

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Herman Yip-Chi Ng, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the witnesses or any information that could disclose the identity of the witnesses 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. Ng, 2016
ONCPSD 12**

**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. HERMAN YIP-CHI NG

PANEL MEMBERS:

**DR. C. CLAPPERTON
MS. D. GIAMPIETRI
DR. R. SHEPPARD
MAJ. KHALIFA
DR. J. RAPIN**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF
ONTARIO:**

MS. C. SILVER

COUNSEL FOR DR. NG:

MS. A. SPAFFORD

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date:	February 22, 2016
Decision Date:	February 22, 2016
Release of Written Reasons:	June 1, 2016

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 February 22, 2016. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and that the member is incompetent and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Ng 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. Ng 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. Ng admitted that he failed to maintain the standard of practice and displayed incompetence as defined by subsection 52(1) of the Code, with respect to his infection control practices, and his maintenance of equipment in his practice. Dr. Ng did not contest that he failed to maintain the standard of practice and displayed incompetence as defined by subsection 52(1) of the Code, with respect to the twenty-six (26) patients

whose care was reviewed by Dr. Lemieux in her report dated July 6, 2015. Dr. Ng did not contest that he engaged in disgraceful, dishonourable or unprofessional conduct by making substitutions to and backdating Patient A's chart, and by providing the College with untruthful and misleading information in his letters to the College dated May 13, 2015 and August 7, 2015 with respect to Patient A's chart.

THE FACTS

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

1. Dr. Ng is a 68 year-old general practitioner with a practice in Toronto, Ontario.

Patient A

2. Patient A was a patient of Dr. Ng for several years.
3. On a date in mid-February, 2015, the College received a Complaint Form from Patient A expressing concerns about the manner in which Dr. Ng conducted himself during an appointment on a date earlier in February 2015. Patient A was also concerned that Dr. Ng failed to maintain adequate cleanliness in his office environment.
4. On February 27, 2015, an unannounced inspection conducted at Dr. Ng's clinic revealed significant cleanliness/asepsis concerns, including the disposing of used non-safety engineered syringes in a dirty sink, no clear delineation between soiled and clean areas, improper cleansing and disinfecting of instruments and dirty and cluttered examination/utility/consultation room.
5. On April 15, 2015, Dr. Ng provided what he purported to be the original patient chart of Patient A, together with a transcription of same.

6. By letter dated May 11, 2015, the College investigator asked that Dr. Ng confirm that he had not altered the chart in any way or made any changes to it, and that all entries were made on the dates shown on the chart.
7. By letter dated May 13, 2015 from his counsel, Dr. Ng advised the College that he had not altered the chart in any way and that all entries were made contemporaneously.
8. The College retained the services of a forensic document examiner to review Patient A's patient chart. The Forensic Report dated April 27, 2015 confirmed that parts of Dr. Ng's chart for Patient A had been substituted and backdated.
9. The College retained the services of Dr. Lemieux to review the care provided by Dr. Ng to Patient A and Dr. Ng's infection control procedures and his maintenance of equipment in his practice.
10. In her report dated July 2, 2015, Dr. Lemieux opined on Dr. Ng's infection control procedures as follows:

Dr. Ng did not meet the standard of practice of the profession as of March 12, 2015 with respect to infection control procedures and maintenance of equipment in his practice.

Dr. Ng's care in relation to infection control as of March 12, 2015 displayed a lack of knowledge, care and judgment in that he was unaware of and/or did not implement basic office infection control processes and procedures that are readily available to all Ontario physicians through Public Health Ontario. In my opinion, his deficit is severe as the breaches in infection control were numerous and place patients at risk.

Dr. Ng's practice, behaviour and conduct in relation to infection control as of March 12, 2015 exposed his patients to harm and was likely to expose

his patients to injury. Significant risks resulting from his practice, behaviour and conduct include transmission of respiratory pathogens such as influenza, enteric pathogens such as C difficile and blood borne pathogens such as hepatitis B or C.

11. Dr. Lemieux's review of Dr. Ng's care of Patient A was based on Dr. Ng's chart, which had been altered by Dr. Ng.

12. Dr. Ng provided a response to the Forensic Report and the report of Dr. Lemieux by letter dated August 7, 2015. With respect to the Forensic Report, Dr. Ng reiterated the position he had taken in a letter to the College from his counsel dated May 13, 2015, that is, that he had not altered Patient A's patient chart.

Section 75(1)(a) Investigation

13. Based on Patient A's letter of complaint and the unannounced inspection conducted at Dr. Ng's clinic on February 27, 2015, on March 10, 2015 the Inquiries, Complaints and Reports approved the appointment of investigators to conduct a broader investigation into Dr. Ng's practice under section 75(a) of the Health Professions Procedural Code.

14. On March 3, 2015, the College notified Toronto Public Health ("TPH") that Dr. Ng was using unacceptable infection prevention and control (IPAC) practices while providing patient care at his office.

15. On March 6, 2015, an inspection by TPH concluded that Dr. Ng failed to use adequate IPAC practices. On the same day, TPH gave a verbal order under section 13 of the *Health Protection and Promotion Act*, requiring Dr. Ng to close his office until further notice.

16. On March 11, 2015, TPH served a written order requiring Dr. Ng to make improvements to his office including disposing sharps in an approved sharps container, ensuring the premises is clean and in good repair at all times, there is an area that has a sink for cleaning and disinfecting instruments and single use items are discarded safely after use. Toronto Public Health made an Interim Investigation Report dated March 13, 2015.

17. On March 23, 2015, TPH re-inspected Dr. Ng's practice and concluded that he made the necessary corrective IPAC measures and reopened the premises for patient care. TPH's Final Investigation Report is dated March 30, 2015.

18. On July 2, 2015, the College conducted a re-inspection of Dr. Ng's office which revealed continuing infection control issues.

19. The College retained the services of Dr. Lemieux to review the standard of care provided by Dr. Ng. Based on an office inspection, an observation of Dr. Ng's practice, an interview with Dr. Ng and a review of twenty six (26) patient charts as well as a review of five (5) patient charts whose care she observed on June 8, 2015, Dr. Lemieux opined, in part, as follows:

- In 25 charts, Dr. Ng failed to properly maintain a CPP, medication record or immunization record.
- In 16 charts, Dr. Ng failed to meet the standard in assessing, documenting, investigating and managing patients with a thyroid nodule, microcytic anemia, low hemoglobin/ hematocrit, ulcer pain, infected heel wound, ongoing albuminuria, diabetes, toothache and not referring patients for dental care, using non-evidence based treatments for prostatitis, H-pylori titers, zoster infections, carpal tunnel syndrome, enuresis in a 2 year old child, in having performed a laryngoscopy on a patient, and not having used a growth chart and not following the Ontario immunization schedule.

- Dr. Ng failed to meet the standard of care in 5 out of 5 of the patients observed, including performing blood pressure assessment, assessing a patient's complaint of fatigue and back pain, following up on an abnormal HgA1C, assessing a patient's complaint of chest pain and shortness of breath, managing a patient's oral pain.
- Dr. Ng demonstrates a lack of knowledge/skill/judgment in the areas of pap screening, use of glucometer, use of otoscope, H pylori screening, ordering diagnostic testings such as mammography, pelvic ultrasound, thyroid ultrasound and abdominal ultrasound, office emergency procedures, periodic screening, management of diabetes, chest pain assessment, use of Rourke or developmental record and Ontario immunization schedule.
- In 15 out of 23 charts, Dr. Ng's practice is likely to expose his patients to harm/injury.
- In 5 out of 5 patients observed, Dr. Ng's practice may expose his patients to harm/injury.
- With respect to Dr. Ng's Infection Control Practice, Dr. Lemieux opined as follows:
- Dr. Ng carried out improper reprocessing multi-use equipment and displayed a lack of knowledge of proper reprocessing process.
- Once hygiene product was available in his office after the Toronto Public Health investigation, he did not utilize it once during the patient observations on June 8, 2015; he did not manage sharps appropriately; he did not document hepatitis B status properly; he did not manage multi-dose vials properly; he

did not have controls for refrigerated items; he did not understand or carry out syndromic surveillance.

Dr. Ng's clinical practice created a definite risk of harm for patients who attended his office prior to February 27, 2015. The risk was one of transmission of respiratory, enteric and bloodborne pathogens, and transmission of multi-drug resistant organisms such as methicillin-resistant *Staphylococcus aureus* (MRSA). The nature of the harm ranged from possible acute infection to colonization with a risk of future infection. Depending on the pathogen, infection could have caused significant morbidity and even mortality. It is not possible to quantitate the probability of the harm...any patient may have been exposed to harm.

20. Based on the facts set out above, Dr. Ng admits that he failed to maintain the standard of practice and displayed incompetence as defined by subsection 52(1) of the *Health Professions Procedural Code*, with respect to his infection control practices, and his maintenance of equipment in his practice.

21. Dr. Ng does not contest that he failed to maintain the standard of practice and displayed incompetence as defined by subsection 52(1) of the *Health Professions Procedural Code*, with respect to the twenty-six (26) patients whose care was reviewed by Dr. Lemieux in her report dated July 6, 2015.

22. Dr. Ng does not contest that he engaged in disgraceful, dishonourable or unprofessional conduct by making substitutions to and backdating Patient A's chart, and by providing the College with untruthful and misleading information in his letters to the College dated May 13, 2015 and August 7, 2015 with respect to Patient A's chart.

FINDINGS

The Committee accepted as true all of the facts set out in the Statement of Facts. Having regard to these facts, the Committee found that Dr. Ng has committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession; and 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. Ng is incompetent.

PENALTY AND REASONS FOR PENALTY

Counsel for the parties presented a joint submission on penalty to the Committee. The proposed penalty was an order that Dr. Ng appear before the panel to be reprimanded and pay the College costs in the amount of \$4,460.00 within 30 days of the date of the Order.

The Committee was informed that Dr. Ng signed an Undertaking on February 22, 2016, resigning from the College effective immediately and undertaking to neither apply nor re-apply as a physician to practise medicine in Ontario or in any other jurisdiction after the effective date of the Undertaking. A copy of the Undertaking was entered into evidence.

The protection of the public is of paramount importance in the well-established principles that govern the selection of a penalty in a disciplinary proceeding. Other principles to be considered are the maintenance of public confidence in the integrity of the medical profession and in its ability to regulate itself effectively in the public interest; specific deterrence as it applies to the member; general deterrence in relation to the membership as a whole; and, the rehabilitation of the member where applicable. The Committee's task is to weigh these principles in light of the specific facts and circumstances of the case in order to arrive at a penalty that is fair, reasonable, and appropriate.

The Committee considered the nature and extent of the findings of professional misconduct in this case. The Committee was shocked and appalled by the filthy and

deplorable conditions in Dr. Ng's office as well as the multiple instances of inadequate infection control procedures. Dr. Ng's lack of knowledge and judgment in this regard is extreme, and he continually placed his patients at risk of harm in a variety of ways, including from the transmission of respiratory, enteric, and blood-borne pathogens.

Dr. Ng's clinic was shut down by Toronto Public Health because of unsanitary conditions. When his clinic was ultimately permitted to reopen, the College's re-inspection revealed continuing infection control issues. Dr. Ng had been given a chance to address his deficiencies in exposing patients to infection but he failed to do so adequately.

Dr. Ng's misconduct and incompetence was not limited to poor hygiene and inadequate infection control at his clinic. The College's section 75(a) investigation revealed Dr. Ng's subpar clinical knowledge, skills, and judgment in a high percentage of the patients whose care the College reviewed.

Expert evidence revealed multiple clinical areas in which Dr. Ng's care of his patients failed to maintain the standard of practice of the profession. This failure meant that Dr. Ng's patients were exposed to potential harm or injury.

Furthermore, Dr. Ng initially failed to cooperate with the College investigation and, in fact, obstructed it by altering the patient chart of the original complainant and then lied about doing so. Dr. Ng's dishonesty and disrespect for the authority of the College are totally unacceptable.

The Committee found that aggravating factors in Dr. Ng's case include the multiple areas of clinical practice in which Dr. Ng failed to maintain the acceptable standard of practice, and his repeated failures to meet this standard despite the opportunity provided to him to correct his deficiencies regarding cleanliness and infection control.

The Committee found that Dr. Ng's dishonesty in responding initially to the College investigation was a further aggravating factor.

Dr. Ng has no previous disciplinary history with the College. The Committee recognized that Dr. Ng did not contest the College's allegations of professional misconduct and incompetence with respect to infection control procedures. Doing so avoided a contested hearing.

Dr. Ng signed an Undertaking to resign from the College and never to re-apply to practise medicine in Ontario or in any other jurisdiction.

CASELAW

College counsel submitted three prior Discipline Committee decisions with some factual similarities to Dr. Ng's case. The Committee was aware that it is not bound by prior disciplinary decisions and that each case will have unique characteristics; in general, however, similar cases should be dealt with in a similar fashion.

In *CPSO v. Shum* (2013), the Committee found that Dr. Shum, a family physician, failed to maintain the standard of care and was incompetent regarding cleanliness and infection control procedures. His clinical care of patients was also deficient. In accepting a joint submission, the Committee ordered that Dr. Shum's certificate of registration be revoked, that he be reprimanded, and that he pay costs to the College.

In *CPSO v. Farazli* (2014), the Committee found that Dr. Farazli, an internal medicine specialist, was responsible for serious infection control issues. The Committee found that many of Dr. Farazli's patients, who had undergone procedures at her clinic, were exposed to a risk of harm in a variety of ways. Upon Dr. Farazli signing an Undertaking to resign from the College and to never re-apply, the Committee ordered that she be reprimanded and that she pay costs to the College.

In *CPSO v. Prevost* (2015), the physician, an obstetrician and gynecologist, failed to maintain the standard of care and was incompetent in numerous areas pertaining to his clinical care of patients, documentation, and attention to issues of consent. Dr. Prevost

undertook to resign from the College and not to re-apply. The Committee accepted a joint submission that he be reprimanded and that he pay costs to the College.

The Committee accepts that the jointly-proposed penalty in the instant case in the circumstances of Dr. Ng's resignation is consistent with the penalties ordered in these earlier decisions. There is an established precedent for the Committee to consider a member's undertaking to resign from the College and never re-apply as effectively addressing the need to protect the public when the physician's incompetence and misconduct has placed his patients at risk of harm.

While the decision on penalty is a matter for the Committee, the Committee understands the legal principle that a joint submission must be accepted unless to do so would be both contrary to the public interest and bring the administration of justice into disrepute.

The Committee found that, in light of the facts and circumstances outlined above, Dr. Ng should not be permitted to continue to practise. His multiple failings and deficiencies have continually placed his patients at risk.

The Committee was satisfied that Dr. Ng's undertaking to resign from the College and never re-apply to practise medicine in this or any other jurisdiction will ensure that the public is protected. If Dr. Ng had not undertaken to resign, the Committee would have concluded that revocation of his certificate of registration would be the appropriate penalty.

The Committee accepted that the penalty proposed by the College and agreed to by Dr. Ng is reasonable and adequate in the circumstances. The public reprimand of Dr. Ng will express the profession's abhorrence of his misconduct and incompetence, and will also serve the goal of general deterrence. It will further support the maintenance of public confidence in the integrity of the profession.

The Committee also concluded that this was an appropriate case in which to order Dr. Ng to pay costs to the College of a one-day hearing in the amount of \$4,460.00.

At the conclusion of the hearing, Dr. Ng waived his right of appeal and the reprimand was administered by the Committee.

ORDER

Therefore, having stated the findings in paragraphs 1 and 2 of its written order of February 22, 2016, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Ng to appear before the panel to be reprimanded.
4. Dr. Ng pay to the College costs in the amount of \$4,460 .00, within 30 days of the date of this Order.

TEXT OF PUBLIC REPRIMAND**Delivered on February 22, 2016**

Dr. Ng, the Committee is shocked at the breadth and variety of your deficiencies. They encompassed a lack of knowledge in your clinical care, and grievous lack of attention to infection control. Photos of your filthy office were truly disturbing. When the public health department closed your premises and you were subsequently allowed to re-open, you still did not conform to the infection control requirements. Failing to do so reveals a cavalier disregard for your patient's safety. You put them at risk.

Failing to maintain the standard of practice in many clinical areas also put your patients at risk. Besides clinical and infection control measures that were grossly lacking, you also revealed a lack of integrity personally. You altered a chart, and even though a forensic examiner detected your falsification of the chart, you persisted in lying to the College.

Your actions are reprehensible. The College has a primary duty to protect the public. As a self-governing profession, the public places a high expectation on the College to fulfil its mandate. As a member of the College, you had a similar responsibility to uphold the standards of the College. Your actions harmed the medical profession. Frankly, speaking on behalf of the doctors of the province, your behaviour is an embarrassment to the standards expected of all physicians.

**** NOT AN OFFICIAL TRANSCRIPT ****