College of
COMPLEMENTARY HEALTH
PROFESSIONALS OF BC

COLLEGE OF COMPLEMENTARY HEALTH PROFESSIONALS OF BRITISH COLUMBIA (the "College")

In the matter of a Regulatory Complaint under the *Health Occupations and Professions Act,* SBC [2022] c 43 ("HPOA"), regarding:

Hong Tang, R.TCMP INQ-2025-0018TCMA

CONSENT ORDER
(pursuant to section 158 of the HPOA)

BY THE REGISTRAR:

WHEREAS:

A. On February 1, 2021, Hong Tang, registered traditional Chinese medicine practitioner (the "Respondent") entered into an undertaking and consent agreement with the College of Traditional Medicine Practitioners and Acupuncturists of British Columbia (CTCMA) (the '2021 Undertaking'). The Respondent undertook not to repeat the conduct of violating clinical record keeping and consent to treatment standards.

B. On June 28, 2024, CTCMA amalgamated with three other health profession regulatory colleges to form the College. All previous agreements entered into with CTCMA came into the jurisdiction of the College.

C. On September 23, 2025, pursuant to section 33 (1)) of the *Health Professions Act*, RSBC 1996, c 183 (the "HPA"), the College initiated an investigation following a complaint submitted by a member of the public alleging that the Respondent had failed to monitor the cupping treatment of a patient, leaving the cups on for too long without checking in regularly, resulting in severe blistering. The Complainant also alleged that the Respondent had failed to respond appropriately with first aid when the injury was discovered (the "Complaint").

D. On November 12, 2025, the Respondent was provided with notice of the investigation regarding the Complaint.

E. On April 1, 2026, the HPA was repealed and replaced by the HPOA. Pursuant to section 428 of the HPOA, the Complaint continued under the provisions of the HPOA.

F. The investigation was conducted in accordance with Part 3 of the HPA and Division 12 of the HPOA.

G. The Respondent was provided with an opportunity to respond to the investigation before the College's Investigation Committee deliberated on the disposition of the Complaint.

H. On July 2, 2026, a panel of the College's Investigation Committee assessed the matter pursuant to section 134 (2) (b) of the HPOA.

I. Pursuant to section 136 of the HPOA, the Panel determined it had reasonable grounds to believe the Respondent committed an act of misconduct by:

i. Breaching the *Record Keeping Practice Standard* (in place at the time) by:

a. Failing to include the details of the Patient's family doctor, medical history and risk factors/ ongoing health concerns in the clinical record

b. Failing to note an assessment and diagnosis in the treatment record

c. Failing to record the Patient's informed consent to receive cupping treatment

d. Failing to record a discussion of the potential benefits and risks or side effects of cupping treatment

e. Failing to maintain accurate billing records, itemised invoices or receipts for treatment

ii. Breaching the *Safety Program Handbook* (in place at the time) by:

a. Failing to put in place a reasonable plan for emergency situations, failing to maintain a list of nearby emergency medical services, and failing to maintain guidelines for injuries such as burns and scalds

b. Failing to maintain a functional first aid kit

iii. Breaching the *Ethical Practice and Professional Accountability Standard* by:

a. Failing to provide safe, quality patient care to the Patient by failing to record any considerations or patient history that was relevant to the treatment provided

b. Failing to adequately monitor the patient during cupping treatment

iv. Breaching the *Consent to Treatment Practice Standard* and the "*Practice Guidance – Preventing Injuries in Cupping & Moxibustion Practices*" by:

a. Failing to obtain specific consent to proceed with cupping treatment

b. Failing to inform the patient of the risk of blisters and burns from cupping treatment

c. Failing to record informed consent to treatment in the clinical record

v. Breaching sections of the 2021 Undertaking by:

a. Failing to comply with appropriate clinical record-keeping practices as they relate to the collection, maintenance, disclosure and retention of clinical records, and

b. Failing to obtain complete intake information including a complete and accurate medical history and to record appropriate informed consent at the outset of treatment and updated consent as the treatment progresses.

J. Pursuant to section 136 (2) (a) of the HPOA, the Panel directed the Registrar to dispose of the Complaint by making an order with the Respondent's consent pursuant to section 158 of the HPOA.

K. The Respondent consents to the making of this Consent Order pursuant to section 158 of the HPOA.

L. The Respondent acknowledges that she has read and understood the terms of this Consent Order and was given the opportunity to seek independent legal advice before consenting to the terms of the order.

M. The Respondent acknowledges that, in accordance with section 256 of the HPOA, the Registrar must publish the terms of the Disciplinary Order and the reasons for the Disciplinary Order.

N. The Respondent acknowledges that a breach of the terms of this Consent Order constitutes misconduct pursuant to section 11 of the HPOA and any alleged breach may result in an investigation under the HPOA and lead to further regulatory consequences.

DISCIPLINARY ORDER

PURSUANT TO SECTION 158 (2) (b) AND 269 OF THE HPOA, THE REGISTRAR ORDERS THAT:

1. The Respondent acknowledges that she engaged in misconduct and consents to a reprimand for the following conduct:

a) Breaching the *Record Keeping Practice Standard* (in place at the time) by:

i. Failing to include the details of the Patient's family doctor, medical history and risk factors/ ongoing health concerns in

the clinical record

ii. Failing to note an assessment and diagnosis in the treatment record

iii. Failing to record the Patient's informed consent to receive cupping treatment

iv. Failing to record a discussion of the potential benefits and risks or side effects of cupping treatment

v. Failing to maintain accurate billing records itemised invoices or receipts for treatment

b) Breaching the *Safety Program Handbook* (in place at the time) by:

i. Failing to put in place a reasonable plan for emergency situations, failing to maintain a list of nearby emergency medical services, and failing to maintain guidelines for injuries such as burns and scalds

ii. Failing to maintain a functional first aid kit

c) Breaching the *Ethical Practice and Professional Accountability Standard* by:

i. Failing to provide safe, quality patient care to the Patient by failing to record any considerations or patient history that was relevant to the treatment provided

ii. Failing to adequately monitor the patient during cupping treatment

d) Breaching the *Consent to Treatment Practice Standard and the "Practice Guidance – Preventing Injuries in Cupping & Moxibustion Practices* by:

i. Failing to obtain specific consent to proceed with cupping treatment

ii. Failing to inform the patient of the risk of blisters and burns from cupping treatment

iii. Failing to record informed consent to treatment in the clinical record

e) Breaching sections of the 2021 Undertaking by:

i. Failing to comply with appropriate clinical record-keeping practices as they relate to the collection, maintenance, disclosure and retention of clinical records

ii. Failing to obtain complete intake information including a complete and accurate medical history and to record appropriate informed consent at the outset of treatment and updated consent as the treatment progresses.

2. The Registrar accepts the Respondent's undertaking not to repeat the following conduct, which constitutes a breach of the current College Bylaws, Professional Standards and Clinical Practice Standards:

a) Failing to maintain health care and billing records that are accurate, complete, up to date and which clearly reflect the care provided and the patient's current health status, contrary to Principle 1 of the Record Keeping Professional Standard

b) Failing to record the patient's consent to treatment in the health care record contrary to the Informed Consent Professional Standard

c) Failing to prepare for emergencies or injuries, contrary to Principle 2 of the Practice Environment Professional Standard

d) Contrary to Principle 1 of the Integrated Person-Centered Care Professional Standard:

i. Failing to provide a clinical environment which is safe by closely monitoring patients during treatments

ii. Failing to provide a clinical environment which allowed for patients to signal for assistance during treatment

iii. Failing to address an injury which occurred during treatment or taking appropriate steps to address it

3. The Respondent is required to repeat, at her own cost, all modules of the College TCM Interactive Safety Course and confirming to the College that she has done so, within six months of consenting to the order.

4. That requires the Respondent to complete the following course, at her own cost and confirming to the College that she has done so, within six months of consenting to the order;

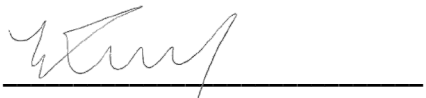
a) 217B Clinical Procedures: Medical Ethics & Legal Issues (Tzu Chi International College)

5. The Respondent, after completing the required coursework in (3) and (4) above, attends a meeting with a College Practice Advisor (CPA) no later than eight months from the signing of this order, to discuss best practices for cupping, injuries and consent to treatment, with any further meeting to be required at the CPA's discretion.

6. The Respondent cooperates with random audits of her clinic or any other practice locations (as the case may be), to assess records (as defined in

Schedule 1 of the Freedom of Information and Protection of Privacy Act) by an inspector appointed by the Registrar for a period of 24 months commencing on the date of signing the consent order.

College of Complementary Health Professionals of British Columbia:



Marta Kumor Fane
Deputy Registrar

Dated at Vancouver this 1st day of September, 2026.