his own expense of the College's Medical Ethics and Informed Consent Course.

Dr. Wu further proposed a penalty which included a prohibition of nerve blocks until training and preceptorship acceptable to the Quality Assurance Committee of the College permitted him to do so.

Dr. Wu agreed to give consent to provide the College with OHIP billing record access.

Dr. Wu agreed with a public reprimand and an order that the results of the proceedings be included on the register.

Dr. Wu requested that monitoring be limited to chronic pain cases in his practice for two years, and agreed he shall not practise or engage in any professional encounter or interaction with any patient seeking medical treatment for chronic pain management except in the presence of a monitor acceptable to the College.

Dr. Wu agreed that it would be appropriate to submit to, and not interfere with, unannounced inspections of his office and practice and patient charts by a College representative for the purpose of monitoring and enforcing his compliance with the terms of his Undertaking not to perform nerve blocks, for a period of five years.

Costs in the amount of \$2,500 were proposed.

#### *IV) OVERVIEW OF THE EVIDENCE*

The Committee received documentary evidence in the form of excerpts from patient charts (exhibit #3); curriculum vitae (Dr. A, Dr. B and Dr. Wu); Notice of Hearing dated April 12, 2001; letter of January 2, 2007 from Dr. Wu to Ms. X [College staff] (with attachments); a Book of Documents of Dr. Howard Wu containing letters of reference; Certificates of Continuing Medical Education, Certificates of Recognition and Appreciation, Memberships, Symposia, and Articles and Speaking Engagements; and an

Order of the Executive Committee of the College under s. 37 of the Code, effective January 30, 2008.

The Committee also heard evidence from the following witnesses:

Witness #1 (College): Dr. A

Dr. A's evidence was initially heard in a *voir dire*. Counsel for the defence objected to Dr. A's evidence on the basis that it was not relevant to the matter before the Committee. Counsel for the College submitted that it was relevant and necessary to have Dr. A's evidence to understand the context for the review of Dr. Wu's practice, the circumstances leading up to the signing of the Undertaking and the circumstances around nerve blocks performed after the Undertaking. The Committee concluded that the evidence given by Dr. A was relevant, as it was logically related to the circumstances and nature of the issue of penalty, and therefore, admitted Dr. A's evidence.

Dr. A was qualified to give expert evidence in the field of Anesthesia and Pain Management by the Committee, and with consent of both parties.

Dr. A gave evidence that she had been retained by the College in or about 2001 to review and opine on Dr. Wu's pain management practice, and in detail regarding his technique and follow-up of nerve blocks. This was undertaken as a consequence of an investigation into an unrelated matter. Dr. A reviewed patient records (seven or eight randomly selected charts), a coroner's report, and also interviewed Dr. Wu. She subsequently submitted a report dated February 26, 2001 and an addendum dated March 1, 2001.

On the basis of her review, Dr. A opined that Dr. Wu did not meet the standard of care in regard to performing nerve blocks, in particular, those considered to be major nerve blocks such as epidural, caudal, spinal, stellate ganglion and paravertebral. The factors influencing her decision included that Dr. Wu had little training, indications for and effects of nerve blocks were missing from some of his charts, and he seemed unaware of adverse effects and appropriate actions to take in a related emergency. There was little

documentation regarding the type of pain. In some cases, nerve blocks were done to treat inappropriate conditions. She thought he was “ok” with superficial blocks (minor blocks, easy landmarks, no close significant structures). “These are low risk, safe to do and easy to learn.” Dr. A also described the added risk when patients are treated under heavy sedation.

Dr. A was taken to the patient records (exhibit #3) and agreed that most of the nerve blocks performed by Dr. Wu subsequent to signing the Undertaking to the College were major paravertebral blocks.

Under cross examination, Dr. A agreed that she has always practised in a hospital context and that about 20% of her practice is the management of chronic pain.

The Committee found Dr. A’s evidence to be persuasive, clear and fair. She delivered her opinion in a forthright and unbiased manner. The Committee found her to be a credible witness and her evidence was helpful.

Witness #2 (College): Ms. Y

Ms. Y gave evidence that she was the College investigator in 2001 responsible for the Dr. Wu file. Subsequent to the investigation, a Notice of Hearing was issued, dated April 12, 2001 (exhibit #5). No hearing was held, and the matter was resolved by Dr. Wu signing the Undertaking dated April 5, 2002 (attached to exhibit #2).

The Committee accepted the evidence of Ms. Y as credible, succinct and straightforward.

Witness #3 (Defence): Dr. B

The Committee accepted Dr. B as an expert in community-based pain management and risk assessment of nerve blocks, with the consent of both parties.

Dr. B submitted a report dated November 11, 2008 to the defence, to respond to this hearing. Dr. B gave evidence that it was less risky to perform nerve blocks when patients were not heavily sedated. Dr. B knew that Dr. Wu had signed an Undertaking not to do nerve blocks, and that he had done nerve blocks between 2002 and 2005. He indicated that, based on the records, the seven patients who received nerve blocks in that interval were not heavily sedated.

Under cross examination, Dr. B agreed that the risks of nerve blocks varied, depending upon whether patients are conscious or heavily sedated, and include injection into a blood vessel, a high spinal leading to seizure/loss of consciousness, cardiovascular collapse and respiratory arrest. Paravertebral blocks need care and technical precision. Dr. B agreed that the risk of complications increased if the technique is imprecise, the risk is unappreciated, and where the physician lacks knowledge of resuscitation.

The Committee found Dr. B to be a credible witness. His responses were direct, unbiased and clearly related to the questions posed.

Witness # 4 (Defence): Dr. Howard Wu

Dr. Wu is a current member of the CPSO with a solo practice in Markham, Ontario. He did his undergraduate study at the University of Western Ontario and obtained his medical degree from Queen's University in 1994. He completed a residency in Family and Community Medicine at the University of Toronto in 1997. During residency he had a one-and-a-half month rotation learning pain management and attended a pain clinic, where he became familiar with nerve blocks.

Between 1997 and 2003, Dr. Wu worked at a medical centre in Orillia. He was a part-time Pain Consultant from 1997 to 2000 at a pain clinic. Between 2000 and 2003, he

served as a part-time palliative care consultant at a clinic for geriatric and palliative care and as Coordinator and Pain Consultant part-time at the Chinese Division of Chronic Pain/Addiction Medicine at another medical centre.

Currently, Dr. Wu is working as a solo family physician at a medical centre in Markham, Ontario. He has approximately 2,500 patients. Office hours are Monday to Friday 9:30-5:30, and 5:00-7:30 several nights per week, as well as alternate Saturdays 9:00-12:00. His patients are 85% of Chinese origin, and range from newborns to the elderly. About 70% wish to speak Chinese. Approximately 3% of patients are seen for chronic pain. He has only two patients who need nerve blocks, and has referred these patients to local pain clinics. His patients know that he cannot do nerve blocks.

Dr. Wu spoke of his community activities, where he volunteers for health-related charitable organizations, at one of which he is currently the Chair of the Chinese Advisory Committee. He was open and passionate in his wish to give back to the community by assisting in getting mainstream medical messages to the Chinese community in a culturally sensitive way. He has received a number of awards and certificates of recognition for this work. Recently, he has been instrumental in acquiring government funding for a series of initiatives to promote smoking cessation.

In respect of continuing medical education, Dr. Wu has submitted a lengthy compilation of certificates (exhibit #8, tab 2) and attends CME an average of 1-3 times per month.

Dr. Wu testified that when contacted by the College in 2006 and asked for billing information, he realized that he had breached his Undertaking and took action to have his counsel write a letter to the College disclosing his breach. When asked why he performed nerve blocks on seven patients between 2002 and 2005, Dr. Wu indicated that he had compassion for these patients and did not want to disappoint them or referring physicians. These were complex patients and he did not want to see them suffer. He now believes that he has a better referral system so that nerve blocks, when indicated, can be done in a timely way. He has learned of other options available, including talking to colleagues, and asking for help.

His current practice focuses on family medicine, smoking cessation, and health promotion. Chronic pain is a small part (3%) of his practice.

Since the s. 37 interim order, Dr. Wu has had a monitor with him for all clinical patient contacts. This has cost him approximately \$50,000, and put a strain on his finances. He supports a wife, son, and a mother-in-law for part-time child care. Dr. Wu spoke of cherishing his role as a family doctor for his own population. He admitted and apologized for his wrongdoing. He claimed to have learned his lessons and was earnest in his assertion that he was governable and wanted to give back through his role as a family doctor for the rest of his life.

Dr. Wu admitted that he had read Dr. A's report and addendum. He further acknowledged that he had read and understood and then signed the Undertaking not to do any nerve blocks. He said that he performed a nerve block two weeks later acceding to pleas from his patient to do it. When taken through the seven patient charts, Dr. Wu admitted that his recollection was poor on some details related to the nerve blocks and his records were not helpful. He may have given injections at other sites than those contained in the OHIP billing record, and agreed that some details were not charted or imprecise. He agreed that he could have referred patients on to colleagues but did not do so.

Dr. Wu agreed that he had not been asked for billing data until 2006. He consented to the request and subsequently sent a letter to the College admitting his breach of the Undertaking.

The Committee felt Dr. Wu gave his evidence in an honest and straightforward manner. His description of events was consistent with other evidence. His admissions were freely given and the Committee had no sense that there was an attempt to avoid the issues. He appeared contrite and sincere when professing his wish to serve as a physician in his community for the rest of his life and displayed no contempt for the College and its processes.

V) *REASONS FOR DECISION*

The Committee determined that a suspension of six months, two months of which would be suspended if Dr. Wu completes the College's Medical Ethics and Informed Consent Course, should be imposed.

In regard to the suspension, the parties made submissions on the length of the suspension and the portion to be suspended pending the completion of the College's Ethics and Informed Consent Course. In the Committee's view, a suspension is the clearest sign of denunciation of misconduct of this nature. It is both a specific and general deterrent. It sends a significant message to the member, the profession, and patients.

The duration of a suspension should be fair and consistent with similar cases. The Committee considered the case law cited by the College:

- (i) The *Vasic* case was not considered analogous given that it involved a number of instances of dishonesty over a lengthy period. There was no demonstrable remorse. A 12-month suspension was ordered, three months to be suspended with completion of the College's Medical Ethics Course.
- (ii) In the *Derenda* case, there was a breach of a s. 37 order of the Executive Committee. Furthermore, the member showed disregard for the College, a lack of personal integrity, and boundary violations. Revocation was ordered.
- (iii) In the *Pyne* case, there was a breach of an order made by the Discipline Committee. A 10-month suspension was ordered.

The Committee also considered the case law submitted by counsel for Dr. Wu:

- (i) In the *Gay* matter, there was a breach of an Undertaking, resulting in a two-month suspension.
- (ii) In the case of *Brand*, there were repeated breaches of an Undertaking, resulting in a four-month suspension, three of which were suspended pending completion of the College's Ethics Course.

- (iii) In the case of *Wu* (unrelated to the current matter), there was a breach of an Undertaking and a six-month suspension ordered, five of which were suspended upon completion of the College's Ethics Course.
- (iv) Lastly, in *Skocylak*, following the breach of an order of the Discipline Committee, a four-month suspension was ordered.

In addition to the case law cited above, the Committee considered a number of aggravating factors, which included that Dr. Wu understood the Undertaking and within a short period of time had breached it. He did this repeatedly from 2003 to 2005. He was aware of the expert opinion that he did not meet the standard of care in this respect, yet he continued to perform the procedures. Notwithstanding the lack of evidence of harm, there was the potential for harm.

There were also a number of mitigating factors as follows:

- Dr. Wu has demonstrated, by his post-misconduct behaviour, a wish to co-operate with the College, and as a result of an Agreed Statement of Facts and his admission, he has shortened the hearing process;
- Dr Wu has acknowledged his wrongdoing and he has cooperated in the investigation;
- Dr. Wu has expressed remorse and apologized for his behaviour. His claims that he is not ungovernable were judged to be sincere;
- Dr. Wu's motive in breaching the Undertaking was neither for financial or personal gain but resulted from misplaced compassion/sympathy for patients;
- Dr. Wu is a relatively inexperienced physician who has admitted his error and has now learned from his transgression;
- Dr. Wu has demonstrated dedication to the community he serves and his awards and certificates speak to his efforts to bring improved health care to the immigrant Chinese population;



- Dr. Wu serves a subset of the population who speaks Cantonese or Mandarin and has submitted letters of support from colleagues which attest to his good character and essential role in the Chinese community; and
- Dr. Wu has been active in Continuing Medical Education demonstrating a commitment to high quality patient care.

Given all the circumstances, the Committee has determined that a suspension of six months, with two months to be suspended upon the completion of the Ethics course, is fair and appropriate in this matter. The Committee believes that this suspension adequately denounces the misconduct and upholds the principles of specific and general deterrence. The Ethics Course has a rehabilitative purpose and should address Dr. Wu's failure to understand the gravity of signing an Undertaking with the College. Dr. Wu has demonstrated in his behaviour since the misconduct that he is dedicated to the practice of medicine.

Counsel was in agreement that there be a prohibition of nerve block procedures. The Committee understands that Dr. Wu has an interest in pain management and may at some time wish to seek to perform nerve blocks. If so, the Committee believes that Dr. Wu should come before the Discipline Committee and seek to vary the Order. Such a variance would require that Dr. Wu demonstrate to the Committee that he has the requisite knowledge, skill and approval of the Quality Assurance Committee of the College. This restriction upholds the principle of public protection.

The Committee was of the opinion that monitoring was required. The parties both had a proposal for monitoring in their submissions, however there was no agreement between the parties as to the length and scope of the process. The Committee has no evidence which would support the need to monitor Dr. Wu's family practice. It is clear, however, that his chronic pain practice requires monitoring, given that he has had difficulty in appropriate decision making, suggesting a problem differentiating his duty to patients and that to himself and the College. A monitoring and reporting arrangement for his chronic pain practice is required to ensure that Dr. Wu is compliant with this Discipline Committee's Order. Dr. Wu has indicated that chronic pain patients represent a small

proportion of his practice and that he can arrange to see them at a time set aside specifically as a pain clinic. The Committee is aware that pain is a common symptom encountered in family practice. However, the Committee felt it was appropriate that the monitoring be limited to his chronic pain practice. The cost of the monitor is to be born by Dr. Wu. The monitor should be a registered health professional and there should be a regular reporting arrangement to the College. Provided that Dr. Wu's monitoring reports are satisfactory and demonstrate that he has been compliant, the Committee thought it reasonable that monitoring should cease after two years.

It was the opinion of the Committee that a broader monitoring scheme is unnecessary to protect the public. The proposed monitoring arrangement is straightforward, rational and upholds the principle of protection of the public.

The Committee agreed that it required assurance that all of Dr. Wu's patients (including his family practice patients) be made aware that he is prohibited from doing nerve blocks and that this be achieved by the posting of a sign in his office, fully visible in both languages (English and Chinese) with this information. Further, all of Dr. Wu's patients should have an acknowledgement signed or initialed and incorporated in their medical record indicating that they understand that he is prohibited from doing nerve blocks. This adds an element of protection for the public and supports the integrity of the governing process.

With respect to unannounced practice inspections, the Committee believes this adds a further safeguard with respect to assuring that Dr. Wu complies fully with the Order. Both parties have included this as part of their proposed penalty; however, Dr. Wu asks for a time limit of five years. The Committee agrees that a five year period would be sufficient, provided that the inspections have been satisfactory in demonstrating compliance.

Ongoing monitoring of OHIP billings periodically is indicated to assure the College that Dr. Wu's practice pattern is compliant with this Committee's Order. There should be no time limit while this Order is in effect.

The Committee feels that a reprimand and inclusion of the proceedings on the register is necessary; this is not contested by the parties and is a specific and general deterrent.

The Committee orders costs in the amount of \$3,650, payable to the College within 60 days. The Committee considered this to be an appropriate case for costs and the appropriate amount to be the costs for a one-day hearing. Costs relating to the expert witness for the College should, in the Committee's view, be covered by the College. The Committee considered two factors unique to this case:

First, Dr. Wu has been required to pay approximately \$50,000 for a monitor for the past year, the cost of which has been financially burdensome given his family obligations; and

Second, the penalty assessed by the Committee is largely within the scope of the penalty submissions made by Dr. Wu.

## **ORDER**

Therefore, the Committee ordered and directed that:

1. The Registrar suspend Dr. Wu's certificate of registration for a period of six months to commence within 60 days of this order, two months of which shall be suspended upon Dr. Wu's successful completion, at his own expense, of the College's Medical Ethics and Informed Consent Course.
2. That the following terms, conditions and limitations be imposed on Dr. Wu's certificate of registration:
  - (a) That Dr. Wu be prohibited from performing any nerve blocks in his medical practice;
  - (b) That Dr. Wu provide a signed consent allowing the College to have access to his OHIP billings;

- (c) That Dr. Wu shall submit to and not interfere with unannounced inspections of his office(s) and practice(s) and patient charts by a College representative for the purposes of monitoring and enforcing his compliance with the terms of this Order. If monitoring reports are satisfactory to the College and compliance demonstrated, monitoring shall cease after a period of 5 years;
  - (d) That Dr. Wu post a sign, in a visible location in his office, in both Chinese and English, that he is prohibited by the College from performing nerve blocks, and that a signed consent be enclosed in each patient's chart, that they have been informed of this restriction;
  - (e) That Dr. Wu will have a monitor present for all chronic pain patients, at his own expense and pursuant to the following terms:
    - (i) That the monitor shall be a member of a health profession pursuant to the terms of the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18, who is aware of the terms of the Order and acceptable to the College;
    - (ii) That the monitor keep a log of all chronic pain patients seen, and submits this to the College quarterly with a written report on Dr. Wu's conduct;
    - (iii) That the monitor signs and dates contemporaneously the corresponding entry in the medical record;
    - (iv) That monitoring may cease two years from the date of this Order providing the College is satisfied that Dr. Wu has been compliant with this Order.
3. Dr. Wu shall appear before the Committee to be reprimanded, and results of this proceeding shall be included on the register.
4. Dr. Wu shall pay costs to the College of \$3,650 within 60 days of the date of this Order.

The Committee notes that, should Dr. Wu wish to perform nerve blocks in future, he must seek a variance of this Order.