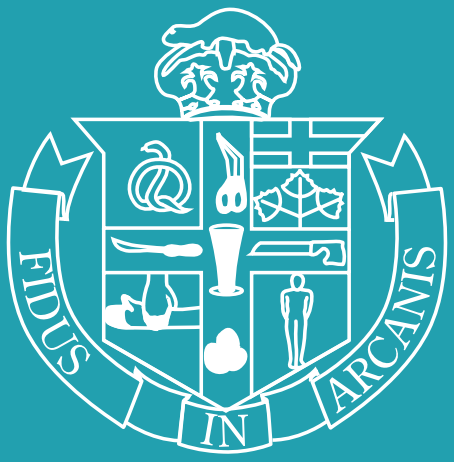
The College of Physicians and Surgeons of Ontario

Meeting of Council



September 7, 2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

NOTICE

OF

MEETING OF COUNCIL

A meeting of The College of Physicians and Surgeons of Ontario will take place on Friday September 7, 2018 in the Council Chamber of the College, at 80 College Street, Toronto, Ontario.

The meeting will convene at 9:00 a.m. on Friday, September 7, 2018.

Nancy Whitmore, MD, FRCSC, MBA
Registrar and Chief Executive Officer

August 10, 2018

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEETING OF COUNCIL

September 7, 2018

Council Chamber, 3rd Floor, 80 College Street, Toronto

CALL TO ORDER

9:00 President's Announcements

REGISTRAR/CEO REPORT

- ***For Information***

- ***For Decision***

Council is being asked to make specified changes to the register By-laws relating to the public register and mandatory reporting.

- ***For Decision***

Council is being asked to amend the General By-law to provide express authority for the Registrar to delegate statutory powers.

Revised Opioid Strategy: 2018/19 24

- ***For Decision***

The current opioid strategy was approved by Council in May 2017. A revised strategy for 2018-19 is proposed for Council's approval.

BREAK at 10 am

10:15 Strategic Plan 30

- ***For Decision***

The CPSO is nearing the end of its current strategic plan, which extends until 2018, and it is time to plan for the development of a new one. A process and timeline to do so are proposed for Council's approval.

COUNCIL AWARD PRESENTATION

11:30 Council Award Recipient: Dr. Jason Malinowski, Barry's Bay, Ontario..... 34

LUNCH BREAK at Noon

1:00 CPSO Governance Review 35

- ***For Decision***

Council is asked to consider the following:

- Proposed governance principles;
- Preliminary recommendations for governance change that
  1) require legislative change and
  2) do not require legislative change.

GUEST SPEAKER

2:00 Vision 2020 Update

Guest Speaker: ***Anne Coghlan, RN, MScN***
Executive Director and Chief Executive Officer
College of Nurses of Ontario

BREAK at 2:30 pm

2:45 Governance Follow-Up Discussion

3:30 Governance Committee Report.....48

For Decision:

- **Election of 2018/2019 Academic Representatives on Council**
- **2018-2019 Chair Appointments**

For Information:

- ***Completion of 2018 Council Performance Assessment (Form)***

3:40 MEMBER TOPICS

3:50 INFORMATION ITEMS

4:00 Motion to go In-Camera

IN-CAMERA SESSION

ADJOURNMENT

DRAFT **PROCEEDINGS OF THE**
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
MAY 24, 2018

Attendees:

Dr. Steven Bodley (President)
Dr. Philip Berger
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Ms. Joan Fisk
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Paul Hendry
Mr. Mehdi Kanji
Ms. Catherine Kerr
Mr. John Langs
Dr. Barbara Lent
Dr. Haidar Mahmoud
Mr. Paul Malette
Ms. Ellen Mary Mills
Dr. Akbar Panju
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Dr. John Rapin
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Dr. Andrew Turner
Dr. Scott Wooder

Non-voting Academic Representatives on Council: Dr. Mary Bell and Dr. Janet van Vlymen

Regrets: Ms. Debbie Giampietri, Dr. Deborah Hellyer, Major A. Khalifa, Ms. Judy Mintz, Ms. Gerry Sparrow and Dr. Robert (Bob) Smith

CALL TO ORDER

President's Announcements

Dr. Steven Bodley called the meeting to order at 9:00 a.m., and welcomed members of Council and guests.

Council Meeting Minutes of February 23, 2018

01-C-05-2018

It is moved by Dr. Jerry Rosenblum and seconded by Ms. Joan Fisk that:

The Council accepts the minutes of the meeting of the Council held on February 23, 2018.

CARRIED

Executive Committee's Report to Council: March to April, 2018

Received with no comments.

INTERIM REGISTRAR'S REPORT

Corporate Report, Dashboard Update, Risk Management Report and Registrar's Update were provided by Mr. Daniel Faulkner, Interim Registrar (a copy of which forms **Appendix "A"** to the minutes of this meeting).

GOVERNANCE REVIEW – PART 1

The Governance Review Working Group (GRWG) provided council with an update of the approach, goals and objectives determined by the working group, an overview of the external environment, and an overview of the jurisdictional reviews undertaken and the literature that exists on best practices for effective board and governance structures (a copy of which forms **Appendix "B"** to the minutes of this meeting).

Regulation Re: Definition of Patient For Purpose of Sexual Abuse Where Treatment Includes Psychotherapy

02-C-05-2018

It is moved by Dr. Andrew Turner and seconded by Dr. Akbar Panju that:

Council proposes to make the following regulation pursuant to its authority under ss. 1(6)(b) and 95(1) of the Health Professions Procedural Code relating to the definition of patient and direct that staff engage in formal consultation on the draft regulation in coordination with the provincial government's timing following the provincial election:

For the purposes of the definition of patient under s. 1(6)(a) of the Health Professions Procedural Code, where the treatment provided by the member to the individual involves psychotherapy that is more than minor or insubstantial, an individual will be deemed to be a member's patient for five years after the date on which the individual ceased to be the member's patient.
(a copy of which forms **Appendix "C"** to the minutes of this meeting).

CARRIED

COUNCIL AWARD WINNER

Dr. Judith Plante presented the Council Award to Dr. Sarah Reid of Ottawa, Ontario.

MEMBER TOPICS

Dr. Berger suggested that the CPSO explore the following, and in doing so, that it be informed by direct discussion with and be guided by Indigenous communities:

- Traditional Territorial Statement – Open Council meetings with an appropriate traditional territorial acknowledgement to recognize that the Council meeting is being held on the historical land of Indigenous peoples in Canada who are the original caretakers of the land, and thus show respect for Indigenous peoples and cultures and that this practice begin at the next meeting.

- Cultural Competency Education/Training – Provide indigenous cultural competency education/training led by representatives of Indigenous peoples to Council members to promote awareness and sensitivity to Indigenous realities.

- Public Engagement - CPSO as part of its 2018/19 public engagement and outreach activity should engage directly with Indigenous communities and peoples.

Further, CPSO to circulate the Truth and Reconciliation Commission of Canada's Final Report and action plan to all members of the College Council.

TOPICS FOR INFORMATION

1. Government Relations Report
2. Policy Report
3. Physician Assistants
4. Immunization of School Pupils (ISPA): Government Amendments
5. Quality Management Partnership Report: Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology
6. Discipline Committee Report of Completed Cases

FINANCE COMMITTEE REPORT

Approval of Financial Statements for 2017

03-C-05-2018

It is moved by Mr. Pierre Giroux and seconded by Dr. Barbara Lent that:

The Council approves the financial statements for the fiscal year ended December 31, 2017 as presented (a copy of which forms **Appendix "D"** to the minutes of this meeting).

CARRIED

Appointment of the Auditors for 2018

04-C-05-2018

It is moved by Mr. Paul Malette and seconded by Dr. Brenda Copps that:

The Council appoints Tinkham LLP, Chartered Accountants, as auditors to hold office until the next financial meeting of the Council.

CARRIED

CONTINUITY OF CARE

Continuity of Care – Draft Policy for Consultation (Umbrella Policy)

05-C-05-2018

It is moved by Dr. Philip Berger and seconded by Mr. Pierre Giroux that:

The College engage in the consultation process in respect of the draft policy "Continuity of Care" (a copy of which forms Appendix **"E"** to the minutes of this meeting).

CARRIED

Continuity of Care: Availability and Coverage – Draft Policy for Consultation

06-C-05-2018

It is moved by Ms. Lynne Cram and seconded by Dr. Scott Wooder that:

The College engage in the consultation process in respect of the draft policy "Continuity of Care: Availability and Coverage" (a copy of which forms Appendix **"F"** to the minutes of this meeting).

CARRIED

Continuity of Care: Managing Tests – Draft Policy for Consultation

07-C-05-2018

It is moved by Mr. Mehdi Kanji and seconded by Ms. Mary Ellen Mills that:

The College engage in the consultation process in respect of the draft policy "Continuity of Care: Managing Tests" (a copy of which forms Appendix "**G**" to the minutes of this meeting).

CARRIED

Continuity of Care: Transitions in Care – Draft Policy for Consultation

08-C-05-2018

It is moved by Mr. Paul Malette and seconded by Dr. Akbar Panju that:

The College engage in the consultation process in respect of the draft policy "Continuity of Care: Transitions in Care" (a copy of which forms Appendix **"H"** to the minutes of this meeting).

CARRIED

Continuity of Care: Walk-in Clinics – Draft Policy for Consultation

09-C-05-2018

It is moved by Ms. Lynne Cram and seconded by Mr. John Langs that:

The College engage in the consultation process in respect of the draft policy "Continuity of Care: Walk-in Clinics" (a copy of which forms Appendix **"I"** to the minutes of this meeting).

CARRIED

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 4:20 p.m.

_____
Dr. Steven Bodley, President

_____
Franca Mancini, Recording Secretary

***DRAFT* PROCEEDINGS OF THE**
MEETING OF COUNCIL
OF
THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
MAY 25, 2018

Attendees:

Dr. Steven Bodley (President)
Dr. Philip Berger
Dr. Brenda Copps
Ms. Lynne Cram
Mr. Harry Erlichman
Ms. Joan Fisk
Mr. Pierre Giroux
Dr. Rob Gratton
Dr. Paul Hendry
Mr. Mehdi Kanji
Ms. Catherine Kerr
Mr. John Langs
Dr. Barbara Lent
Dr. Haidar Mahmoud
Mr. Paul Malette
Ms. Ellen Mary Mills
Dr. Akbar Panju
Mr. Peter Pielsticker
Dr. Dennis Pitt
Dr. Judith Plante
Dr. Peeter Poldre
Ms. Joan Powell
Dr. John Rapin
Dr. Jerry Rosenblum
Dr. David Rouselle
Dr. Patrick Safieh
Dr. Elizabeth Samson
Ms. Gerry Sparrow
Dr. Andrew Turner
Dr. Scott Wooder

Non-voting Academic Representatives on Council: Dr. Mary Bell and Dr. Janet van Vlymen

Regrets: Ms. Debbie Giampietri, Dr. Deborah Hellyer, Major A. Khalifa, Ms. Judy Mintz, and Dr. Robert (Bob) Smith

CALL TO ORDER

President's Announcements

Dr. Steven Bodley called the meeting to order at 9:00 a.m., and welcomed members of Council and guests.

Governance Review Part – 2

Council broke into small groups to consider the following questions:

i. What are the characteristics of a high-functioning modern board?
ii. Thinking ahead to identify the core principles that should underpin CPSO's governance Structure – thoughts and/or early suggestions?

iii. What changes to the College's governance structure should improve the College's effectiveness?

The issue will be returned to the next meeting of Council.

Opioid Strategy: Update

Maureen Boon provided an update on the status of the Opioid Strategy along with related data results from the Narcotics Monitoring System. (a copy of which forms **Appendix "J"** to the minutes of this meeting).

By-Law Amendments to Rescind Methadone Committee

10-C-05-2018

It is moved by Dr. Barbara Lent and seconded by Dr. Patrick Safieh that:

the Council of the College of Physicians and Surgeons of Ontario makes the following By-law No. 119:

By-law No. 119

1. Section 41 of the General By-Law is revoked and the following is substituted:

Establishment

1. The following committees are the standing committees.

Council Award Selection Committee

Education Committee

Finance and Audit Committee

Governance Committee

Methadone Committee *[repealed: May 2018]*

Nominating Committee *[repealed: May 2003]*

Outreach Committee

Premises Inspection Committee

Compensation Committee *[repealed: May 2017]*

2. Section 45 of the General By-Law is revoked.

CARRIED

Motion to Go In Camera

11-C-05-2018

It is moved by Dr. Philip Berger and seconded by Dr. Jerry Rosenblum that:

The Council exclude the public from the part of the meeting immediately after this motion is passed, under clauses 7(2)(b) and (e) of the Health Professions Procedural Code.

CARRIED

IN CAMERA

Council entered into an in camera session at 11:30 a.m. and returned to open session at 12:05 p.m.

GOVERNANCE COMMITTEE REPORT

2019 Executive Committee Election

13-C-05-2018

It is moved by Dr. Joan Powell and seconded by Ms. Joan Fisk that:

the Council appoints: Dr. Peeter Poldre (as President), Dr. Brenda Copps (as Vice President), Dr. Akbar Panju (as physician member), Ms. Lynn Cram (as public member), Mr. Peter Pielsticker (as public member), and Dr. Steven Bodley (as Past President), to the Executive Committee for the year that commences with the adjournment of the annual general meeting of Council in December 2018.

CARRIED

ADJOURNMENT

As there was no further business, the President adjourned the meeting at 1:45 p.m.

_____
Dr. Steven Bodley, President

_____
Franca Mancini, Recording Secretary

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: **Registrar/CEO Report**

FOR INFORMATION

The College's work is guided by its Strategic Plan which charts the course to our vision: Quality Professionals - Healthy System - Public Trust.

The CPSO is nearing the end of its current strategic plan, and plans are underway to begin the strategic planning process this fall (see separate briefing note). In the meantime, operations are guided by the 2018/2019 Corporate Plan, described below.

1. 2018/2019 Corporate Plan

The Corporate Plan is an internal document that supports objectives for the Registrar/CEO and enables monitoring of significant initiatives across all levels of the College.

The Plan sets out the focus of CPSO work in 2018/2019, in anticipation of the Strategic Plan to be completed in 2019.

The Corporate Plan involves a refocusing on the CPSO's core regulatory functions, with investigations as the first priority. The goal is to improve the timeliness, efficiency and effectiveness of core processes within the existing legislative and regulatory framework.

Investigations:

- The College receives approximately 2700 public complaints per year of varying complexity. As volumes have increased, timelines have also increased, resulting in dissatisfaction for both complainants and physicians.

- Given that the Inquiries, Complaints and Reports Committee (ICRC), on average, takes no action in 65% of cases they review, there is an opportunity to manage lower risk complaints differently in order to provide a better experience for complainants and physicians.

- The current complaints process will be changed to manage more low-risk matters via early resolution. Refocusing on increased resolution where possible has multiple potential benefits:

  - ICRC panels will be able to focus on more serious matters
  - complainants and physicians will be contacted more quickly
  - increased complainant and physician satisfaction, and
  - reduction in overall time to resolution.

- The following changes to the process are being pursued:
  - **Faster Response Time**: Revitalizing Intake area to respond to complainants within 2 business days to understand concerns/expectations, describe the complaints process, resolve issues where possible, and ensure complainants feel heard.
  - **Medical Complaints Director**: New role to review all written complaints for assessment and streaming to resolution or investigation using defined criteria.
  - **Alternative Dispute Resolution**: Initiating the ADR process as described in the RHPA to resolve matters.
  - **Medical Advisors (MAs)**: Increasing involvement of MAs at different points in a resolution or investigation.
  - **Process Review**: Evaluating the investigative process for efficiency in certain investigations, while being mindful of the requirement to conduct adequate investigations.
  - **Faster decision release**: Focusing on concise and streamlined ICRC decisions.

- In parallel to the above, backlogged low-risk complaints will be prioritized for accelerated resolution.

Communications

- The significant changes set out in the 2018/2019 Corporate Plan need to be effectively communicated to the public and profession. This provides an opportunity to modernize and enhance our communications products and activities.

- The goals of our new Communications Plan include the following:
  - Relationship building and influence: Focusing on public/patients, the profession, media, and government. This includes a stakeholder management plan and outreach by the CEO across the province.
  - Modernizing communications products (including College policies): This will make information clearer, more dynamic and accessible in the following areas
    1) Website – further updates to improve content and organization
    2) Dialogue - transformation to a digital format
    3) Policies – redesign to make them shorter and easier to read.

- These new approaches will build on our previous work and enable effective communication of both current changes to the investigations process, planned changes to other core regulatory functions like QA/QI and Registration and the release of a new strategic plan in 2019.

- As a first priority, the communications plan will focus on the changes in the investigations area.

2. Dashboard

The Q2 Dashboard sets out the status of strategic and operational targets connected to the existing strategic plan. The dashboard has been revised to focus on 2 core regulatory functions: assessments and investigations. (See appendix A)

At the December meeting, Council will be provided with a new scorecard which will measure the performance and set targets for all the core regulatory functions. This scorecard will align with the revised 2018/2019 Corporate Plan.

FOR INFORMATION

Contact: Dr. Nancy Whitmore
Maureen Boon
Sandra McCulloch
Louise Verity

Date: August 20, 2018

Attachments:

Appendix A: Dashboard – Q2

Dashboard – 2018 – Q2

Strategic Priority	Objective	Measure/Target	Q1	Q2	Comments
Assure/Enhance Physician Competence	Every physician assessed every 10 years (EDEX)	2475 assessments/year **NOTE**: target adjusted to **2475** to redirect resources to peer redesign.			1092 assessments completed to August 15, 2018. This is 44% of quarterly target. Tracking to 1638 by year end.
Optimize Investigations, Discipline and Monitoring	Reduce time for completion of high risk investigations	90% of high risk investigations completed in 243 days. *(old)*			January 1st – June 30th , 2018: 90% of high risk investigations were completed in an average of 203 days, (75 investigations involving 60 unique physicians).
	Reduce time to mitigate risk for high risk investigations	<u>New</u> 90% of high risk investigations had risk mitigated in an average of 150 days.			**<u>New</u>** 90% of high risk investigations had risk mitigated in an average of 145 days (75 investigations involving 60 unique physicians).
	Schedule discipline hearings more quickly	Time from referral to hearing date is 1 year			January 1st – June 30th,2018: 90% of hearings (21) began on average, 300 days (9.9 months) from the NOH date.
	Reduce decision release time	Time from hearing date to decision release date <u>2 months for uncontested (UC)</u> <u>6 months for contested (C)</u>			January 1st – June 30th , 2018: 90% of uncontested decisions (18) were released, 43.5 days (1.4 months) from the last hearing date January 1st – June 30th , 2018: 90% of contested decisions (9) were released, 149.1 days (4.9 months) from the last hearing date.

LEGEND

	Objective	Measure	Target	On Track	Approaching Target	Attention Required
Assure and Enhance Physician Competence	Every physician assessed every 10 years	# of physician assessments in College programs	2600 assessments/year **NOTE**: target has been adjusted to 2475 for Q3 and Q4.	Tracking to >= 2475	Tracking to 2300-2474	Tracking to <2300
Optimize Investigations, Discipline and Monitoring Processes	Reduce time for completion of high risk investigations	# days to complete investigation	90% of High Risk investigations completed in ***243 days or less.*** **New** ***90% High Risk Investigations had risk mitigated in 150 days of less***	90% High Risk investigations done in <=***243d.*** ***New*** ***90% Time to mitigate risk in high risk investigations done in <=150 days***	90% High Risk investigations done ***244-256 d***. ***New*** ***90% Time to mitigate risk for high risk investigations done 151 to 170 days***	90% High Risk investigations done in ***257d+***. ***New*** ***90% Time to mitigate risk for high risk investigations done 171d+***
	Schedule discipline hearings more quickly	Time from referral (notice of hearing) to hearing date	Hearings begin within 1 year	90% began within 365 days (1 yr)	90% began w/i 366-457 days (12-15 mos)	90% began more than 457 days (15 mos)
	Reduce discipline decision release times	Time from hearing date to decision release date	Uncontested (UC): 2 months Contested (C): 6 months	90% released <= 2 mos (UC) <= 6 mos (C)	90% released 2-4 mos (UC) 6-8 mos (C)	90% released > 4 mos (UC) > 6 mos (C)

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: Amendments to Register By-laws

FOR DECISION

ISSUE:

- Council is asked to amend certain General By-law provisions relating to the public register and mandatory reporting in order to remove duplications and inconsistencies with the new legislative and regulatory provisions passed under Bill 87 on May 1, 2018.

BACKGROUND:

- On May 1, 2018, Ontario Regulation 261/18 was passed and new mandatory reporting provisions were proclaimed in the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*.

- The Regulation requires the College to post the following on the public register:

    i. Findings of guilt under the *Criminal Code of Canada* and the *Controlled Drugs and Substances Act* (CDSA);
    ii. Bail conditions imposed in connection with charges under the *Criminal Code* and the CDSA;
    iii. Outstanding charges under the *Criminal Code of Canada* and the CDSA;
    iv. Disciplinary findings by other (non-CPSO) regulatory or licensing authorities; and
    v. Each licence or registration to practice a profession in any jurisdiction (including Ontario, but other than CPSO registration).

- The General By-law already required most of the above to be posted on the register, but there are some differences in scope and in language. Since these are now mandated under the regulation, these by-laws are no longer needed and should be removed or revised in order to avoid duplication and inconsistency.

- One of the new provisions proclaimed in the Code requires members to report charges and bail conditions to the College. The General By-law already required reporting of bail conditions, but with different timing. Accordingly, this by-law provision is no longer necessary and should be removed to avoid duplication and inconsistency.

- The proposed amendments also include a minor housekeeping amendment to Paragraphs 49(1)21 and 23.

PROPOSED BY-LAW AMENDMENTS:

- The proposed by-law amendments are set out in Appendix A, with the revisions marked.
- Since the by-law amendments relate to information required to be on the register, the proposed by-law must be circulated to the profession at least 60 days before approval by Council (Code, s. 94(2)).

NEXT STEPS:

- If Council agrees, the proposed amendments will be circulated to the profession and then brought back to Council in December to be passed.

DECISION FOR COUNCIL:

1. Does Council approve the proposed amendments to the General By-law in respect of register provisions?

Contact: Marcia Cooper, Ext. 546

Date: August 17, 2018

Appendices: Proposed By-law Amendments

Appendix A

Proposed By-law Amendments

1. Paragraph 49(1)19 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:

19. Where there has been ~~a finding of guilt against a member under the *Criminal Code* or~~ a finding of an offence against a member under the *Health Insurance Act*, made on or after June 1, 2015, ~~if the person against whom the finding was made was a member at the time of the finding,~~ and if the finding and/or appeal is known to the College~~:~~, ~~a brief summary of:~~

(i) a brief summary of the finding;

(ii) a brief summary of the sentence;

(iii) where the finding is under appeal, a notation that it is under appeal, until the appeal is finally disposed of; and

(iv) the dates of (i)-(iii), ~~where~~ if known to the College~~.~~,

except if one or more of the conditions set out in section 1(2) of Ontario Regulation 261/18 have been satisfied.

2. Paragraph 49(1)20 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:

20. Any currently existing conditions of release following a charge for a ~~criminal or provincial~~ *Health Insurance Act* offence, or subsequent to a finding of a *Health Insurance Act* offence ~~guilt~~ and pending appeal, ~~that relate to the member's practice,~~ or any variations to those conditions, when known to the College.

3. Paragraphs 49(1)21 and 23 of By-law No. 1 (the General By-law) are revoked and the following are substituted:

21. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a caution-in-person, if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file, is dated on or after January 1, 2015, a summary of that decision, and, where applicable, a notation that the decision has been appealed or reviewed.

23. In respect of a decision of the Inquiries, Complaints and Reports Committee that includes a disposition of a Specified Continuing Education or Remediation

Program ("SCERP"), if the complaint that led to the decision, or, in a case where there is no complaint, the first appointment of investigators in the file is dated on or after January 1, 2015, a summary of that decision, including the elements of the SCERP, and, where applicable, a notation that the decision has been appealed or reviewed.

4. Paragraph 49(1)26 of By-law No. 1 (the General By-Law) is revoked and the following is substituted:

26. Where a member has been charged with an offence under ~~the *Criminal Code of Canada* or~~ the *Health Insurance Act*, and the charge is outstanding and is known to the College, the fact and content of the charge and, ~~where~~ if known to the College, the date and place of the charge.

5. Paragraphs 49(1)27 and 28 of By-law No. 1 (the General By-Law) are revoked:

~~27. Where a member is currently registered or licenced to practice medicine in another jurisdiction, and such license or registration has been made known to the College as of or after September 1, 2015, the fact of that licensure or registration.~~

~~28. Where a member has been the subject of a disciplinary finding by another medical regulatory or licensing authority on or after September 1, 2015, and that finding is known to the College,~~

~~(i) the fact of the finding;~~

~~(ii) the date of the finding, where known to the College;~~

~~(iii) the jurisdiction in which the finding was made;~~

~~(iv) the date upon which the College was notified of the finding; and~~

~~(v) the existence and status of any appeal, when known to the College.~~

6. Paragraph 51(1)(d) of By-law No. 1 (the General By-Law) is revoked:

~~(d) any currently existing conditions of release (not including any information subject to a publication ban) following a charge for a criminal or provincial offence, or subsequent to a finding of guilt and pending appeal, and any variations to those conditions;~~

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: Delegation of the Registrar's Powers

FOR DECISION

ISSUE:

Council is asked to amend the General By-law to provide express authority for the Registrar to delegate statutory powers. The proposed by-law would provide additional protection in relation to the College's current practice of delegating the Registrar's powers when the Registrar is unavailable, and would allow for more efficient processes with respect to such circumstances and in other instances where the Registrar may wish to delegate her powers.

BACKGROUND:

Registrar's Powers

The Health Professions Procedural Code assigns extensive authority and duties to the Registrar for a wide scope of College business. One of the key authorities afforded to the Registrar is the authority, set out in Section 75(1)(a) of the Code, to appoint investigators if the Registrar believes on reasonable and probable grounds that a member has committed an act of professional misconduct or is incompetent. This discretionary authority (and certain other discretionary statutory powers) has historically been delegated to the Deputy Registrar and associate Registrars in the Registrar's absence, or in the event of a conflict.

The RHPA, the Code and the College's By-laws do not expressly state that the Registrar has the authority to delegate her powers. However, courts have repeatedly recognized that registrars and other statutory officials are not required to personally attend to each power provided to them by statute. While registrars are ultimately responsible for the actions of departmental officials, they need not perform each function themselves. Accordingly, the Registrar has the implied authority to delegate statutory powers.

Proposed By-law

In order to provide additional support for the Registrar's power to delegate and to allow for more efficient processes, it is recommended that the delegation power be made explicit in the form of a by-law. The following by-law is proposed to be added to the General By-law:

> **Delegation**
>
> **1b.** The Registrar may delegate any of his or her powers or duties to other officers, agents, or employees of the College.

Under the authority of this by-law (as well as the implied authority to delegate), the Registrar may continue to informally delegate administrative and voluminous functions to College staff. These powers do not require a formal delegation order. The Registrar may choose to delegate certain discretionary decisions (such as the appointment of investigators under s.75(1)(a) of Code and/or the use of Alternative Dispute Resolution for certain complaints) more formally by issuing one or more standing delegation directions specifying that certain individuals have authority for these decisions.

Note that the proposed by-law does not need to circulate to membership prior to being passed by Council.

DECISION FOR COUNCIL:

1. Does Council approve the proposed amendment to the General By-law?

Contact: Marcia Cooper, Ext. 546

Date: August 17, 2018

Attachments:

Appendix A: Proposed General By-law Amendments

Appendix A

By-law No. ____

The general by-law, which is By-Law No. 1, is amended by adding the following heading and subsection:

Delegation

1b. The Registrar may delegate any of his or her powers or duties to other officers, agents, or employees of the College.

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: Revised Opioid Strategy: 2018/19

FOR DECISION

ISSUE:

The current opioid strategy (see https://www.cpso.on.ca/opioids) was approved by Council in May 2017. This briefing note sets out a proposed revised strategy for 2018-19 for Council's approval.

OVERVIEW:

Since May 2017, there has been significant progress against the approved opioid strategy, and the majority of our initiatives have been completed or are being integrated into ongoing operations. Also, the internal and external environments have changed significantly since the strategy was approved. In this context, a revision of the Opioid Strategy is proposed.

The most significant change is to shift the focus of the strategy from investigations to the promotion of quality improvement (e.g., physician access to their own prescribing data and educational resources). The CPSO will not make an additional request for data from the Narcotics Monitoring System at this time, but will continue to respond to prescribing issues. Work completed and lessons learned in the first phase of the strategy will continue to inform our approach to prescribing issues.

CURRENT CONTEXT:

Since May 2017, there has been significant progress against the approved strategy. Not only will this work inform our approach to opioids moving forward, but there are additional benefits that extend to other College work. Three achievements are highlighted below, and a full list can be found in Appendix A.

Internal

- **NMS Investigations**: The 84 NMS investigations initiated in 2016 are complete. Several significant practice problems that required regulatory response were identified. Most of these resulted in remediation, as per Investigations and Resolutions' objective, with only

two cases referred to Discipline. Overall, the majority resulted in no further action. (Link to outcome summary: https://www.cpso.on.ca/CPSO/media/documents/Positions%20and%20Initiatives/Opioids/Opioid-Investigations-Backgrounder.pdf)

- **Review of NMS Investigations**: The processes utilized for the NMS investigations were reviewed and Investigations and Resolutions has made recommendations about which tools and processes will benefit future NMS, opioid and other types of investigations. Implementation of these recommendations has begun.
- **ICES Analysis**: The AHRQ request made by CPSO to ICES to understand physician prescribing of opioids identified extreme outliers of high-risk physicians and factors associated with high-risk prescribing. The analysis was done using 2016 data and names were not provided. ICES will not provide the names to CPSO directly.

External

- **New Provincial Government**: At this time there has been no direct communication from the new government about its expectations of CPSO generally, or its position on prescription monitoring or the opioid crisis specifically. The new Premier has, however, expressed a lack of support for supervised injection sites, and the Minister of Health has ordered a freeze on overdose prevention sites as evidence is reviewed.
- **Opioid Deaths Continue to Rise**: The Chief Coroner report released on Opioid Mortality for January to October 2017 found that there were a total of 1053 opioid-related deaths – a 52% increase compared to the same time period in 2016. About 3/4 of accidental opioid-related deaths over six months have been attributed to non-pharmaceutical opioids.

PROPOSAL:

In the context of the current internal and external environment, a revision of the Opioid Strategy is proposed, as follows.

Proposed Objectives

1. Promote safe/appropriate prescribing via assessments and quality improvement
2. Respond to inappropriate opioid prescribing

The elements of the revised strategy are described in the following table:

	Revised Elements	Details
1 Guide	Review the Prescribing Drugs policy	Policy review will incorporate Methadone expectations and is anticipated to be completed in 2019.
2 Assess	Revise approach to methadone assessments under QAC	Interim post-federal exemption approach has been established and will be reviewed to determine future direction.
	Incorporate opioid prescribing into assessments	A review of opioid prescribing is being incorporated into the existing random assessments.
	Include opioids prescribing as a factor in risk-based assessments	Factors associated with high-risk opioid prescribing have been identified and could be used to inform targeted assessments.
3 Communicate	Promote best practice for opioid prescribing	• Update public opioid statement • Key Messages to Physicians: o Know and follow guidelines and standards for opioid prescribing o Understand own opioid prescribing practices (e.g., MyPractice reports) o Take proactive action to make improvements, as necessary (e.g., UofT e-learning modules and list of resources on CPSO website) o Access patient medication histories, as available o Self-directed quality improvement practices will be seen positively in the event of an assessment o Do not abruptly cease to prescribe opioids or refuse to take on patients using opioids
	Advocate to government	Key Messages to Government: • All physicians should have real time access to patient medication histories • All physicians should have access to comparative prescribing data for QI (e.g., MyPractice reports) • A provincial prescription monitoring program should be established
	Communicate to patients	Key Messages to Patients: • Opioids are important • Call CPSO if you have concerns about your physician's prescribing of opioids • Physicians ultimately make the prescribing decision
	Participate in outreach activities	Respond to outreach requests
4 Respond	Continue to respond to opioid prescribing concerns, using remediation approach, as appropriate	Move from proactive identification of potentially inappropriate prescribing via NMS data to responding to prescribing concerns raised by others.

CONSIDERATIONS:

The opioids crisis persists. Despite the many efforts of governments, organizations and individuals, it is not expected that it will be resolved in the foreseeable future, although the nature of the crisis will likely change. Given this, it is important for the College to have a position and a strategy. The revised opioids strategy proposed above moves from a focus on investigations to quality improvement. This is consistent with the remedial approach we have followed to date, and may be beneficial for the vast majority of physicians and their patients.

NEXT STEPS:

Should Council confirm the proposed revisions to the strategy, it will be in effect until May 2019, notwithstanding changes that may result from the Strategic Plan. The following next steps are suggested:

- Prepare communications to physicians and patients
- Engage with the government, as possible and appropriate
- Collaborate with key stakeholders to promote safe prescribing by physicians

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DECISION FOR COUNCIL:

1. Does Council approve with the proposed opioid strategy for 2018-19?

Contact: Maureen Boon, extension 276
Lauren Nagler, extension 338

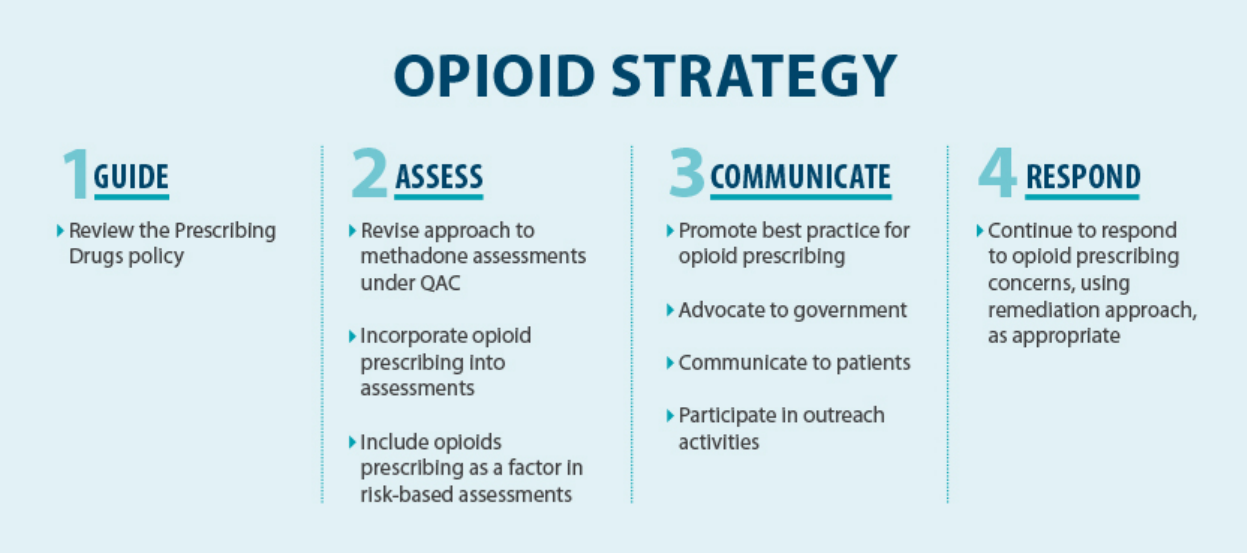
Date: August 17, 2018

Attachments:

Appendix A: Opioid Strategy 2018-19
Appendix B: Summary of Opioid Strategy Achievements

Appendix A: Opioid Strategy 2018-19

The graphics below show the key areas of focus and elements of the revised opioid strategy for 2018-19.



Appendix B: Summary of Opioid Strategy Achievements to Date

	Achievement	Impact
1 Guide	Interim updates of Prescribing Drugs policy and Methadone Maintenance Treatment for Opioid Dependence policy	• Timely update of policies ensured expectations reflected current opioid guidelines and change in exemption status for methadone prescribers
2 Assess	Transition of Methadone Committee to a specialty panel of the QAC	• Transition has occurred and assessments of methadone prescribers can now be considered under the RHPA
	Transition of methadone program in absence of Health Canada Section 56 exemption	• Ensures continuity of expectations and oversight to support safe methadone prescribing
	Planning to increase focus on opioid prescribing in assessments	• Opportunity to identify prescribing concerns and offer QI information during assessments
3 Investigate	Conducted 84 NMS Registrars Investigations • 95% completed in one year • Majority resulted in NFA no further action or remediation	• Identified significant practice problems requiring regulatory response • Met investigative objective to facilitate appropriate prescribing where possible and avoid broad based patient abandonment • Identification of new process and tool changes to be used in future investigations
4 Facilitate Education	Comprehensive inventory of educational offerings targeted at multiple stages of practice	• Educational offerings publicly available for self-directed QI and targeted to remediation for IEPs
	Developing an evidence-based approach to remediation	• Informs future work of the College in addressing identified learning needs
A Communicate	Developed an Opioids Statement and communicated with patients	• Transparency of activities for the public and profession, clear expectations for physicians and course of action for patient concerns
	Dialogue coverage in every issue since fall 2015	• Communication to keep the profession informed
	Involvement in 17 opioid-related outreach events since January 2017	• Expectations of the College were widely communicated to physicians and patients
B Use Data and Analytics	ICES Analysis Complete	• Identification of extreme outliers of opioid prescribing and associated factors
	Development of member risk scores for opioid prescribing	• Potential to inform targeted risk-based assessments
C Collaborate	Involvement with external stakeholders on opioid activities (20+ working groups and projects)	• Communication of College expectations and awareness of the work of others • Contribution to work to improve physician prescribing and prescription monitoring

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: Strategic Plan

FOR DECISION

ISSUE:

The CPSO is nearing the end of its current strategic plan, which extends until 2018, and it is time to plan for the development of a new one. A process and timeline to do so are proposed here for Council's approval.

CURRENT STATUS:

The CPSO is nearing the end of its current strategic plan, which extends until 2018. It sets out the College's vision, priorities (Registration, Physician Competence, and Investigations, Discipline & Monitoring), four strategic initiatives (QMP, Transparency, Education and Data Management) and four principles (see https://www.cpso.on.ca/About-Us/Quality-Professionals,-Healthy-System,-Public-Trus for complete 2015-18 Strategic Framework). Over the last three years the College's strategic priorities have been operationalized in the Corporate Plan, and significant progress has been made. 2018 is an interim reporting year as the organization transitions to the new Registrar/CEO and begins preparation for a new strategic plan.

BACKGROUND:

Different processes have been used to develop and refresh CPSO's strategic plans over the last 10 years. Below is a short summary of each.

2008-2013

In 2007/2008, the CPSO conducted a full strategic planning process, with the involvement of a consultant and oversight by a Steering Committee, including a 2-day Council retreat, significant stakeholder input, focus groups, etc. The process resulted in the current vision statement, different from previous ones in its focus on a 'healthy system'. The 5-year plan identified specific objectives and 10 priorities for the period from 2008-2010.

2010-2013

In 2010, Council revisited the plan and confirmed mid-term priorities for 2010-2013.

2014-2018

In 2014, it was agreed that the foundations of the strategic plan were sound, and Council selected four current strategic initiatives to focus on for the period of 2015-2018.

PROPOSAL:

Given the changes occurring both internally and externally, a comprehensive strategic planning process is proposed. The key components of the process will include internal and external consultation, an environmental scan, a facilitated session with Council and SMT to develop the strategic priorities, and action planning with SMT to develop strategic initiatives for each priority. The proposed approach would be overseen by the Executive Committee and rely on existing structures and staff support for the majority of the work, with the involvement of external consultants for key elements of the process (e.g. consultation and facilitation).

It is recommended that consultants be hired to lead the consultations and facilitated sessions and to write the strategic plan. Consultants are a neutral party to collect honest stakeholder feedback and facilitate Council and Staff sessions to ensure necessary objectives are achieved. Staff will oversee and work with the consultants to ensure alignment with the College's desired approach and the development of a useful strategic plan.

The goal will be to utilize existing Council meetings for updates and engagement and replace the annual Education day prior to the February Council meeting with a closed strategic planning session.

Timeline

It is proposed that the strategic planning process begin in September 2018 and final approval of the strategic plan would be anticipated in May 2019. A more detailed timeline of key events is included in the table below.

EVENT	DATE
Hire Consultant	September 2018
Stakeholder Consultations and Environmental Scanning	October and November 2018
Consultant Introduction and Update on Activities	December 2018 Council Meeting
Strategic Planning Session with Council and Senior	February 2019 Council Meeting

EVENT	DATE
Management Team (full-day)	(replacing Annual Education Day)
Action Planning with Senior Management Team	March 2019
Presentation of Strategic Plan to Council for Approval	May 2019 Council Meeting

This timeline would support the 2020 corporate planning and budgeting processes that take place between June and August. This strategic planning process would renew the College's vision, mission and values and identify strategic priorities and initiatives.

Sample Strategic Plans

Prior to beginning the strategic planning process, it is useful to determine the desired outcome in order to guide the process and development of the final strategic plan. A review of other strategic plans show that both content (e.g., language used, contextual information, description, types of priorities and initiatives and how they relate to each other) and presentation (e.g., colours, style, use of graphics, photos, schematics, white space) contribute to conveying desired messages. Links to strategic plans from several other organizations are included below to demonstrate different approaches.

- **College of Nurses of Ontario:**
  - Link to Plan: http://www.cno.org/globalassets/docs/general/cnostratplan.pdf
- **College of Physicians and Surgeons of BC:**
  - Link to plan: https://www.cpsbc.ca/files/pdf/2018-2020-strategic-plan.pdf
  - Link to overview with objectives: https://www.cpsbc.ca/about-us/strategic-plan-2018-2020
- **Southlake Hospital:**
  - Link to plan: http://www.southlakeregional.org/doc.aspx?id=561
- **Ontario's Death Investigation System (Coroner):**
  - Link to plan: https://www.mcscs.jus.gov.on.ca/sites/default/files/content/mcscs/docs/ec168212.pdf

Strategic Planning Objectives

Based on our review of other strategic plans and the current context, it is suggested that the new CPSO plan have the following overarching objective:

- To create a clear and compelling strategic plan that will balance focus on core regulatory responsibilities with an ability to respond to the changing environment in order to best serve the public.

More specifically, it is suggested the College's new strategic plan:

- **Drive transformation** – Highlighting the intensive focus on change currently underway, and the necessity of these changes positioned in the context of the broader system
- **Be forward thinking, responsive and agile** – Considering the anticipated future needs of the patients of Ontario, and demonstrating how the CPSO will meet these needs; moving towards being more flexible and responsive (becoming a "modern" regulator)
- **Focus efforts on our core regulatory work** – Being clear about what is our role as a regulator and what is not our role, and how we fit into the broader health system (our mandate is clear); focuses CPSO's efforts on the issues that are most important
- **Focus on "right touch regulation"** – Conveying a focus on protecting against the highest risks, not every risk
- **Be clear, concise and implementable** – Including clear deliverables to support the achievement of strategic priorities and measures to monitor progress; easy to understand

NEXT STEPS:

- Hire consultants in early October
- Stakeholder engagement throughout the fall

DECISION/DISCUSSION FOR COUNCIL:

1. Does Council approve the proposed plan and timelines for the strategic planning process?
2. Does Council agree with the proposed objectives?
3. What other considerations are important as we plan and conduct the process?

Contact: Maureen Boon, extension 276
Lauren Nagler, extension 338

Date: August 17, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

August 17, 2018

TOPIC: COUNCIL AWARD RECIPIENT

FOR INFORMATION

ISSUE:

At the September 7th meeting of Council, **Dr. Jason Malinowski** of Barry's Bay will receive the Council Award.

BACKGROUND:

The Council Award honours Ontario physicians who have demonstrated excellence based on eight "physician roles":

- The physician as medical expert/clinical decision maker
- The physician as communicator
- The physician as collaborator
- The physician as gatekeeper/resource manager
- The physician as health advocate
- The physician as learner
- The physician as scientist/scholar
- The physician as person and professional

CURRENT STATUS:

Council member Ms Joan Powell will present the award.

DECISION FOR COUNCIL:

No decisions required.

Contact: Tracey Sobers, Ext. 402
Date: August 17, 2018

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: CPSO Governance Review

FOR DECISION

ISSUE:

- Council is asked to consider the following:
  - Proposed governance principles;
  - Preliminary recommendations for governance change that
    1) require legislative change and
    2) do not require legislative change.
- The objective of the governance review is to adopt principles regarding a high performing board and governance structure and to identify recommendations where indicated in support of governance reform.

BACKGROUND:

- The governance review discussion at May Council included an overview of other governance structures and identification of best practices in governance.
  - Council considered the strengths and weaknesses of the current governance structure, and identified elements of other governance models that are appealing.
  - Council broke into small group discussions and considered the characteristics of a high functioning modern board, core principles that should underpin CPSO's governance structure, and changes to the College's governance structure that would improve the College's effectiveness.
- A number of themes emerged from the small group discussions.
- Following May Council, Harry Cayton, Chief Executive of the Professional Standards Authority (the statutory body which oversees the regulation and registration of health and care professions in the UK) provided a presentation to the Governance Review Working Group (GRWG) on *International trends in professional regulation.* He is considered an expert in regulatory governance and has been asked to consult on a number of regulatory governance reviews in Canada and internationally.

Review of Governance Literature on Best Practices and International Trends

- In light of the literature on board best practices and trends in regulatory governance the GRWG and Council have been considering the following:

  - Board function (greater separation of operational function from strategic function)
  - Board size – move to a smaller board
  - Board composition (public and professional member ratios, skillset required)
  - Board member selection (election vs. appointment)
  - Separation of board and statutory committees (previous agreement there should be no overlap in membership between the Discipline Committee and Council)
  - Committee composition and member selection
  - Public and professional engagement/role of advisory council/outreach program (groups would add value if board is smaller).
- Research on board best practices supports a smaller, strategy-focused board, and membership that has the skillset required to support the function of the board.
- Internationally, regulators see value in and are moving towards an equal number of professional and public members on their boards, and separation of board and statutory committees.
- These practices are aligned with the governance model the CNO has proposed in their governance vision (Final Report: A vision for the future). While recognizing that some areas of change are more challenging to address than others, the GRWG generally support the CNO governance model and floated the idea of adopting CNO's governance recommendations and vision.

CURRENT STATUS:

1. Proposed Draft Principles

- The goal of the governance review includes identifying governance principles and best practice structural changes to update and strengthen the integrity of the regulatory system and mandate to ensure public protection.
- The development and adoption of principles helps to establish the appropriate foundation for recommendations for change.
- Regulators undergoing similar exercises have a similar emphasis on the development of governance principles. Specifically, the CNO has developed principles to guide their governance work and the College of Physicians and Surgeons of BC have adopted them.
- Discussions about governance to date have elicited a number of principles that can be used to underpin the governance review and recommendations for change moving forward.
- Many of these are consistent with those developed by the CNO. Following considerable discussion, the GRWG recommends that Council adopt the governance principles adopted by CNO.
- The principles represent a focus on good governance. There is an opportunity to work collaboratively with CNO and other health regulators. The principles are set out below for consideration.
- Adoption of governance principles reflects a commitment to regulating in the public interest in accordance with the following:

1) **ACCOUNTABILITY**[1]
   - We make decisions in the public interest
   - We are responsible for our actions and processes
   - We meet our legal and fiduciary duties as directors

2) **ADAPTABILITY**
   - We anticipate and respond to changing expectations and emerging trends
   - We address emerging risks and opportunities
   - We anticipate and embrace opportunities for regulatory and governance innovation

3) **COMPETENCE**
   - We make evidence-informed decisions
   - We evaluate our individual and collective knowledge and skills in order to continuously improve our governance performance
   - We seek external expertise where needed

4) **DIVERSITY**
   - Our decisions reflect diverse knowledge, perspectives, experiences and needs
   - We seek varied stakeholder input to inform our decisions

5) **INDEPENDENCE**
   - Our decisions address public interest as our paramount responsibility
   - Our decisions are free of bias and special interest perspectives

6) **INTEGRITY**
   - We participate actively and honestly in decision making through respectful dialogue
   - We foster a culture in which we say and do the right thing
   - We build trust by acting ethically and following our governance principles

7) **TRANSPARENCY**
   - Our processes, decisions and the rationale for our decisions are accessible to the public
   - We communicate in a way that allows the public to evaluate the effectiveness of our governance

[1] Accountable (of a person, organization, or institution): required or expected to justify actions or decisions; responsible.

DECISIONS FOR COUNCIL

1. Does Council have any feedback on the proposed principles?
2. Does Council support adopting the CNO governance principles?

2. Overview of Existing Governance Framework

- The GRWG has discussed a number of potential changes to the CPSO governance structure.
- The size and composition of Council as well as dated quorum requirements for the ICR and Discipline Committees are set in the *Medicine Act*, *RHPA* and *Code*. Most of the significant structural changes require support from government in that they require legislative or regulatory change. The broader structure and composition of Council is set out in the *Medicine Act* and *RHPA/Health Professions Procedural Code (HPPC)*, including:
    - Size[2]
    - Composition[3]
    - Mandate[4]
    - Selection process (public appointments; academic appointments, and regional elections), and
    - ICR, DC, Fitness to Practise and Registration Committee quorum requirements are set in the *HPPC*.
- The functions and role of statutory committees such as the Executive, ICRC, Discipline, Fitness to Practise, Registration, Patient Relations, and Quality Assurance committees is also set out in legislation.
- Non-statutory committee structures and processes are generally set out in the General By-law and are within the control of the College. For example:
    - The mandates of non-statutory committees are set out in by-law.
    - By-law committee mandates and in some cases membership is set in by-laws (Governance, Council Award Selection and Education Committees).
    - The Governance Committee makes nominations recommendations to Council based on nominations guidelines contained in the *Governance Process Manual (Note: they are now out of date given the direction of the governance review and a desire to ensure separation of the operating and strategic functions)*.
- For an overview of the existing governance framework please see **Appendix A**.

[2] The *Medicine Act* composition requirements results in Council consisting of at least 32 and no more than 34 members.
[3] The *Medicine Act* stipulates that Council consist of at least 15 and no more than 16 elected physicians; 3 physicians appointed from the faculties of medicine and 13-15 public members appointed by the provincial government.
[4] Section 3 (1) of the *HPPC* sets out the objects of the College and thus responsibilities of Council.

3. Preliminary Recommendations for Governance Reform

The Issues

- The GRWG feels that change should be made to the College's governance structure for the following reasons:
    1) To build public confidence and trust.
    2) To ensure the structure effectively supports the College mandate and modern governance practises – a number of elements of the current structure are dated (overlap between Council and committee membership and legislated Council quorum requirements on some statutory committees).
    3) Some aspects of the current governance structure are seen as a barrier to serving the public interest and ensuring fairness and integrity of College processes (i.e. overlap in membership between the adjudicative structure and Council; district elections).
    4) There is also recognition from the GRWG and Council that that there may be ways Council and committees can function more effectively and efficiently and similarly, ways Council and committees can further align themselves with best practices in governance.
    5) The College's public Council member resources are stretched at a time when caseloads are growing on committees where public and physician members of Council are required to meet quorum requirements. Strategies are required to ensure that the College is able to meet quorum requirements and support an extensive workload. While strategies that require legislative change are not in our direct control, we may be able to address some issues by focusing resources on core functions of the college and deploying non-Council resources on committees where there are no legislative quorum requirements.

Preliminary Structural Recommendations

- The GRWG feels there is considerable value in aligning with other colleges who are considering governance modernization. Ontario's 26 regulatory health colleges have a consistent governance structure under the *RHPA*.
- Because the governance work completed by CNO is the most comprehensive and thorough, the GRWG has focused discussions on components of the CNO vision that could be adopted by the CPSO.
- The GRWG generally support and recommend changes recommended in the CNO's Final Report: A vision for the future that reflect best practice and trends; particularly:
    1. a smaller board
    2. an equal number of public to physician Council members
    3. a separation of the board (members and decision-making) from statutory committees (role clarity) and

4. a competency based selection process.

- The rationale for the recommendations (and principles to which they align) are comprehensively addressed in the CNO's Final Report: A vision for the future.
- The CNO's rationale for select recommendations is provided below:

Size:

- Smaller boards are able to have more generative discussions and effective decision-making, meet more frequently, and avoid "social loafing" that occurs with larger boards.
- Advisory groups (e.g. consumer, educator, clinician) and a stakeholder engagement approach can be used to achieve diverse input on issues the board will consider.

Composition:

- Equal number of physician and public members reinforces public confidence that the board is focused on the public and not on professional interests and will be seen to be impartial and not controlled by the profession.
- This is a compromise between public trust and maintaining professional expertise in regulation.

Role clarity of board and statutory committees - Separation of the board (members and decision-making) from statutory committees:

- Mandates are distinct and require different competencies for governance and statutory decision-making. The board sets policies and the statutory committees apply them.
- The group that sets policy should not be making statutory decisions. There is a potential to bring bias and perceptions of bias from the board to statutory committees and vice versa.
- Having no directors on statutory committees will enhance the perception of the independence of those committees.

Competency based board - members selected based on having the competencies (knowledge, skills and attitude) needed for the role:

- Examples of competencies include governance, leadership and regulation (protecting the public interest), and analytic, strategic and creative thinking.
- Literature and governance trends support competency based boards.
- Competency based appointments provide the board with the ability to recruit effective, diverse board members.

- There are different ways of attaining competency based boards. For example, the CNO recommendation involves competency based *appointments* whereby an appointments process is developed by the board. Their model includes a Governance Committee recommending the competencies and a Nominating Committee (composed of directors and non-directors) recommending appointments of board and committee members.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the preliminary recommendations for structural change?
2. Does Council support the preliminary recommendations for structural change?

4. Preliminary recommendations that do not require legislative change

- Throughout the course of the review the GRWG has taken a critical look at where good governance practices can be adopted that do not require legislative change.
- Draft recommendations and the accompanying rationale are contained below.
- The recommendations are designed to help ensure the College is able to focus on core regulatory work and, effectively utilize non-council public and profession resources to ensure the Board is able to 1. Focus on the board related role and 2. Focus on committee work where mandated by statute (on either ICR or DC).
- The recommendations are also designed to ensure appropriate separation of board and statutory committees.
- The draft recommendations are informed by the issues identified above and reflective of the proposed principles.

Table 1: Proposed changes that could be made to the College's governance structure that do not require legislative change

Recommendations	Rationale
1) Board Member Orientation and Education • Enhance board orientation and education to reinforce and support role and focus of Council • Build competencies of current board members to align with research re. board effectiveness: *strategic leadership and strategic decision-making; stewardship, including holding the executive to account; external relations and accountability; board maintenance*; *RHPA's* 11 objects.	• Theme that came out of small group discussion in May. • Improving training and education for Council members is an objective of the Governance Committee. • Research on best practices highlights the value in having board members with governance experience or related skills on the board.
2) Move away from appointing Council members to statutory committees, where possible	• Separation of statutory committees and the board where possible will help manage workload. • Seen as a good practise generally. • It will enhance the perception of the independence of those committees.
3) New professional members directed to Discipline Committee (DC) as opposed to	• Workload and current quorum requirements create scheduling challenges

Recommendations	Rationale
ICR, where possible.	for DC. • There is no requirement that professional Council members sit on ICR.
4) Council members serve first as a member of the board and second as a member of DC or ICR. Other committee work to transition to other non-council physician and public committee members. • Take steps to free up board member time so board members can devote time and attention to board and DC/ICR for the time being until quorum changes are made when presumably focus will be on Board and focussed standing committees (implication – move away from appointing Council members to other committees)	• Focusing resources on core functions of the board and the College more broadly will help ensure achievement of objectives/mandate. • In the context of growing caseloads and public member workloads this would free up public and physician members to support the work of committees with quorum requirements.
5) Policy Working Group Structure • Consider policy working group structure and whether working groups could be consolidated into a single working group or committee with a mandate to support and contribute to policy development and review.	• Policy working group structure contributes to delays (5 working groups currently comprised of busy Council members). There is opportunity to make changes and find efficiencies to the review process. • Changes to policy working group structure would be a more efficient and better use of board member time.
6) Operating Committees (Council Award Selection, Finance and Outreach Committees) • Decrease number of college operating committees (i.e., Should communication strategy, stakeholder strategy, etc. be considered at Council?) • Review the mandates of by-law committees.	• This will free up members to focus on/be available for statutory committees where there are quorum requirements.
7) Focus on Diversity • Recruitment targets for committees to ensure we have members that are representative of the broader	• Diversity in board membership is a best practice that has been found to promote innovation. • The current composition of Council reflects

Recommendations	Rationale
population • Build cultural competence of board members • Consider ways in which technological advancements could promote flexibility in scheduling and allow members to take part in meetings remotely.	some diversity however the GRWG has noted that Council has a ways to go before it is truly reflective of the broader population; improvements can be made with respect to age, career stage, gender and cultural diversity, for example.

DECISIONS FOR COUNCIL:

1. Does Council have any feedback on the preliminary recommendations that can be made without legislative change (implementation plan is required)?
2. Does Council support development of an implementation plan to achieve the preliminary recommendations that can be made without legislative change?

NEXT STEPS:

- Refine high level recommendations for structural change – to be brought back to December Council.
- Refine recommendations that can be made that do not require legislative change.
- Consider implementation as necessary for recommendations that do not require legislative change.

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Maureen Boon, ext. 276
Tanya Terzis, ext. 545

Date: August 20, 2018

Attachments:

Appendix A: Overview of Existing Governance Framework

Appendix A

Table 2 Overview of Existing Governance Framework

	Legislative Requirements	College By-law/Process
Council		
Size	The *Medicine Act* composition requirements (see below) results in Council consisting of at least 32 and no more than 34 members.	
Mandate/Role	Section 3 (1) of the *HPPC* sets out the objects of the College and thus responsibilities of Council.	
Composition	The *Medicine Act* stipulates that Council consist 15 or 16 elected physicians; 3 physicians appointed from the faculties of medicine; and 13-15 public members appointed by the provincial government. Ratio of public and professional members: 19/15 (44% public)	
Selection	The *RHPA* requires public member appointments; academic appointments, and regional elections for physician members.	
Statutory Committees (Executive, ICRC, Discipline, Fitness to Practise, Registration, Patient Relations, and Quality Assurance)		
Mandate/Role	The functions and role of statutory committees is set out in legislation.	
Composition	Currently *HPPC* sets out that the composition of the committees shall be in accordance with by-laws. Upon proclamation of a new provision introduced under	College by-laws contain additional information about composition of College Committees. For example, the General By-

	Legislative Requirements	College By-law/Process
	Bill 87, the composition of the committees shall also be in accordance with any regulations under the *RHPA*.	law currently sets out that the Executive Committee shall be composed of the president and vice-president, the past president, one physician Council member, and 1-2 public members from Council.
Selection	The Council shall appoint the members of the committees (*HPPC*).	The Governance Committee makes recommendations / nominations to Council for committee chairs and member positions.
Composition of Panels	Composition requirements for panels of statutory committees • ICR, Registration and Fitness to Practise Committee panels must be composed of at least one public member of Council • DC panels must be composed of at least 2 public members of Council • DC panels must also be composed of at least one physician Council member	PRC is composed of all non-Council members.
Non-Statutory Committees: Standing committees (Council Award Selection Committee; Education Committee, Finance and Audit Committee; Governance Committee; Outreach Committee; Premises Inspection Committee)		
Mandate/Role		Set out in by-law
Composition		By-law committee membership set in by-laws (Governance, Council Award Selection and Education Committees).
Selection		Nominations guidelines set out appointments and

	Legislative Requirements	College By-law/Process
		selection process. GC makes nominations recommendations to Council based on nominations guidelines contained in the Governance Process Manual.
Composition of Panels		Set out in by-law PIC: quorum consists of 3 committee members, at least one of whom shall be a person who is not a member of the College.

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Vision 2020 Update

http://www.cno.org/en/what-is-cno/councils-and-committees/council/governance-vision-2020/

Anne Coghlan

Executive Director & Chief Executive Officer,
College of Nurses of Ontario

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: Governance Committee Report

FOR DECISION:

- **Election of 2018/2019 Academic Representatives on Council**
- **2018-2019 Chair Appointments**

FOR INFORMATION:

- **Completion of 2018 Council Performance Assessment (Form)**

FOR DECISION:

Election of 2018-2019 Academic Representatives on Council

- The Deans of the six medical schools have been asked to appoint their academic representative for the 2018/2019 session of Council. The following representatives have been appointed:

  Dr. Janet van Vlymen, (Queen's University)
  Dr. Mary Jane Bell, (University of Toronto
  Dr. Terri Paul (new, (Western University
  Dr. Akbar Panju, (McMaster University
  Dr. Robert Smith, (Northern Ontario School of Medicine
  Dr. Paul Hendry, (University of Ottawa

- The academic representatives will meet, prior to the September Council meeting, and recommend the three voting academic representatives for the 2018/2019 session of Council.
- Dr. Terri Paul is a new Western University representative for 2018-2019.
- Appointments to Council will be effective following the induction of new Council members at the annual meeting of Council on December 7, 2018.

DECISION FOR COUNCIL:

1. Council will decide whether to approve the recommended slate of 2018-2019 voting academic representatives at its September meeting. [If the slate is not approved, a vote will be held at the September meeting of Council].

2018-2019 Chair Appointments

- Committee Chairs, Co-Chairs and Vice Chairs are elected at the September Council meeting. These appointments will take effect following the December 6 and 7, 2018 AGM.
- In considering nominations for these leadership positions, the Governance Committee considers Council's Nominations Guidelines Nominations Guidelines
- All chairs, co-chairs and vice chairs are nominated and appointed annually pursuant to the General Bylaw.
- We do take steps to ensure that chairs generally serve for no more than three consecutive years as chair of a specific committee. Chairs are appointed on occasion for a longer period (sometimes one year) in cases where there are succession planning related issues.
- Annual reappointment during the three-year term depends on criteria, including link to Council, role requirements, demonstrated key leadership and committee-specific competencies, succession planning, term limits and performance.
- The Governance Committee has nominated a number of committee chairs who are not members of Council. This development is consistent with the objective coming out of the Governance Review work to reduce overlap in membership between statutory committees and Council (in particular the Discipline Committee).
- In cases where committees have two chairs or vice chairs, chair appointments are staggered where possible, to ensure consistency in leadership from one year to the next, and for mentoring of new chairs.
- Role descriptions and key behavior competencies for Council and non-Council Committee Chairs are set out in the Governance Process Manual
- Committee Chairs must have an understanding of, and a commitment to the public interest mandate of the College.
- The Governance Committee nominates the following chairs, co-chairs and vice-chairs for 2018-2019:

2018-2019 PROPOSED COMMITTEE CHAIR/CO-CHAIR/VICE CHAIR NOMINEES

Committee	Proposed 2018-2019 Chairs/Vice Chairs
Council Award Selection Committee	Dr. Steven Bodley *(as per CPSO By-Law), (non-Council for 2019)*
Discipline Committee	Dr. Melinda Davie *(non-Council)* Dr. Carole Clapperton *(non-Council)*
Education Committee	Dr. Akbar Panju
Executive Committee	Dr. Peeter Poldre *(as per CPSO By-Law)*
Finance Committee	Mr. Peter Pielsticker
Fitness to Practise Committee	Dr. Steven Bodley *(non-Council in 2019)*
Governance Committee	Dr. Steven Bodley *(as per CPSO By-Law) , (non-Council in 2019)*
Inquiries, Complaints and Reports Committee	Dr. David Rouselle, *ICRC Chair* Dr. Carol Leet/Dr. James Edwards *(non-Council), Co-Vice Chairs, Settlement Panels* Ms. Lynne Cram/Mr. Harry Erlichman, *Co-Vice Chairs, General Panels* Dr. Edith Linkenheil, *(non-Council) Vice Chair, Obstetrical* Dr. Akbar Panju, *Vice Chair, Internal Medicine* Dr. Brian Burke, *(non-Council), Vice Chair, Mental Health and Health Inquiry Panels* Dr. Dale Mercer *(non-Council) Vice Chair, Surgical* Dr. Stephen Whittaker*, (non-Council), Vice Chair, Family Practise*
Outreach Committee	Dr. Jerry Rosenblum
Patient Relations Committee	Ms. Lisa McCool-Philbin *(non-Council)*
Premises Inspection Committee	Dr. Dennis Pitt *(non-Council in 2019)*
Quality Assurance Committee	Dr. Hugh Kendall, *(non-Council)* Dr. Deborah Robertson, *(non-Council)* Dr. Meredith MacKenzie (Vice Chair), *(non-Council)*
Registration Committee	Dr. Akbar Panju

DECISION FOR COUNCIL:

1. Council will decide whether to approve the recommended slate of 2018-2019 Chairs/Co-chairs/Vice Chairs.

FOR INFORMATION:

Completion of 2018 Council Performance Assessment (Form)

- **All Councillors are asked to please complete the 2018 Council Performance Assessment Form, (Appendix A) and submit your completed form by the end of the September Council meeting to Debbie McLaren or Franca Mancini.**
- The College's performance assessment program is intended to inform and support ongoing development and continuous improvement.

- Completion of the Council Performance Assessment Form provides Councillors with an opportunity to assess and improve Council performance.
- The Council Performance Assessment Form will also be provided to Councillors as an attachment to an e-mail for ease of electronic completion and submission.
- The results will be tabulated and presented at the December meeting of Council.

Contact: David Rouselle, Chair, Governance Committee
Suzanne Mascarenhas, Ext. 843
Debbie McLaren, Ext. 371
Louise Verity, Ext. 466

Date: August 15, 2018

Attachments:

Appendix A: Council Performance Assessment Form (for completion)

2018
Council Performance Assessment Form

Your Name: ***(optional)*** _____

INSTRUCTIONS:

This questionnaire requires you to focus on and assess key areas that affect the Council's performance as a whole and its key responsibilities for governance of the CPSO.

Please answer each question by indicating the most applicable response. At the end of each section of the survey there is an opportunity for you to provide qualitative comments**.** At the end of the questionnaire there is also an opportunity for you to provide further input regarding your perspective of the Council's strengths and developmental opportunities for improved performance. Please answer all questions as candidly as possible. Thank you for your time in contributing to the growth and development of the Council.

Number of Years on Council: **1<** **1–2** **3–4** **5–6** **7>**

A. VISION AND MANDATE	**RATING**			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I understand the vision and the mandate of the College.				
2. The Council formally reviews its vision.				

COMMENTS: X

B. STRATEGIC PLAN AND PRIORITIES	**RATING**			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. The College's strategic plan is documented.				
2. The Council creates a set of key priorities that must be implemented in support of the strategic plan of the College.				
3. The Council establishes a small number of strategic initiatives to focus attention and resources to help achieve the College vision.				
4. The dashboard report presented by the Registrar clearly reports progress on College priorities.				

2018
Council Performance Assessment Form

COMMENTS: x

C. COUNCIL'S ROLE AND RESPONSIBILITIES	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I am familiar with the College's governance practices and policies.				
2. The Council effectively develops and approves principles and policies that fulfill its duty to protect the public interest.				
3. The Council effectively discharges its statutory functions.				
4. The Council periodically monitors and assesses its performance against its strategic direction and goals.				
5. The College has an effective system of financial oversight.				
6. The Council meets with external auditors, reviews their reports and recommendations and, ensures any deficiencies are corrected.				

COMMENTS: x

D. GOVERNANCE OPERATIONS	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. As a Council member, I understand my fiduciary obligations.				
2. I know and understand the Code of Conduct.				
3. I understand the Conflict of Interest Policy.				
4. As a member of Council, I declare potential conflicts of interest according to Council's conflict of interest.				

2018
Council Performance Assessment Form

COMMENTS: X

E. COUNCIL OPERATIONS	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I receive appropriate information for Council meetings.				
2. I receive information for Council meetings on a timely basis.				
3. Council's meetings are effective and efficient.				
4. The President chairs Council meetings in a manner which enhances performance and decision-making.				
5. I feel comfortable participating in Council discussions.				
6. Council has a formal written orientation package for Council.				
7. My orientation to the College Council was effective.				
8. I am aware that Council has a mentorship program.				
9. Council's mentorship program is helpful.				
10. I find Council's continuing education activities useful.				

COMMENTS: X

2018
Council Performance Assessment Form

F. RELATIONSHIP WITH REGISTRAR	RATING			
QUESTIONS:	**YES**	**SOME-WHAT**	**NO**	**DON'T KNOW**
1. I understand that a committee of Council that reports to the Executive Committee approves the Registrar's annual performance objectives and conducts the Registrar's annual performance review.				
2. The President asks Council for feedback which informs the Registrar's performance review and advises Council of the outcome of the review.				
3. The Council maintains a collegial working relationship with the Registrar.				
4. The Council does not get involved in day-to-day operational matters.				
5. Committees do not get involved in day-to-day operational matters.				

COMMENTS: X

2018
Council Performance Assessment Form

STRENGTHS AND DEVELOPMENTAL NEEDS:

1. **List two strengths of the Council:**

X

2. **List two ways Council could be improved:**

X

3. **Additional Comments:**

X

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THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

MEMBER TOPICS

No Meeting Materials

Council Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: College Oversight of Fertility Services

FOR INFORMATION

ISSUE:

- In order to bring fertility services within the scope of the Out-of-Hospital Premises Inspection Program (OHPIP), Council approved a proposed Regulation Amendment (RA), which was submitted to the Ministry in spring 2017.

- The Ministry subsequently provided comments on the RA in spring 2018, to which the Executive Committee directed a response on the behalf of the College in August 2018.

- Council is provided with an overview of the Ministry's comments and the responses directed by the Executive Committee.

BACKGROUND:

- In December 2015, the Ministry asked the College to develop and implement a quality and inspections framework for the delivery of fertility services across the province. The Ministry concurrently announced expanded government funding for these services, which are provided through in-hospital and out-of-hospital clinics.

- In order to fulfill the Ministry's request, the College needs expanded regulatory authority to enter and inspect premises where fertility services are performed.

- The College developed regulatory amendments to bring fertility services within the scope of the Out-of-Hospital Premises Inspection Program (OHPIP).

- Council approved the proposed changes and they were formally submitted to government as a proposed Regulation Amendment ("RA") in spring 2017.

CURRENT STATUS:

- The Ministry responded with follow-up comments to the College's RA in spring 2018. The Executive Committee reviewed these comments in August 2018 and directed responses on the behalf of the College, which are outlined below.

Ministry Comments and Proposed Responses

- The Ministry proposed a change to the definition of "premises" in the regulation to ensure that fertility clinics funded under the *Ministry of Health and Long-Term Care Act* are within the scope of the College's power to inspect.
    - The College responded to the Ministry in support of this suggestion.
- The RA initially contemplated giving the College the authority to inspect hospital-based fertility clinics, in addition to out-of-hospital clinics. However, the Ministry ultimately suggested that existing legislative requirements and hospital mechanisms sufficiently regulate the quality and oversight of fertility services provided in hospitals and hospital-based clinics.
    - The College responded to the Ministry in support of the suggestion to remove hospital-based fertility clinics from the scope of the College's authority.
- The RA includes a broad duty on members whose premises are subject to the regulation to collect and provide information, as requested by the College and the inspector. The Ministry suggested that the change was unnecessary because the College is already empowered to examine and collect various types of information relevant to a procedure in connection with carrying out an inspection.
    - However, the College proposed keeping the change, given that a broader power would give the College the appropriate authority to require collection of information, such as in third party reports, between inspection cycles.
- The RA proposed specific notification and inspection timelines for members performing fertility procedures, which will allow the College to enforce compliance with the new rules for fertility clinics once they take effect.
    - The Ministry requested further information about why the change is necessary and the College will respond to the Ministry to clarify.
    - The Ministry also suggested removing existing notice and inspection timelines for procedures using anaesthesia or sedation and other defined procedures. The College

responded that it continues to require these timelines to enforce compliance with these types of facilities that have not given proper notice.

- Finally, the Ministry has requested input from the College regarding the date that oversight of fertility clinics should take effect.
    - The College proposed a 6-month window, in order to allow ample time for the College to communicate the new requirements to members and other stakeholders.

NEXT STEPS:

- CPSO staff will work with the Ministry to determine the government's timeline and process for moving forward with the regulatory amendments, and Council will receive future updates as needed.

Contact: Wade Hillier Ext. 636
Karen Atkin Ext. 702
Lindsay Cader Ext. 463
Heather Webb Ext. 557

Date: August 16, 2018

Council Committee Briefing Note

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

September 2018

TOPIC: Policy Report

FOR INFORMATION

Updates:

1. Consultation Request from the College of Nurses of Ontario re: Registered Nurse Prescribing

2. College of Registered Psychotherapists of Ontario - Draft Regulation on Categories of Prescribed Therapies Involving the Practice of Psychotherapy

3. Policy Consultation Update:

    I. Continuity of Care

4. Policy Status Table

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1. Consultation Response: Prescribing by Registered Nurses

- The College of Nurses of Ontario (CNO) recently undertook a public consultation to solicit feedback related to the prescribing of drugs by Registered Nurses (RN prescribing).

- A review of the CNO's consultation materials did not reveal any negative implications for patient safety, and an informal response was provided on May 22nd, 2018.

Background

- Since as early as 2012, the Registered Nurses' Association of Ontario (RNAO) has been advocating for RN prescribing. The RNAO has stated that "RN

prescribing supports professional practice and can improve health system access and alleviate wait times"[1].

- Historically, the Provincial Government been supportive of RN Prescribing. On May 17, 2017, changes were made to the *Nursing Act* which will permit RNs to prescribe medication according to a list, and to communicate a diagnosis for the purpose of prescribing medication.

- Information about the CNO's approach to implementing RN prescribing under the legislation can be found on the CNO website. Rather than a broad expansion of scope, the CNO proposes that prescribing be fairly circumscribed:

    - RNs will not be permitted to prescribe until they have completed CNO-approved education;
    - RN prescribing will be limited to medications for non-complex purposes; and
    - Permitted medications are those related to immunization, travel health, topical wound care, contraception and smoking cessation.

- For the purposes of public consultation, the CNO provided stakeholders with an opportunity to submit feedback via an online survey.

- The content set out in the CNO survey was reviewed in relation to relevant CPSO policies, including *Prescribing Drugs, Dispensing Drugs,* and *Physicians' Relationships with Industry.* Feedback from Medical Advisors and from Dr. Carol Leet was sought in relation to the medications proposed for RN prescribing.

- This assessment revealed no negative implications for patient safety. Specifically:

    - Clinical concerns were not identified with respect to the medications proposed for RN prescribing;
    - Significant consistency was identified between CPSO policies and the CNO's language and approach;
    - A few instances were identified where the CNO's proposed language lacked clarity or where the CNO was silent on issues that the CPSO addressed in an explicit manner.

- Based on this assessment, an informal response was provided to CNO staff.

- The informal response provided some suggestions and constructive comments to enhance clarity and precision of language.

[1] RNAO, *RN Prescribing Statement,* 2015. Available at: http://rnao.ca/sites/rnao-ca/files/RN_Prescribing_0.pdf.

- Staff will continue to monitor the issue of RN prescribing and will keep Council apprised of any developments.

2. College of Registered Psychotherapists of Ontario - Draft Regulation on Categories of Prescribed Therapies Involving the Practice of Psychotherapy

- In early June, the College of Registered Psychotherapists of Ontario (CRPO) consulted on a draft regulation prescribing therapies involving the practice of psychotherapy[2]. Feedback on the regulation proposal was due on June 15th, 2018.

- The draft regulation addressed one element of a number of items that the Minister of Health and Long-Term Care requested the CRPO to do by July 1, 2018.

- The proposed regulation states that the following are the categories of prescribed therapies involving the practice of psychotherapy:

    - Cognitive and Behavioural therapies
    - Experiential and Humanistic therapies
    - Psychodynamic therapies
    - Somatic therapies
    - Systemic and Collaborative therapies

- The proposed regulation only applies to individuals registered with the CRPO.

- The proposed regulation will not have any implications for physicians and has not raised any concerns with respect to patient safety.

- For these reasons, the CPSO did not provide any feedback on the draft regulation.

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[2] Psychotherapy is one of the controlled acts set out in the *Regulated Health Professions Act* (RHPA). The definition of the controlled act of psychotherapy is:

Treating by means of psychotherapy technique, delivered through a psychotherapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

3. Policy Consultation Update

I. Continuity of Care

- Council approved a set of *Continuity of Care* draft policies for external consultation at its May 2018 meeting. The set includes a foundational *Continuity of Care* draft policy, referred to as the umbrella policy, as well as four companion draft policies setting out expectations regarding: *Availability & Coverage*; *Managing Tests*; *Transitions in Care*; and *Walk-in Clinics*. The consultation will continue until December 9, 2018.

- As of the Council submission deadline, the College has received 264 responses to the consultation.[3] All written feedback is posted on the *Continuity of Care* consultation webpage, in keeping with the College's posting guidelines. A report of the online survey results will be available on the consultation page following the consultation.

- Broadly speaking, respondents are supportive of the idea of continuity of care but many, especially physicians, raised concerns about how the policies aim to achieve this objective. Examples of key themes and issues in the feedback are set out below.

    - In general, physician respondents are concerned about their ability to comply with the draft policies and feel that the policies are onerous, paternalistic, will contribute to physician burnout, and unduly shift responsibility from patients to physicians.

    - There was support for the requirements that physicians have an office phone that is answered during operating hours and that they respond to other health-care providers in a timely and professional manner. But concern was raised about the resources required to monitor voicemails and about being liable if patients leave messages regarding issues that require immediate care.

    - Physician respondents also worried about their ability to make coverage arrangements for after-hours care or during temporary absences, and some felt it was not feasible to arrange for 24-7 coverage for critical test results.

    - There was strong support for the draft expectations regarding 'no news is good news' strategies. However, some respondents suggested that these strategies be prohibited.

[3] 98 comments were provided in writing and 166 online surveys have been completed or partially completed. It is worth noting that the respondents are predominantly physicians.

- There was strong support for physicians using their professional judgment to determine whether to track tests for non-high-risk patients. However, the requirement to track test results for high-risk patients received mixed feedback, as some respondents were supportive while others found it burdensome.

- Many family physician respondents objected to the requirement that they communicate consultant appointment information to patients. Specialist respondents supported this requirement.

- Physician respondents felt that the nature of walk-in clinic care would make it difficult to comply with the requirement to follow-up on all tests results and to arrange for coverage of critical test results.

- Some physician respondents supported the draft requirement that physicians practising in a walk-in clinic send a record of the encounter to the patient's primary care provider and some suggested setting out a timeline for doing so.

- Stakeholder Summits are being planned for late fall to engage key stakeholders in discussion sessions about the draft policies. The intention is to facilitate increased engagement in the consultation process and to ensure that the College's work is informed by the expertise that exists among stakeholders.

- Staff are also planning to conduct public opinion polling to increase the representation of the public voice in the review process and are exploring opportunities to utilize the Citizen Advisory Group that has been developed by a number of Health Regulatory Colleges in Ontario.

4. Policy Status Table

- The status of ongoing policy development and reviews, as well as target dates for completion, is presented for Council's information as **Appendix A**. This table will be updated at each Council meeting.

- For further information about the status of any policy issue, please contact Craig Roxborough, Interim Manager, Policy, at extension 387.

DECISIONS/DISCUSSION FOR COUNCIL:

For information only

Contact: Craig Roxborough, Ext. 339

Date: August 17, 2018

Appendices:

Appendix A: Policy Status Table

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY REVIEWS

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Prescribing Drugs	This policy sets out the College's expectations of physicians who prescribe drugs or provide drug samples to patients.	This policy is currently under review. A Working Group has been struck to undertake this review and a preliminary consultation on the current policy has been undertaken. Further updates with respect to the status of this review will be provided at future meetings of Council.	2019
Maintaining Appropriate Boundaries and Preventing Sexual Abuse	This policy helps physicians understand and comply with the legislative provisions of the *Regulated Health Professions Act, 1991 (RHPA)* regarding sexual abuse. It sets out the College's expectations of a physician's behaviour within the physician-patient relationship, after the physician-patient relationship ends, and with respect to persons closely associated with patients.	This policy is currently under review. The review will be informed by the College's Sexual Abuse Initiative, the Minister of Health and Long-Term Care's Task Force on the Prevention of Sexual Abuse of Patients, and Bill 87, the *Protecting Patients Act, 2017*. A Working Group has been struck to undertake this review and a preliminary consultation on the current policy has been undertaken. Further updates with respect to the status of this review will be provided at future meetings of Council.	2019
Practice Management Considerations for Physicians Who Cease to	This policy explains the practice management measures physicians should take when they	This policy is currently under review. A newly titled *Closing a Medical Practice* draft policy was approved for external consultation by	2019

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation	cease to practise or will not be practising for an extended period of time.	Council in February 2018. A consultation on the draft policy took place between February and April 2018. The draft policy is being revised in light of the feedback received. The timeline for this review has been adjusted to align with the development of the new *Continuity of Care* draft policies. Further updates with respect to the status of this review will be provided at a future meeting.	
Management of Test Results	The current policy articulates a physician's responsibility to: 1. Have a system in place to ensure that test results are managed effectively in all of their work environments, and 2. Follow-up appropriately on test results.	This policy is currently under review. A joint Working Group has been struck to undertake this review alongside the development of a new *Continuity of Care* policy. Following Council approval in May 2018, the draft Managing Tests policy was released for t external consultation. For more information please refer to the Continuity of Care entry below.	2018
Continuity of Care	The College does not currently have a policy on *Continuity of Care*.	In May 2016, Council reviewed and discussed a *Continuity of Care Planning and Proposal* document providing analysis and recommendations relating to the development of a new policy. A joint Working Group has been struck to undertake this policy development process alongside the review of	2018

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
		the *Test Results Management* policy. In May 2018, Council approved a set of draft *Continuity of Care* policies for external consultation. An update on the consultation as well as ongoing activities and anticipated next steps is provided as part of the *Policy Report* included in your Council materials.	
Confidentiality of Personal Health Information	This policy sets out physicians' legal and ethical obligations to protect the privacy and confidentiality of patients' personal health information.	This policy is currently under review. A working group has been struck to assist with this policy review and is providing direction on the expectations to be included in the draft policy. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Medical Records	This policy sets out the essentials of maintaining medical records.	This policy is currently under review. Initial stages of the review are underway and a preliminary consultation was held between September and December 2017. A working group has been struck to assist with this review. Further updates with respect to the status of this review will be provided at a future meeting.	2019
Disclosure of Harm	This policy sets out the expectations of physicians in situations where patients	This policy is currently under review. Initial stages of the review are underway, with a preliminary consultation set to launch in	2019

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	experience harm in the course of medical treatment.	September 2018. Further updates with respect to the status of this review will be provided at future meetings of Council.	
Fetal Ultrasound for Non-Medical Reasons	The purpose of this policy is to clarify physician obligations with respect to ordering and performing fetal ultrasounds.	This policy is currently under review. Initial stages of the review are underway, with a preliminary consultation set to launch in September 2018 with the specific aim to evaluate the value and usefulness of this policy. Further updates with respect to the status of this review will be provided at future meeting of Council.	2019
Female Genital Cutting (Mutilation)	This policy sets out physicians' obligations with respect to female genital cutting/mutilation.	This policy is currently under review. Initial stages of the review are underway, with a preliminary consultation set to launch in September 2018 with the specific aim to evaluate the value and usefulness of this policy. Further updates with respect to the status of this review will be provided at future meeting of Council.	2019
Anabolic Steroids, Substances and Methods Prohibited in Sport	The current policy articulates the College's expectations of physicians regarding the use of anabolic steroids and other substances and methods for the	This policy is currently under review. Initial stages of the review are underway, with a preliminary consultation set to launch in September 2018 with the aim to evaluate the value and usefulness of this policy. Further	2019

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY	SUMMARY	STATUS/NEXT STEPS	PROJECTED COMPLETION
	purpose of performance enhancement in sport (i.e., doping).	updates with respect to the status of this review will be provided at future meeting of Council.	

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICIES SCHEDULED TO BE REVIEWED

POLICY	TARGET FOR REVIEW	SUMMARY
Complementary/Alternative Medicine	2016/17	This policy articulates expectations relating to complementary and alternative medicine. The review of this policy has been deferred, due to competing priorities.
Dispensing Drugs	2016/17	This policy sets out the College's expectations of physicians who dispense drugs.
Professional Responsibilities in Postgraduate Medical Education	2016/17	This policy sets out the roles and responsibilities of most responsible physicians, supervisors, and trainees engaged in postgraduate medical education programs.
Third Party Reports	2017/18	This policy clarifies the College's expectations regarding physicians' roles in and standards of care for conducting medical examinations and/or preparing reports for third parties.
Delegation of Controlled Acts	2017/18	This policy assists physicians to understand when and how they may delegate controlled acts. The policy also offers guidelines for the use of medical directives.
Mandatory and Permissive Reporting	2017/18	This policy sets out the circumstances under which physicians are required by law, or expected by the College, to report information about patients.
Criminal Record Screening	2017/18	This policy sets out circumstances in which applicants for certificates of registration and existing physicians are required to submit to a criminal record screen.
Professional Responsibilities in Undergraduate Medical Education	2017/18	This policy sets out the roles and responsibilities of most responsible physicians and supervisors of medical students engaged in undergraduate medical programs.
Medical Expert: Reports and Testimony	2017/18	This policy sets out the College's expectations of physicians who act as medical experts.

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Social Media – Appropriate Use by Physicians (Statement)	2018/19	This document provides guidance to physicians about how to engage in social media while continuing to meet relevant legal and professional obligations.
Providing Physician Services During Job Actions (formerly Withdrawal of Physician Services During Job Actions)	2018/19	This policy sets out the College's expectations of physicians during job actions. Council approved the Providing Physician Services During Job Actions policy at its March 2014 meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 1, 2014.
Physicians' Relationships with Industry: Practice, Education and Research (formerly Conflict of Interest: Recruitment of Subjects for Research Studies and MDs Relations with Drug Companies)	2019/20	The draft policy sets out the College's expectations for physicians who interact with industry in a number of key areas. Council approved the Physicians' Relationships with Industry: Practice, Education and Research policy at its September 2014 Meeting. The policy was posted on the College's website, and published in *Dialogue*, Volume 10, Issue 3, 2014.
Telemedicine	2019/20	The policy sets expectations for physicians using telecommunications technologies to interact with patients in different locations, in actual or stored time.
Marijuana for Medical Purposes	2020/21	The policy sets expectations for physicians relating to the prescribing of dried marijuana for medical purposes.
Professional Obligations and Human Rights	2020/21	The policy articulates physicians' existing legal obligations under the Ontario *Human Rights Code*, and the College's expectation that physicians will respect the fundamental rights of those who seek their medical services.
Consent to Treatment	2020/21	The policy sets out expectations of physicians regarding consent to treatment.
Planning for and Providing Quality End-	2020/21	This policy sets out expectations of physicians regarding planning for and

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
of-Life Care (formerly Decision-Making for the End of Life)		providing quality care at the end of life.
Blood Borne Viruses	2020/21	This policy sets expectations with respect to reducing the risk of acquiring or transmitting a blood borne virus, as well as expectations for physicians if they are exposed to a blood borne virus, and lastly, if they are infected with a blood borne virus.
Physician Treatment of Self, Family Members, or Others Close to Them (formerly Treating Self and Family Members	2021/22	This policy sets out the circumstances in which it may be acceptable for physicians to provide treatment for themselves, family members, or others close to them.
Physician Behaviour in the Professional Environment	2021/22	This policy provides specific guidance about the profession's expectations of physician behaviour in the professional environment.
Medical Assistance in Dying	2021/22	This policy articulates the legal obligations and professional expectations for physicians with respect to medical assistance in dying, as set out in the federal legislation, provincial legislation, and relevant College policies.
Accepting New Patients	2022/23	This policy sets out the College's expectations of physicians when accepting new patients.
Ending the Physician-Patient	2022/23	This policy sets out the College's expectations of physicians when ending the

POLICY STATUS REPORT – SEPTEMBER 2018 COUNCIL

POLICY	TARGET FOR REVIEW	SUMMARY
Relationship		physician-patient relationship.
Uninsured Services: Billing and Block Fees	2022/23	This policy articulates the College's expectations of physicians in relation to billing for uninsured services, including offering patients the option of paying for uninsured services by way of a block fee.
Ensuring Competence: Changing Scope of Practice and Re-entering Practice	2023/2024	This policy sets out the College's expectations related to reporting and demonstrating competence prior to changing scope of practice and/or re-entering practice. It also outlines the College review process for ensuring competence when physicians change their scope of practice and/or re-enter practice.
Public Health Emergencies	2023/2024	This policy sets out the College's expectations of physicians during public health emergencies, and affirms the commitment of the profession to responding to public health emergencies by providing physician services.

Discipline Committee
Report of Completed Cases – September 2018

This report covers discipline cases completed (i.e., the written decision and reasons on finding and, if applicable, penalty have been released) between May 5, 2018 and August 16, 2018. The decisions are organized according to category, and then listed alphabetically by physician last name.

Sexual Abuse – 1 case

1. Dr. G. Doodnaught

Name:	Dr. George Doodnaught
Practice:	Anesthesiology
Practice Location:	Toronto
Hearing:	Agreed Facts, Uncontested Facts and Unopposed Penalty
Finding/Penalty Decision Date:	May 22, 2018
Written Decision Date:	July 23, 2018

Allegations and Findings

- Sexual Impropriety – **proved**
- Sexual Abuse **– proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Guilty of an offence relevant to suitability to practise - **proved**

Summary

Criminal conviction of 21 counts of sexual assault of patients

On November 19, 2013, Dr. Doodnaught was convicted of 21counts of sexual assault with respect to a number of patients. The trial judge found that all of the assaults took place while the patient was in surgery under conscious sedation that was administered by Dr. Doodnaught. The trial judge's specific findings for these patients include the following:

Patient B
During Patient B's surgery at the Hospital, Dr. Doodnaught kissed her on the lips, and fondled her breasts multiple times. She recalls being asked if she was all right, but was too scared to say anything but "yes." In the recovery room, she told her family member what happened, and within weeks, formally reported the abuse to the Hospital, asking that her complaint be filed in Dr. Doodnaught's record.

Patient C
During Patient C's surgery at the Hospital, she awoke to find Dr. Doodnaught's penis in her mouth. The surgeon heard Patient C say more than once, "take that out of my mouth." In the recovery room, Patient C disclosed the abuse to her family member, who told her it was impossible. She did not report it until she heard media reports in 2010 because she could not believe a doctor would do such a thing.

Patient D
During Patient D's surgery at the Hospital, she woke up to find Dr. Doodnaught placing his penis in her hand and using her hand to masturbate himself. While in the hospital and again on the way home, Patient D told her boyfriend about the abuse. He told her it couldn't have happened.

Patient G
During Patient G's surgery at the Hospital, Dr. Doodnaught kissed her, repeatedly inserting his tongue into her mouth. She told her family members about the abuse when they came to visit. They said it must have been the drugs.

Patient H
During Patient H's surgery at the Hospital, she awoke several times to find that Dr. Doodnaught had placed his genitals in her hand and was manipulating her hand to massage his genitals. At the end of the surgery, Dr. Doodnaught told Patient H that she had been fondling his genitals throughout the surgery. She apologised and said she didn't understand why that was happening. After the surgery, Dr. Doodnaught said to Patient H, "don't go fondling any more doctors." Although she disclosed the abuse to a friend, she was too afraid to complain while in hospital, and too embarrassed and ashamed when she got home.

Patient J
During Patient J's surgery at the Hospital, she awoke several times to find Dr. Doodnaught kissing her, inserting his tongue into her mouth, fondling her breast(s), and placing his penis in her mouth. Throughout the assault, Dr. Doodnaught made sexual comments to Patient J, including: "you reached for me as soon as you went under." He also told her that he didn't think that she would like sex that much, asked her if she would "suck him off," asked her when her husband was not at home, and told her he'd come over and "give her a good fuck." After the procedure, Dr. Doodnaught told the scrub nurse that Patient J "grabbed my balls." The day after the surgery, Patient J disclosed the abuse to a social worker.

Patient M
During Patient M's surgery at the Hospital, Dr. Doodnaught kissed her on both cheeks, grabbed and squeezed her breasts, and placed his penis in her hand. She asked him, more than once, "do I have to do this?" as she did not want to hold his penis. He responded that she did and that it was part of her healing and part of her surgery. After the surgery, Patient M kept asking Dr. Doodnaught what happened. Dr. Doodnaught whispered to Patient M, "what happens in Vegas, stays in Vegas," which had clear sexual connotations. Patient M thought that maybe she was the one who behaved badly in the operating room. She felt embarrassed and ashamed. When her boyfriend came in, she disclosed that something sexual happened, without giving him details.

Patient N
During Patient N's surgery at the Hospital, she became conscious. Dr. Doodnaught said "I want you to put this in your mouth," and he placed his penis in her mouth. Several weeks after the surgery, Dr. Doodnaught called her at home, and told her she had invited him to see her garden. She was terrified. She came forward after her relative told her that the doctor had been arrested.

Patient O
During Patient O's surgery at another off-site Clinic, she felt Dr. Doodnaught touch, rub and squeeze her breasts. She was aware, angry, and wanted him to stop. She tried to verbally and physically protest but was unable. She told her friend about the assault within days of the surgery.

Patient Q
During Patient Q's surgery at the Hospital, Dr. Doodnaught said to her, "You are a sexy lady. Do you do blow jobs?" She felt him squeeze both of her breasts hard, which pained her. She tried to cry out and move away. He also attempted to insert his penis into her mouth. Again, she tried to protest but was unable. She did not disclose the abuse until after hearing media reports because she thought no one would believe her.

Patient R
During Patient R's surgery at the Hospital, Dr. Doodnaught placed his penis in her hand. She felt stress and panic. When she tried to move her hand away, he repeatedly told her, "No no, no no, don't do that, you're doing a great job." She then heard, "that was great." After the surgery, Dr. Doodnaught made a comment to Patient R that he wanted to tell her boyfriend that "he was a lucky guy." Patient R was distressed after the surgery and disclosed the events to her family member, her boyfriend, and her friend. She did not report it to the authorities until after there was a press release because she concluded that if her friends and family didn't believe her, no one would.

Patient S
During Patient S's surgery at the Hospital, she woke up. Dr. Doodnaught was chatting with her, then came up behind her, grabbed and squeezed her breasts and pressed his body against the back of her head. She was shocked and did not know what to do. After the surgery, Dr.Doodnaught visited her in her room and told her that they had had a great personal conversation during the surgery and that she had told him a lot of personal things about herself and that everything she had told him would be kept in confidence. Shortly after Dr. Doodnaught left, Patient S told a friend who came to visit that she thought Dr. Doodnaught had molested her during the surgery. She later told her family member and the police, after seeing it on the news.

Patient T
Patient T woke up during a procedure at the Hospital to Dr. Doodnaught saying to her, "wake up sweetie, the surgery is over" and kissing her on her lips and cheeks. He also ran his hand over her breasts. She reported the abuse to her family in the recovery

room. Her relative said she must have been hallucinating, which caused Patient T to try to put it out of her mind until she saw it on the news and came forward.

Patient U
During Patient U's surgery at the Hospital, while she was in and out of consciousness, Dr. Doodnaught repeatedly kissed her on her mouth and moved his penis in and out of her mouth. Patient U told a friend, who told her she was hallucinating. Patient U later reported to police after that same friend advised her of the news reports, and apologised for not believing her.

Patient V
While Patient V was on the gurney for her surgery at the Hospital, she recalls Dr. Doodnaught saying "hold this." She complied, and immediately realized that she was holding Dr. Doodnaught's penis. She told a friend who visited her a few days after the surgery, but did not tell her family member because she could not believe this could happen to "an old lady" like her "in a safe environment."

Patient W
During Patient W's surgery at the Hospital, she felt Dr. Doodnaught touching her breasts, and kissed her in a sexual manner. She was upset and wanted to scream for help. Dr. Doodnaught then whispered: "you asked for a kiss." This made her feel worse. Within days of the surgery and while still in hospital, Patient W disclosed what occurred to her family member and the surgeon. The latter told her she was dreaming. After Dr. Doodnaught's arrest was announced in the media, she contacted the police.

Patient X
During her surgery at the Hospital, Patient X woke up while Dr. Doodnaught was rubbing her breast and kissing her on the lips. The next day, she told a friend that she had a "crazy dream" that the anaesthetist kissed her. She didn't think it was possible for it to have happened. She came forward after hearing that Dr. Doodnaught had been arrested.

Patient Z
During Patient Z's surgery at the Hospital, she woke up. She heard Dr. Doodnaught tell her that he liked her shaved pubic area, and said "do you want to see mine?" He then undid his scrubs, touched her breasts with both hands, and inserted his penis in her mouth. While still in hospital, Patient Z disclosed the abuse to her hospital roommate and to friends. She also confronted Dr. Doodnaught. He told her that "it never happened" and that she had placed his thumb in her mouth. After she saw the news report about Dr. Doodnaught on TV, she immediately contacted the police.

Patient AA
When Patient AA woke up near the end of the surgery at the Hospital, Dr. Doodnaught was leaning over her, kissing her and massaging her breast. She did not disclose the

assault until she saw media reports because she was embarrassed and tried to block it out.

Patient CC
During Patient CC's surgery at the Hospital, Patient CC woke up. Dr. Doodnaught's penis was in her mouth. She wanted to scream but couldn't do anything. She was scared. This happened 3 or 4 times. Patient CC also felt Dr. Doodnaught's hand on her breast. At one point he kissed her on the lips. During the assaults, Dr. Doodnaught repeatedly told Patient CC "don't worry, I'll take good care of you." Shortly after the surgery, she disclosed the assault to her friend, who wanted to tell someone, but Patient CC was frightened and worried people would tell her she was crazy. She came forward after she saw Dr. Doodnaught's picture on TV.

Patient DD
During Patient DD's surgery at the Hospital, she recalls Dr. Doodnaught fondling and caressing her breasts, kissing her with his tongue into her mouth, and placing his penis in her mouth. She could not believe this was happening. She said to Dr. Doodnaught, "What about the other people?" and Dr. Doodnaught said "Don't worry, I know how to be discreet." In the recovery room, Dr. Doodnaught grabbed her hand and said to Patient DD, "as soon as you were out, the first thing you reached for was my dick". The next morning, Patient DD awoke in her hospital room to find Dr. Doodnaught caressing her cheek. While still in the hospital, she told her family member, who said, "Are you sure it wasn't the drugs?" and the nurse, which led to a report.

On February 25, 2014, Dr. Doodnaught was sentenced to 10 years' imprisonment. In imposing sentence, the trial Judge found that "The offender's moral blameworthiness is at the high end of the spectrum. His conduct did enormous damage and was reprehensible in the extreme. It must be condemned in the strongest of terms." The trial judge emphasized that "George Doodnaught betrayed the extraordinarily high level of trust accorded to him. […] The power imbalance between himself and his victims was absolute." The judge found that Dr. Doodnaught "exploited the trust he was given and used it to enable him to commit his crimes. He paid no heed to the harm it was doing to his victims, who were sedated but aware of what was happening to them and unable to fight back." Dr. Doodnaught's appeal to the Court of Appeal for Ontario was dismissed on October 13, 2017.

<u>Sexual abuse of 11 other patients</u>

Dr. Doodnaught engaged in sexual abuse of patients and disgraceful, dishonourable and unprofessional conduct with respect to 10 other patients.

Patient A
When Patient A awoke at the conclusion of the surgery at the Hospital, Dr. Doodnaught's penis was going into her mouth. He was also massaging her breasts under her hospital gown. Dr. Doodnaught continued for about 30 seconds before

Patient A was taken to the recovery room. Patient A attempted to push Dr. Doodnaught away, but was unable to get her hands up. Patient A did not complain to anyone at the hospital because she felt that she would not be supported by her boss or the administration in the hospital. She disclosed the abuse to a lawyer when she read about the charges against Dr. Doodnaught in the newspaper.

Patient E
Several hours after Patient E's surgery at the Hospital, when she was in her hospital room, Dr. Doodnaught came to see her and told her that people do "crazy stuff" when they wake up from the anaesthetic, and that when she woke up, she grabbed him and wanted to "give him a blow job". Dr. Doodnaught placed his penis in Patient E's mouth while she lay on her hospital bed. Patient E was shocked, and asked Dr. Doodnaught what he was doing. Dr. Doodnaught removed his penis and covered himself with his lab coat when a nurse entered the room.
Patient E disclosed the abuse to police when her friend gave her a copy of a newspaper article about the charges against Dr. Doodnaught.

Patient F
Prior to Patient F's surgery at the Hospital, Dr. Doodnaught rubbed her face with his hand and said, "I'll look after you, don't be afraid."During the surgery, Dr. Doodnaught placed his penis in Patient F's hand and told her that she could put it in her mouth if she liked, as his wife did that to him. Patient F disclosed the abuse to her family members as soon as she came out of the operating room, and later to her doctor.

Patient I
In the operating room, prior to her surgery at the Hospital, Dr. Doodnaught touched and pressed on Patient I's breasts with both hands and kissed her on her lips. Patient I tried to call for help, but was unable to speak due to the anaesthetic. After her surgery, Patient I disclosed the abuse to her family member and asked her family member to lodge a complaint with the hospital, but ws told that it could not have happened. Patient I later came forward with her complaint after she heard about the charges against Dr. Doodnaught on television.

Patient K
During her surgery at the Hospital, Dr. Doodnaught pushed Patient K's head against his stomach, rubbed her breasts with his hand, and took Patient K's hand and rubbed it against his penis. Patient K asked Dr. Doodnaught what he was doing. Dr. Doodnaught told her that he was comforting her, and continued. Patient K pulled her hand away and tried to divert him by telling him about her life. After that, Patient K went to sleep. When Patient K awoke after her surgery, she disclosed the abuse to her family members that were present. Her family members told her that she was dreaming. Patient K's family member reported the abuse to the hospital during an unrelated hospital stay after seeing a story about Dr. Doodnaught in the newspaper.

Patient L
During her surgery at the Hospital, Patient L awoke. She felt Dr. Doodnaught's penis in her mouth. When she opened her eyes, Dr. Doodnaught was standing there. She told him that it felt like someone put a penis in her mouth, and Dr. Doodnaught straightened up and asked her how that could be. During the remainder of the surgery, Dr. Doodnaught told Patient L about his family, and she talked about her own family. At the end of the conversation, Dr. Doodnaught kissed Patient L on her cheek. Patient L disclosed the abuse to a lawyer after she heard about the charges against Dr. Doodnaught on the radio.

Patient P
During her surgery at the Hospital, Dr. Doodnaught rubbed Patient P's shoulders and rubbed her left breast with his hands under her hospital gown. Patient P tried to move to stop him, but her arm was tied down, and Dr. Doodnaught held her arm down and said, "no, no." Patient P then went into a deeper sleep. Later, during the same surgery, Patient P awoke again to Dr. Doodnaught massaging both of her breasts under her gown. She again tried to move her arms, which were tied down, and then blacked out again. When she came to again, Dr. Doodnaught had placed his penis in Patient P's hand and used her hand to masturbate himself. When she became aware, she pulled her hand away, because it was no longer strapped down. When she heard about the charges against Dr. Doodnaught on television, Patient P disclosed the assault to her family member.

Patient Y
In the hallway prior to her surgery at the Hospital, Dr. Doodnaught repeatedly rubbed Patient Y's face with the back of his hand. After he took her to the operating room, Dr. Doodnaught rubbed Patient Y's hands and arms, making her feel uncomfortable. Dr. Doodnaught then rubbed Patient Y's left breast with his hand under her hospital gown. Patient Y wanted to tell her surgeon, but her surgeon did not arrive before she fell asleep. After her surgery, Patient Y disclosed the abuse to a family friend who came to pick her up from the hospital. Patient Y also later disclosed the abuse to her family doctor, who directed her to speak to police, which she did.

Patient BB
Before she was sedated prior to her surgery at the Hospital, Dr. Doodnaught told Patient BB to "dream that you and I are on a beach together". During the surgery, Dr. Doodnaught placed his penis in Patient BB's mouth and her hand. After her surgery, Dr. Doodnaught came to Patient BB's room and asked her if she remembered anything, and told her that she had made him promise that he would come to her room, and that she had asked him to hold her hand throughout the surgery. Patient BB did not disclose the abuse right away because she thought she might have dreamed it as a result of the anaesthetic. After a friend told her about the charges against Dr. Doodnaught, Patient BB contacted the police.

Patient EE
After Patient EE's surgery at the hospital, Dr. Doodnaught kissed her on the mouth five or six times as she was waking up. When Patient EE woke up, she saw Dr. Doodnaught standing beside her and no one else in the room. Dr. Doodnaught asked Patient EE if she was okay. Afterward, Dr. Doodnaught took Patient EE to the intensive care room, where Patient EE disclosed the abuse to her family member, who told her that she should tell her surgeon what happened. Patient EE did not tell her surgeon because she felt her surgeon would not believe her. Patient EE reported the abuse after her family member learned about the charges against Dr. Doodnaught on television and again told her to come forward.

Disposition

On May 22, 2018, the Committee ordered and directed that:

- the Registrar revoke Dr. Doodnaught's certificate of registration effective immediately.
- Dr. Doodnaught attend before the panel to be reprimanded.
- Dr. Doodnaught pay costs to the College in the amount of $10,180.00 within 30 days of the date this Order.

On May 29, the Committee further ordered that:

- in addition to the orders made in its Order of May 22, 2018, Dr. Doodnaught shall reimburse the College for funding provided to patients under the program required under section 85.7 of the Code, by posting an irrevocable letter of credit or other security acceptable to the College, within thirty (30) days of this order in the amount of $497,860.00.

Incompetence - 4 cases

1. Dr. C.S. Doyle

Name:	Dr. Christopher Stephen Doyle
Practice:	Psychiatry
Practice Location:	Mississauga
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date	February 1, 2018
Penalty Decision Date:	August 7, 2018
Written Decision Date:	August 7, 2018

Allegations and Findings

- Incompetence - **proved**
- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Doyle is a psychiatrist who received his Independent Practice Certificate with the College of Physicians and Surgeons of Ontario ("College") in 2001. During the relevant period, Dr. Doyle worked at the Hospital and maintained a private practice in Mississauga.

Patient A

Patient A was referred to Dr. Doyle by her family physician, Dr. X, in August of 2013. Together with his referring letter, Dr. X provided Dr. Doyle with medical records for Patient A, containing reference to Patient A's previous sexual boundary issues with a mental health professional while under the professional's care, and reference to Patient A having developed an infatuation with a prior treating psychiatrist.

Dr. Doyle was Patient A's psychiatrist between October 2013 and July 2014, during which time he focused on Patient A's medications. By December of 2013, Dr. Doyle's diagnosed Patient A as "a borderline woman with increased anger and increased depression".

During the time she was Dr. Doyle's patient, Patient A perceived that Dr. Doyle's demeanour towards her changed, in that he became increasingly casual during her appointments, including sitting back with his feet up on the coffee table and using profanities in front of Patient A. Patient A told Dr. Doyle that she was depressed and not motivated to exercise anymore. She had previously reported to Dr. Doyle that she enjoyed cycling and running. Dr. Doyle told Patient A about his own interest in cycling

and showed her an app on his cell phone that he used to track cycling progress and that showed his progress against other cyclists in the online community. He told Patient A that she could use the app as well to track her exercise progress and keep motivated.

Patient A explained in her complaint and in her interview with the College that as a result of Dr. Doyle's casual demeanor and the information that he shared with her during the sessions, Patient A began to feel that Dr. Doyle wanted to foster a friendship or relationship with her. In July 2014, Patient A told Dr. Doyle about her feelings for him. Dr. Doyle indicated that he was flattered but that her feelings were not appropriate for the physician-patient relationship. Patient A perceived that Dr. Doyle to be extremely uncomfortable by her disclosure. He stopped the session and asked Patient A to see his secretary to make a subsequent appointment, while in the past, Dr. Doyle had scheduled all subsequent sessions himself on his cell phone at the end of Patient A's appointments. Patient A booked a follow-up appointment for August 2014 with Dr. Doyle through the secretary and left the session feeling confused, ashamed and humiliated.

The following day Patient A sent Dr. Doyle an email apologizing and seeking clarity as to what had transpired in her appointment. Dr. Doyle responded explaining that he could no longer see Patient A and while her feelings are understandable, they are not appropriate for their relationship. He explained that this is called "eroticized transference" and that due to his previous issues, it is not something that he can safely manage at this time. He wrote that he appreciates her honesty, but that it prevents them from working together therapeutically.

Patient A described the emotional impact of Dr. Doyle's response to her disclosure and the termination of her care as "devastating." She went to see her family physician in July 2014, reporting suicidal thoughts and self-blame as a result of this interaction with Dr. Doyle. She went to the hospital with a suicide plan several days later and was voluntarily admitted to Hospital for several days.

Further to the email exchange, which Patient A perceived as notice of termination, Patient A had no contact with Dr. Doyle. She did not attend the subsequent appointment that she had booked with Dr. Doyle. Patient A submitted a complaint to the College in July 2014, describing mixed feelings: she wrote that Dr. Doyle "does seem to care about what he does and is extremely competent with the medications".

Dr. Doyle states that he waited for Patient A during her scheduled appointment in August 2014, at which point he planned to properly terminate the patient-physician relationship. Dr. Doyle did not take any action in respect to the transfer of care for Patient A, he did not send a termination letter to Patient A and did not communicate with the referring physician about the end of the therapeutic relationship. He did not make arrangements for the prescription of Patient A's medications, nor did he assist in finding another psychiatrist for Patient A.

The Expert Report

An expert retained by the College to review this matter opined that:

- Dr. Doyle failed to meet the standard of practice of the profession in this case and that his medical record-keeping was inadequate to serve as a record to 'tell the patient's story' and to support diagnostic decision-making and treatment planning. The expert opined that if Dr. Doyle behaved as described by Patient A, this would be a failure to uphold the professionalism, and boundaries essential to the physician-patient relationship. The expert further opined that Dr. Doyle failed to meet the standard of practice of the profession in the manner he terminated the doctor-patient relationship.
- Dr. Doyle's deficits in clinical record keeping are very significant and may arise from lack of knowledge on the standard of care requirements, or poor judgement. The expert noted that Dr. Doyle's notes reflected an awareness of the patients' vulnerabilities, though this was not incorporated into his treatment plan. According to the expert, the boundary crossings, failures in professionalism and in recognition/management of the dynamics in the therapeutic encounter could reflect a lack of skill, knowledge, judgement or a combination of the forgoing. The expert further noted that Dr. Doyle's failure to maintain the standard of practice in the manner of patient termination could have resulted from Dr. Doyle's lack of knowledge, lack of skill in managing the situation, or lack of judgement.
- If Patient A's clinical record is representative of Dr. Doyle's practice of medical record-keeping, his self-described 'informal style' with patients, and boundary crossings, it is likely that patients would be exposed to harm, which is estimated to be higher than what would be expected from care provided by a practitioner who maintained the standard of care in these areas.

Upon review of the information that on one occasion, in the context of discussing Patient A's depression, Dr. Doyle told Patient A about his other patient (whose name he did not disclose) who suffered from severe depression and did not care for himself such that his teeth had fallen out, the expert opined that although unintended, this practice is ill advised and could lead to confidentiality breaches, given the possibility that Patient A could have later seen an edentulous man in the waiting area, and reasonably believe that she could then put a face to the story she heard directly from Dr. Doyle. The expert noted that Dr. Doyle has twice written to the College indicating that he should not have spoken about the other patient to Patient A. In the expert's opinion this was not a violation of the standard of care.

Section 75(1)(a) Investigation

Following the complaint of Patient A, the College conducted an investigation into Dr. Doyle's private practice. The expert retained by the College reviewed Dr. Doyle's 24 patient charts, transcribed clinical notes, and interviewed Dr. Doyle. The expert opined that Dr. Doyle failed to meet the standard of practice of the profession in 16 of the 24

patient charts reviewed. The expert further opined that Dr. Doyle's care displayed a lack of knowledge in 1 of the 24 patient charts reviewed and that Dr. Doyle's care displayed a lack of skill and/or judgement and exposed or is likely to expose his patients to harm or injury in 19 of the 24 patient charts reviewed.

The issues identified by the expert included, but were not limited to, the following:

- Inadequate documentation/record-keeping;
- Lack of diagnostic clarity/consistency;
- Inadequate risk assessments and/or interventions for self-harm and aggressive ideation;
- Lack of attention to substance use history and/or inadequate assessment of alcohol/substance use;
- Use of non-professional and/or non-objective language in clinical notes
- Inadequate psychotropic medication intervention and/or sub-therapeutic medication dosing;
- Failure to make mandatory report to MOT and/or CAS;
- Inadequate follow-up/frequency of monitoring/appointments;
- Inappropriate prescribing of stimulant medication;
- Inappropriate prescribing of a narcotic;
- Inappropriate prescribing of medical marijuana in patient with primary psychotic illness;
- Ongoing prescribing of a medication (stimulants, benzodiazepines) that patient is known to be abusing;
- Inadequate medication monitoring (efficacy, side effects, interactions, blood work);
- Failure to maintain appropriate/professional boundaries;
- Inappropriate polypharmacy and/or combinations of benzodiazepines, atypical antipsychotics and/or sedative hypnotics; and
- Inappropriate prescribing of medications for non-psychiatric conditions and without notifying the patient's primary care provider.

Upon interviewing Dr. Doyle, the expert made positive findings, which include, but are not limited to the following:

- Dr. Doyle was able to describe the essential elements required in the psychiatric history, mental status examination, for a consultation report leading to a differential diagnosis and treatment plan;
- Dr. Doyle was able to accurately describe differential diagnoses for different clinical presentations and the necessary historical detail required to discriminate between these differentials to provide a working diagnosis;
- Dr. Doyle was able to describe the relevant diagnostic criteria in the DSM-IV framework he used for the common diagnoses he made;
- Dr. Doyle was generally able to discuss appropriate dosing for psychiatric medications, and the concerns with polypharmacy, particularly with combination sedative hypnotics and combination atypical antipsychotics;

- Dr. Doyle was mostly able to describe standard of care baseline investigations and recommended monitoring for the use of atypical antipsychotics and divalproex and lithium;
- Dr. Doyle was able to describe the requirements for mandatory reporting regarding driving and reporting child safety concerns;
- Dr. Doyle was able to describe the potential negative impact of cannabis on many psychiatric illnesses and the lack of empirical evidence of benefit;
- Dr. Doyle was able to describe appropriate strategies and interventions for patients abusing medications he prescribes;
- Dr. Doyle was able to discuss the potential hazards to a patient regarding provision of prescription medications for non-psychiatric conditions that he does not monitor, and the particular risks of doing so with opiates;
- Dr. Doyle was able to describe appropriate interventions for ill patients who have prolonged absences from the practice, or when there is information about a crisis, clinical deterioration, emergency room visits etc.; and
- Dr. Doyle was able to identify as inappropriate, the use of non-professional language in the patient records.

The expert's concerns identified in the interview include, but are not limited to:

- Although Dr. Doyle acknowledged the risks of and poor evidence for use or combination of antipsychotics, this was commonly observed in his use of these medications, more than would be expected in a similar practice of a general adult psychiatrist.
- Although Dr. Doyle described appropriate lithium monitoring, this was generally not observed in his records. Dr. Doyle generally would not monitor kidney function or serum calcium levels, which increases the risk of patient morbidity and is not supported by guidelines.
- Although Dr. Doyle was able to appropriately describe standard of care strategies for abusing medication he prescribed, he acknowledged that he did not do so enough. This was a significant concern in the care provided in some of the records reviewed.

<u>You Tube Videos</u>

The expert reviewed a series of YouTube videos posted by Dr. Doyle on his YouTube channel named "DrChristopherDoyle" between 2012 and 2014. The expert reported the following concerns about the videos:

- Lack of judgement, professionalism and boundaries with a tone of promotion in a video, in which Dr. Doyle is talking about his use of "the juice of the purple" that gave him stamina to compete in a bike race against professional cyclists.
- Lack of judgement, professionalism and boundaries in a video, in which Dr. Doyle is pictured after spinning class, shirtless, discussing the benefits of exercise to himself physically and mentally and once again promoting the "purple" drink.

- Lack of judgement, professionalism and boundaries in a video in which Dr. Doyle is depicted in an educational session, in which he states marijuana is “excellent” as a PTSD treatment. According to the expert, marijuana is not the standard of care for PTSD and has the potential to harm some patients.
- Breach of standard for physician advertising, lack of judgement and professionalism and abuse of a fiduciary relationship with respect to a videotaped patient testimonial in the office by a female patient. Dr. Doyle is seen in the background, as the patient enthusiastically describes her experience of working with him, that he “taps into my creative side and empowers me…. Go Dr. Doyle!”
- Nine of the twenty-nine videos reviewed are therapeutic in nature. With respect to these nine videos, the expert opined that each falls below the standard of care.
- Thirteen of the twenty nine videos are educational in nature. With respect to thirteen videos, the expert opined that ten videos fall below the standard of care and three videos meet the standard of care.
- Seven of the twenty nine videos are philosophical in nature and show Dr. Doyle’s reflections on various topics. According to the expert, six of the seven videos show a lack of judgement.

Overall, the expert opined that:

- Twenty three of the twenty nine videos demonstrate a lack of judgment; and
- discussions contained in fifteen of the twenty nine videos expose or are likely to expose patients to risk of harm.

The expert noted that some effort was made by Dr. Doyle to obtain consent from the patients to discuss their clinical material on YouTube, or to post material from their sessions online on YouTube. However, according to the expert, the consents are inadequate such that they were not specific to the purpose for which they were used.

Interim Suspension

On April 10, 2017, the Inquiries, Complaints and Reports Committee (the ICRC) referred specified allegations of professional misconduct to the Discipline Committee. On May 9, 2017, the ICRC issued an interim order suspending Dr. Doyle’s certificate of registration.

Unprofessional Communication

In January 2017, a medical adjudicator from the Canada Student Loans Program called Dr. Doyle, in order to verify the authenticity of a medical report that she was reviewing for an individual who was a patient of Dr. Doyle. The adjudicator described that after dialing Dr. Doyle’s phone number, Dr. Doyle answered with profanity and spoke rudely, stating “If you need your prescriptions filled, go to the [profanity] pharmacy.” Assuming that she had dialed incorrectly, the adjudicator dialed again. Dr. Doyle answered with more profanity, stating “Stop [profanity] calling me”. When the adjudicator introduced

herself and stated the purpose of the call, Dr. Doyle identified himself and apologized, indicating that he thought he was talking to a patient who was calling him non-stop. The adjudicator then reported her experience with Dr. Doyle to the College and described the profanities used as “f-bombs”.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Doyle’s certificate of registration, effective immediately;
- Dr. Doyle appear before the Committee to be reprimanded with 90 days of the date this order becomes final;
- Dr. Doyle pay costs to the College in the amount of $16,500 within 90 days of the date this order becomes final.

2. Dr. P.M. Irwin

Name:	Dr. Paul Maxwell Irwin
Practice:	General Surgery
Practice Location:	Cornwall
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	May 30, 2018
Written Decision Date:	July 20, 2018

Allegations and Findings

- Incompetence - **proved**
- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **withdrawn**

Summary

<u>Cornwall Community Hospital Investigation</u>

In 2014, the Hospital commenced an external review of Dr. Irwin’s surgical care of patients after concerns were raised regarding his clinical practice at the Hospital. In 2015, based on the results of the review indicating serious quality of care issues, the Medical Advisory Committee of the Hospital recommended that Dr. Irwin’s hospital privileges only be renewed if his practice was subject to a graduated return to practice under clinical supervision, and if he completed a six-month residency-type retraining program at a Canadian university centre in a surgical program approved by the hospital. While Dr. Irwin accepted the recommendation for a graduated return to practice under clinical supervision, he challenged the requirement for residency-type retraining. On

March 30, 2016, the hospital's Board of Directors upheld the requirement for the residency-type training as a condition of Dr. Irwin's re-appointment.

In April 2015 the College commenced an investigation based upon the information it had received from the Hospital. An expert retained by the College reviewed a total of 36 charts of Dr. Irwin's patients and found that Dr. Irwin fell below the standard of care in his care of 12 patients. The expert found "substantial deficits" in Dr. Irwin's knowledge and judgment and noted that he was "extremely concerned with the patterns of practice" he observed. Regarding the 24 charts that did meet the standard, the expert noted that a significant number had minor issues such as violations of hospital booking policy and missing dictations.

Among the issues identified by the expert were the following:

- Incomplete medical records. Missing operative reports, missing discharge summaries or combined admission notes and discharge summaries usually indicating that these were not recorded contemporaneously.
- Unacceptable use of slang or colloquial terms in the medical record.
- Low threshold of operation. A number of cases were hastily taken to the operating room and would have benefited from more extensive preoperative work-up, further imaging and/or referral to colleagues experienced in alternative techniques.
- Multiple instances of incidental appendectomies and oophorectomies. Incidental appendectomies were historically practised but are rarely indicated in this era of advanced imaging and diagnostics. The frequency of incidental appendectomy was disconcerting in a small sample size of 36 cases and in one of the cases led to an appendiceal stump leak — this was significant in the patient's demise.
- Use of Demerol (meperidine). This medication has been removed from almost all hospital formularies and the indication for the medication is extremely limited. Dr. Irwin prescribed this medication in cases where better alternatives exist.
- Usage of antibiotics. Best Practices in General Surgery (BRIGS) has an Ontario based website that details optimal usage of antibiotics. Dr. Irwin's practice is at significant variance from the norm.
- Use of mesh in a potentially contaminated field. Use of polypropylene mesh is contraindicated in a field with open bowel. These cases reflect either a knowledge deficit or a cavalier attitude towards patient care.

Patient A

Dr. Irwin saw Patient A several times in 2013 and in 2014 performed surgery on Patient A to detach the damaged bowel. About a week following the surgery, Patient A developed abdominal pain and later had to undergo additional surgery which was performed by another physician.

In 2014, Patient A complained to the College that although Dr. Irwin was in charge of her care while she was in hospital, he failed to properly communicate with her and her

family about her care. She said he visited her late in the evenings when she was on medication and did not answer her family's questions or keep them informed.

An expert retained by the College to provide an opinion on Dr. Irwin's care of Patient A reported that Dr. Irwin's care of the patient fell below standard and demonstrated a lack of knowledge and judgment in that Dr. Irwin:

- failed to adequately justify the patient's need for colon and ovarian surgery;
- failed to disclose to the patient that she had both ovaries in situ identified on preoperative imaging
- failed to sufficiently document that he had informed, discussed and ensured that the patient had a reasonable understanding of her medical and surgical management;
- did not further investigate the patient's abdominal pain and constipation before embarking on surgery;
- failed to adequately investigate whether the right ovarian cyst was responsible for any of Patient A's symptoms. At the minimum, he should have sought the opinion from a gynecologist prior to consenting her for an oophorectomy, especially as the CT showed both ovaries, one of which was documented to be normal;
- failed to display adequate judgment when he identified both ovaries intra-operatively and then proceeded to resect them. No evidence was found in the documentation aside from Dr. Irwin's own view that the patient requested to have both ovaries removed. Despite the patient's signed consent for the removal of one ovary, the expert did not believe that she was fully aware that the recommendation was for interval follow-up as per the radiologist. Prophylactic bilateral oophorectomies in premenopausal women have been associated with premature death, cardiovascular disease, cognitive decline and osteoporosis. Based on these facts the expert opined that Patient A's bilateral salpingo-oophorectomy was not justified. The expert further opined Dr. Irwin's clinical practice in this case subjected the patient to colon and ovarian surgery that may not have been entirely necessary and that has resulted in complications and subsequent harm.

Dr. Irwin responded to the expert's report stating that:

- his approach to diverticular disease is non-operative, but that in his clinical judgment the patient had more than simple diverticular changes;
- the patient consented and intended to have any remaining ovaries removed; and
- the patient was peri-menopausal, thus reducing the potential risks of a bilateral salpingo-oophorectomy.

Dr. Irwin acknowledged his deficiencies in documentation.

Upon review of Dr. Irwin's response, which did not change his opinion, the expert noted that the response did not substantiate Dr. Irwin's belief that the patient suffered from complicated diverticular disease, nor was there any documentation of a discussion with Patient A confirming the clear radiologic evidence that she had two ovaries, or that she

understood the risks, benefits and expectations of bilateral oophorectomies. The expert expressed concern that Dr. Irwin's comments reflected a lack of acknowledgement and lack of insight that an anastomatic leak was the cause of Patient A's peritonitis and sepsis.

Out-of-Hospital Premises Inspection Investigation

In addition to his hospital practice, Dr. Irwin also worked at the Clinic in Ottawa where he performed endoscopies and administered sedation.

In December, 2015, during the College's Out-of-Hospital Premises Inspection Program conducted at the Clinic, the physician assessor observed Dr. Irwin performing gastroscopies and colonoscopies and had concerns with his technique and skill. The Premises Inspection Committee issued a Fail to the Clinic where patient safety issues had been revealed. The Committee had serious concerns regarding the quality of care that Dr. Irwin provided to his patients and referred the matter to the Inquiries, Complaints and Reports Committee (the "ICRC').

The expert retained by the College to provide an opinion on Dr. Irwin's care of patients at the Clinic reviewed 10 patient charts and directly observed two endoscopic procedures. The expert concluded regarding the 10 charts reviewed that Dr. Irwin demonstrated a lack of knowledge, skill or judgment in his care of 8 patients, and failed to meet the standard of care in 3 patients. With respect to the two patients observed, the expert concluded that Dr. Irwin has several deficiencies in his skills. The expert reported the following:

Standard of care

- fails to meet the standard of care in terms of his charting and documentation
- fails to keep up to date regarding current endoscopic guidelines.
- screening, surveillance and follow up of abnormal pathology should follow some formal guidelines

Lack of knowledge, skill and judgment

- displays lack of judgment, skill and knowledge and needs to keep up to date regarding current endoscopic guidelines.
- screening, surveillance and follow up of abnormal pathology should follow some formal guidelines. For example, recommended guidelines for the surveillance of low grade dysplasia and Barrett's esophagus were not followed
- in patients with poor bowel preparation, and inadequate visualization, additional testing or a repeat colonoscopy with more aggressive bowel preparation should have been offered.

Harm or injury

- in reviewing Dr. Irwin's charts, it does not seem that the patients are at an increased risk of harm or injury. Documentation and organization is the main deficiency.
- Concerns about Dr. Irwin's endoscopic proficiency: noted deficiencies and lack of endoscopic skills, which may potentially place patients at risk by missing pathology and increasing the risk of complications.

Breach of ICRC Order Restricting Dr. Irwin's Practice

On February 14, 2017, the ICRC ordered and directed the Registrar to impose terms, conditions and limitations on Dr. Irwin's certificate of registration restricting his practice to providing small surgical procedures requiring local anaesthesia and surgical consultations and required that he practice with a clinical supervisor who will review a minimum of 20 charts per month.

On December 12, 2017, the ICRC amended the order, increasing the frequency and intensity of supervision based on information received by the College. Dr. Irwin was required to provide the College with the addresses of all his practice locations. Dr. Irwin did not advise the College that, in addition to practising at clinics in Ottawa and Akwesasne, he had a "home practice" which involved visiting approximately 10 patients in their home. Some of the care provided by Dr. Irwin to patients in Akwesasne and in the home visits exceeded the restrictions on his scope of practice. There is no evidence this care was otherwise inappropriate or below standard.

Past History

In January, 2005, the College received a complaint in relation to Dr. Irwin's care of a patient who died following surgery he provided for resection of a cancerous tumour. The Complaints Committee noted that there was no record of Dr. Irwin performing a complete clinical examination of his patient before the operation and that a thorough pre-operative assessment of the lesion should have been done. The Committee cautioned Dr. Irwin to ensure that he conducts a complete and thorough evaluation of patients pre-operatively, so that he can obtain properly informed consent from the patient before proceeding with surgery.

In January 2011, the College received a complaint about the care provided to a patient who underwent excision of a neck lesion and supraclavicular nodes at the Hospital in late 2010. The complainant alleged that Dr. Irwin only obtained his consent for a biopsy of a lesion and excised the mass without consent. The Committee found that:

- there was considerable confusion in the clinical record regarding what consent was provided by the patient;
- Dr. Irwin did not document the consent discussion until after the surgical procedure had been performed;

- Dr. Irwin's dictation of his operative note was not done until two months after the procedure and after the patient had complained to the College; and
- Dr. Irwin's operative note had virtually no detail.

The Committee issued a written caution to Dr. Irwin on his poor consent process in the case, including his documentation of that process, and on his failure to ensure a timely dictation of his operative note. In addition, the Committee required that Dr. Irwin complete a specified continuing education or remediation program involving the following:

- a course on medical ethics and informed consent;
- educational sessions with a preceptor on charting and record-keeping; and
- a reassessment.

In November of 2014, the College received a patient complaint regarding Dr. Irwin's care provided in 1999 when he performed a gastroscopy, colonoscopy and incisional hernia repair at the Hospital. Following the procedure, the patient developed sepsis and other complications. An expert opinion obtained by the College found Dr. Irwin's care met the standard and did not demonstrate a lack of knowledge, skill or judgment. However, the ICRC concluded that Dr. Irwin did not meet the standard with respect to his decision to discharge the patient when there was evidence that clearly demonstrated a wound infection following the surgery. The Committee found that Dr. Irwin should have diagnosed a wound infection and that his discharge note indicating that there were no signs of wound infection and her white blood cell count was normal was inaccurate. The Committee issued advice to Dr. Irwin with respect to his post-operative wound management and assessment before discharge, particularly in patients with fever and elevated white blood count.

In March, 2015 the College received a complaint from a patient in relation to care he received from Dr. Irwin at the Hospital in 2012 when Dr. Irwin performed an elective anterior resection of his colon for diverticulitis. After the surgery, he developed sepsis and Dr. Irwin found an anastomotic leak and created a colostomy. Further complications arose thereafter. An expert opinion obtained by the College found Dr. Irwin's care met the standard and did not demonstrate a lack of knowledge, skill or judgment, but did note that Dr. Irwin's operating notes lacked detail. The ICRC agreed that Dr. Irwin's documentation in the operative note lacked sufficient details, including details of the anastomosis and the consent discussion. It also concluded that there was an excessive delay in bringing the complainant back to the OR when he began to experience complications, particularly as he was high risk and should have been followed closely.

The Committee issued advice to Dr. Irwin to:

- document thoroughly in the OR note;
- document the details of his consent discussion with patients; and

- ensure closer post-operative follow-up of high-risk patients, and noted that in this case there was excessive delay in returning the patient to the OR when the patient had concerning clinical signs of complication.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Irwin's certificate of registration for a period of five (5) months commencing immediately.
- the Registrar impose the following terms, conditions and limitations on Dr. Irwin's certificate of registration:

    - Dr. Irwin's practice is restricted to providing small surgical procedures requiring local anesthesia and surgical consultations.
    - Dr. Irwin shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor"), who will sign an undertaking in the form attached hereto as Appendix "A." [to the Order] For a period of at least six (6) months commencing on the date Dr. Irwin returns to practice following the suspension of his certificate of registration, Dr. Irwin may practise only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management and continuing education. Clinical supervision of Dr. Irwin's practice may end after a minimum of six (6) months, only upon the recommendation of the Clinical Supervisor and, in its discretion, approval by the College. Clinical supervision of Dr. Irwin's practice shall contain the following elements:

        - The Clinical Supervisor will review a minimum of fifteen (15) of Dr. Irwin's patient charts every two (2) weeks, which shall be drawn from both his surgical procedures and surgical consultation areas of practice if he has engaged in both areas of practice during the period under review, and any other practice area if he has expanded his scope of practice in accordance with paragraph 5(xii) of this Order; and
        - The Clinical Supervisor will meet with Dr. Irwin in person a minimum of once a month and will report to the College every month, or more frequently if there is a risk of harm or other concerns.

    - The Clinical Supervisor will also facilitate the education program set out in the Individualized Education Plan ("IEP") in the form attached hereto as Appendix "B" [to the Order].
    - If Dr. Irwin fails to retain a Clinical Supervisor as required above or if, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Irwin shall within twenty (20) days retain a new College-approved Clinical Supervisor who will sign an

undertaking in the form attached hereto as Appendix "A," and if he has not been able to do so within twenty (20) days he shall cease to practise until the same has been delivered to the College.

- Approximately six (6) months after the completion of Clinical Supervision, Dr. Irwin shall undergo a reassessment of his practice (the "Reassessment") by a College-appointed assessor (the "Assessor"). The Reassessment may include a review of Dr. Irwin's patient charts, direct observations and interviews with staff and/or patients, and any other tools deemed necessary by the College. The Reassessment shall be at Dr. Irwin's expense and he shall co-operate with all elements of the Reassessment. Dr. Irwin shall abide by all recommendations made by the Assessor subject to paragraph 5(vi) below, and the results of the Reassessment will be reported to the College and may form the basis of further action by the College.
- If Dr. Irwin is of the view that any of the Assessor's recommendations are unreasonable, he will have fifteen (15) days following his receipt of the recommendations within which to provide the College with his submissions in this regard. The Inquiries Complaints and Reports ("ICR") Committee will consider those submissions and make a determination regarding whether the recommendations are reasonable, and that decision will be provided to Dr. Irwin. Following that decision Dr. Irwin will abide by those recommendations of the Assessor that the ICR Committee has determined are reasonable
- Dr. Irwin shall consent to sharing of information among the Assessor, the Clinical Supervisor and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.
- Dr. Irwin shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
- Dr. Irwin shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
- Dr. Irwin shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
- Dr. Irwin shall be responsible for any and all costs associated with implementing the terms of this Order.
- If Dr. Irwin wishes to expand his scope of practice, including to engage in general surgical practice, general family medicine and/or palliative medicine, he will follow the College's Policy on Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice, a copy of which is attached hereto as Appendix "C" [to the Order], and must receive approval to expand his scope from the College in accordance with that policy.

- Dr. Irwin attend before the panel to be reprimanded.

- Dr. Irwin pay to the College costs in the amount of $10,180.00, in accordance with a payment plan approved by the College or, in the absence of such a plan, within thirty (30) days of the date of this Order.

3. Dr. J.A.M.H. Rakem

Name:	Dr. Jamal Ali Mohamed H. Rakem
Practice:	Orthopedic Surgeon
Practice Location:	Welland
Hearing:	Contested
Finding/Written Decision Date:	May 9, 2017
Penalty Decision Date:	January 4, 2018
Penalty Written Decision Date:	July 4, 2018

Allegations and Findings

- Incompetence - **proved**
- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **proved**
- Failed to respond appropriately or within a reasonable time to a written inquiry from the College – **not proved**

Summary

Dr. Rakem practised in the Welland area as an orthopedic surgeon, in an office practice and in the local hospital, from about 2010 to 2014. He completed his medical training in Libya and practised there for ten years, beginning in 1990. Upon immigrating to Canada, he completed the orthopedic training at McMaster University and obtained his Royal College Fellowship in orthopedic surgery in 2007. Dr. Rakem has not practised in Canada since 2014. In August 2016, he resigned from the College.

Narcotic Prescribing Practices

In March 2014, the College received a complaint from a pharmacy concerning a patient's narcotic prescription written by Dr. Rakem and a narcotic prescription written for Dr. Rakem.

The College commenced a formal investigation on June 9, 2014. A College retained expert reviewed the available patient records, pharmacies' prescription records, Narcotic Monitoring System data, and OHIP billing records and reported concerns regarding five of Dr. Rakem's patient records – Patient A, C, D, E and F.

Patient A

Dr. Rakem had seen Patient A in August, 2010 after an accident. The expert noted that between March 2013 and March 2014, Dr. Rakem provided five prescriptions of long-acting narcotics to Patient A, without any clinical records to indicate ongoing assessment and review of narcotic use: there was no record of an attempt to assess Patient A's pain to justify any narcotic or appropriate alternate treatment strategies, and there was no record of evaluation of the efficacy of the narcotic treatment strategy.

Patients C, D, E, and F

Narcotic Monitoring System Records revealed that Dr. Rakem prescribed narcotics and controlled medications to Patients C, D, E, and F, while there was no record that Dr. Rakem diagnosed, assessed, or created a planned treatment evaluation for these patients or evaluated the risk of the narcotics he prescribed.

<u>Other inappropriate prescribing practices</u>

Dr. Rakem admitted that he prescribed medications to his patients and social acquaintances in social setting to 'save them a long trip to his office'. Dr. Rakem further admitted and the Committee found that he had a narcotic prescription filled for himself and had asked a colleague to write a prescription for a large amount of long-acting narcotics so he could take the medications to Libya for humanitarian use and for his mother's use.

The Committee determined that Dr. Rakem is incompetent in that:

- he demonstrated a lack of knowledge regarding the necessity to provide ongoing patient assessment in order to justify ongoing narcotic prescriptions to Patient A for four years and displayed a lack of judgement by failing to assess the harmful risk of the narcotic overdose and addiction to the patient;
- he demonstrated a lack of knowledge of the requirement to provide documentation of diagnosis, assessment, and a treatment plan for prescriptions for patients C, D, E, and F and demonstrated a lack of judgment when he prescribed narcotics to the patients without diagnosing, assessing, or creating a planned treatment and patient evaluation, or considering the risk of harm of his prescriptions;
- he demonstrated a lack of knowledge of the requirement of not prescribing in a social setting for convenience and failed to reflect or further recognize the inherent risk of diversion of the narcotics to the public;
- he demonstrated a lack of insight and poor judgment when he prescribed for himself large quantities of narcotics for humanitarian purposes and for his mother's use in a war-torn Libya without considering the risk of diversion of narcotics to the public by transporting the large quantities of narcotics;

- he failed to recognize his responsibility to be knowledgeable of the College's *Prescribing Drugs* policy and *Record Keeping* policy and the necessity of keeping his clinical record secure.

The Committee further found that Dr. Rakem failed to maintain the standard of practice of the profession in that:

- he prescribed large quantities of long-acting narcotics, including opiate-based medications, to patients without maintaining proper clinical records and without diagnosis, assessment and treatment plan, or assessment and review of narcotic use. Dr. Rakem failed to appreciate that ongoing patient assessments were necessary to prevent risks of narcotics addiction or overdose to patients;
- he submitted to the large quantity narcotic requests of the patients in a social setting for convenience and failed to appreciate that he put the patients at risk for overdose and addiction, and put the public at risk of diversion of narcotics.

Failure to Complete the Boundary Course

The Committee found that Dr. Rakem violated an order of the Discipline Committee, in that he failed to successfully complete the Boundary Course. While Dr. Rakem attended Part A of a three-part Boundary course on May 26 and 27, 2015 and received a fair to poor evaluation, he did not complete the second and third parts of the Boundary course (Parts B and C).

Dr. Rakem confirmed that he did not request an exemption to complete Parts B and C from the College's compliance monitor.

Disposition

The Committee ordered and directed that:

- The Registrar revoke Dr. Rakem's certificate of registration effective immediately.
- Dr. Rakem appear before the panel to be reprimanded.
- Dr. Rakem pay to the College its costs of this proceeding in the amount of $22,000 within thirty (30) days from the date of this Order.

4. Dr. P. K. Shuen

Name:	Dr. Paul King Shuen
Practice:	Obstetrics and Gynecology
Practice Location:	Toronto
Hearing:	Agreed Facts and Contested Penalty
Finding Decision Date:	June 12, 2018
Penalty/Written Decision Date:	June 25, 2018

Allegations and Findings

- Incompetence - **proved**
- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Shuen is an obstetrician/gynecologist with a subspecialty in gynecologic oncology. In September 2016, the College appointed investigators to review Dr. Shuen's practice, following receipt of a letter from the Hospital dated August 2016, notifying that Dr. Shuen had decided to retire from his hospital practice after meeting with hospital staff to discuss concerns relating to his practice.

Dr. Shuen's conduct leading to his resignation from the Hospital

In February 2013, the Hospital was informed that a nurse found "a powdery tablet" in a patient's vagina that looked like prostin/misoprostol, a medication used to induce uterine contractions and labour. There were no orders for this medication in the chart. Dr. Shuen denied any knowledge of it. The substance found in Dr. Shuen's patient in February 2013 was not retained for analysis.

In August, 2015, the Hospital was informed again that a nurse found a white powdery-tablet in the vagina of a patient. The substance was collected but no analysis was done at that time. Dr. Shuen denied any knowledge of the substance found in the patient's vagina. He denied ever placing any medication in the patient's vagina and stated he had never done this before. Dr. Shuen was advised by the Hospital that should the Hospital find out that Dr. Shuen had placed a medication used to induce labour in a patient's vagina in his office, especially without the patient's knowledge, that would be grounds for revocation of Dr. Shuen's privileges, and potentially "battery" if the patient was unaware. Subsequent discussions with the patient, confirmed that the patient was unaware of and did not consent to any medication being placed in her vagina. Dr. Shuen never discussed this with her.

At a department meeting in August, 2015, the Hospital reiterated to staff that using medications to induce labour in an office setting would likely result in revocation of hospital privileges. Hospital policy and practice permitted the use of misoprostol only for intrauterine demise, termination of pregnancies and treatment for post-partum hemorrhaging.

In May, 2016, a hospital incident report reflected that five of Dr. Shuen's patients arrived in triage with rapid labours. One of the patients required an immediate caesarean section. The incident report noted that there was a surge of patients with imminent deliveries on Saturday when less staff and resources are around, that this type of activity is not consistent with the practice of other members of the department, and that

due to multiple precipitous deliveries arriving after being seen in a Physician's office, questions are raised about whether induction measures are being instituted in the office, which would fall outside of best practices with respect to monitoring for patients.

Hospital investigation

In Summer 2016, one of Dr. Shuen's patients was admitted and the nurses were surprised about how quickly her labour progressed given that this was her first child. On internal examination of the patient, the nurse found white pill fragments on her glove. The Hospital commenced investigation. Disclosure was made to the patient and it was confirmed that the patient was unaware of and did not consent to any medication being placed in her vagina. Dr. Shuen never discussed this with her. A chemical analysis conducted on the substances found in Dr. Shuen's patients in 2015 and 2016 confirmed that they were misoprostol.

On August 18, 2016, during a meeting with the Hospital authorities, Dr. Shuen was confronted about his prior denials when he had been asked about powdery white substances found in his patients. Dr. Shuen was advised that the substances found in his patients in 2015 and 2016 had been analysed and were in fact misoprostol. At this meeting, Dr. Shuen again denied any knowledge of these labour inducing medications, and denied ever using them in his office. After a lengthy discussion, including about the potential for revocation of his privileges, Dr. Shuen admitted that he had been using misoprostol in his office for many years for out-patient inductions. Dr. Shuen defended this practice as safe and asserted that his outcomes were better than most of his colleagues. Dr. Shuen's active hospital staff privileges were suspended on August 18, 2016.

On August 21, 2016, in his email to the Hospital, Dr. Shuen stated that he had done a great deal of soul-searching since the meeting of August 18, and could now see the seriousness of his mistakes. He expressed remorse and took responsibility for what he had done. He indicated that he did not intend to fight the Hospital's ruling and requested the Hospital to allow him six months to care for his current load of patients. He indicated that he had always taken very good care of his patients, that his patients counted on seeing him through delivery, and that he felt that because of the current situation, which was his fault, he was letting them down. He noted that if the Hospital granted his request, he would immediately announce his retirement from Hospital work (effective, March 1, 2017) and put an immediate halt to accepting new obstetrics patients. He vowed to never again do anything to artificially induce labour without the patient's consent. By letter dated August 22, 2016, Dr. Shuen resigned his privileges at the Hospital.

College investigation

The College conducted interviews with physicians and nurses at the Hospital. All of those interviewed confirmed that they were unaware of Dr. Shuen's practice of using

misoprostol for office based inductions. An expert retained by the College reviewed Dr. Shuen's seven hospital and corresponding office charts and interviewed Dr. Shuen. The expert opined that Dr. Shuen fell below the standard of care in his practice of obstetrics by inserting an induction agent into patients who had no indication for induction, in an outpatient setting, without their knowledge or consent. During his interview with the expert, Dr. Shuen admitted, among other things, that he did not inform patients, discuss the risks, or obtain patients' consent before engaging in office-based inductions, nor did he document this practice or keep records documenting these patients' outcomes. This was despite earlier suggestions by him, which were not true, that the nurses at the Hospital who had seen his patients were aware of and had consented to this practice. He admitted to engaging in this practice for many years.

Dr. Shuen's practice was contrary to the Hospital's practice and policies, and to the SOGC Guidelines for Induction of Labour (2013 and updated in 2015).

Dr. Shuen's prior inappropriate Conduct at the Hospital

In September 2012, the Chief of Obstetrics and Gynecology spoke with Dr. Shuen about exceeding his cap on deliveries. Dr. Shuen apologized, citing financial pressure from his divorce. In January 2013, the Chief of Obstetrics and Gynecology spoke to Dr. Shuen about his inappropriate and intimidating behaviour with patients and staff. He noted that Dr. Shuen showed very little insight.

Prescribing Concerns

Information was obtained from the Shoppers Drug Mart Pharmacy located in Dr. Shuen's office building regarding medications ordered by Dr. Shuen for "office use." By letter dated May 15, 2017, Dr. Shuen confirmed that he prescribed medications "for office use" that were in fact for himself and his wife. These included sedative-hypnosis for sleep, anti-anxiety medications, antibiotics, medication for erectile dysfunction, cholesterol medication, hormone therapy, anti-depressants, dermatological cream, acne medication, mouth sore medication, thyroid medication, vaccines, and medication for stomach acid, irritable bowel syndrome, constipation, and rectal pain.

This prescribing was contrary to the College Policy on Physician Treatment of Self, Family Members, or Others Close to Them.

Disposition

The Discipline Committee ordered that:

- The Registrar revoke Dr. Shuen's certificate of registration, effective immediately.
- Dr. Shuen appear before the Committee to be reprimanded.
- Dr. Shuen pay to the College costs in the amount of $40,720.00 within 30 days of the date of this Order.

Failed to Maintain the Standard of Practice - 6 cases

1. Dr. H.M.M. Aly

Name:	Dr. Hoda Mohamed Mahmoud Aly
Practice:	Family Medicine
Practice Location:	Toronto
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	May 23, 2018
Written Decision Date:	July 4, 2018

Allegations and Findings

- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **proved**
- Incompetence - **withdrawn**

Summary

Dr. Dr. Aly is a family physician who received her certificate of registration authorizing independent practice in September 2011 after completing her residency at the University of Toronto and obtaining her certification by the College of Family Physicians of Canada. At all relevant times, she was practising at the Don Mills Family Health Team (the Clinic) in Toronto.

In August 2016, following the receipt of information of concern from York Regional Police regarding the arrest of an individual who was wrongfully in possession of Fentanyl that had been prescribed by Dr. Aly to a patient (Patient C as discussed below), College investigators were appointed. Prescribing data obtained from the Narcotics Monitoring System ("NMS") for the time period January 1, 2015 to August 25, 2016 indicated that narcotics prescribing was not a large part of Dr. Aly's practice. The data showed 161 prescriptions filled by 35 unique patients during that time period, including 17 prescriptions for Fentanyl, prescribed to four patients.

An expert retained by the College reviewed Dr. Aly's care in respect of the four patients to whom she prescribed Fentanyl during the time period in question and two of whom were Dr. Aly's close personal relatives. According to the expert, Dr. Aly failed to maintain the standard of practice of the profession in her care of all four patients, her care for those patients displayed a lack of knowledge, skill or judgment, and her narcotics prescribing practice would pose a risk of harm to other patients in her practice.

Patient A

Dr. Aly became Patient A's family physician in 2012. Patient A had a number of health issues, including obesity, difficult mobility, and chronic back pain. She had been escalating use of Tylenol #2 obtained from a friend as well as extra strength Tylenol. She reported these medications to be insufficient for her pain. She was seen in the Emergency Department by another physician at one point and was given morphine, but was unable to tolerate it. She was also given Percocet and experienced nausea, vomiting, and difficult urination. Dr. Aly prescribed a trial of Fentanyl 100 microgram patches to Patient A in January 2016, noting "I gave her enough patches and instructed her to apply them [every] 48-72 hrs on an area where she doesn't sweat." A few weeks later the patient advised Dr. Aly that she did not want the patches and would not get them again.

Dr. Aly's prescribing of narcotics to Patient A did not meet the standard of practice of the profession. She did not demonstrate an awareness of how to titrate narcotics safely and progressively, and instead started Fentanyl at a maximum dose without appropriate use of an opioid analgesic conversion. When interviewed by the expert, Dr. Aly indicated that she knew that there were opioid conversion guidelines, but that because she did not prescribe narcotics often, she did not know at the time how to do the conversion and had made a mistaken estimate. Nor did Dr. Aly have Patient A sign an opioid contract.

Patient B

Dr. Aly was Patient B's family physician from October 2014 to March 2015. Patient B had osteoarthritis, scoliosis, peptic ulcer disease, hypothyroidism, hypercholesterolemia, and migraines. Patient B had been receiving Oxycodone and Fentanyl, as well as Tylenol #3 for over 20 years and was aware that she was dependent on them, though she advised Dr. Aly that she did not escalate or take more than the prescribed dose, or "double doctor." Patient B also had been taking a benzodiazepine. Dr. Aly had Patient B sign an opioid contract in November 2014 and continued to prescribe 200 micrograms of Fentanyl per day to Patient B, as well as Oxycodone and a benzodiazepine. However, in March 2015 Dr. Aly terminated the doctor-patient relationship, noting in the patient chart that the patient was reluctant to follow medical advice and insisted on receiving narcotics rather than exploring other remedies for chronic pain. Dr. Aly noted in the chart that the patient would return to her previous physician.

Dr. Aly's care of Patient B did not meet the standard of practice of the profession. She prescribed high doses of narcotics and did not seek to wean the patient gradually from her dependency. She also failed to monitor the patient consistently, particularly by way of urine drug screening.

Patient C

Patient C was Dr. Aly's close personal relative. Patient C had a number of serious comorbidities. Dr. Aly acted as Patient C's family physician from 2012 until early 2016, including prescribing Fentanyl to Patient C and writing Patient C notes excusing Patient C from school and from attending court due to illness. She did not bill the Ontario Health Insurance Plan for this care, which was primarily provided in Patient C's home.

Patient C had been prescribed morphine and hydromorphone in the past. Dr. Aly first prescribed Fentanyl to Patient C in August 2014 in response to Patient C's complaint of pain associated with surgery. Dr. Aly continued to prescribe Fentanyl to Patient C on occasion.

Dr. Aly's care of Patient C did not meet the standard of practice of the profession. She did not demonstrate an awareness of how to titrate narcotics safely and progressively, nor did she use an opioid contract for Patient C. She demonstrated a significant lapse in judgment in acting as her close personal relative's family physician and in prescribing Patient C narcotics. Dr. Aly stated in her interview with the expert that the reason she did not have Patient C sign an opioid contract was that she was not objective because Patient C was her close personal relative.

The College's *Policy on Treating Self and Family Members* provides, among other things, that physicians should not treat their family members except for minor conditions or in an emergency situation, and only when other qualified health professionals are not readily available. Where it is necessary to treat themselves or family members, physicians must transfer care to another qualified health professional as soon as is practical. Dr. Aly was aware of this policy while she was engaging in the conduct above, and was aware that her conduct contravened the policy. Dr. Aly stated that she felt "pressure" from her family and felt "emotionally involved."

Patient D

Patient D is Dr. Aly's close personal relative. Patient D had a number of serious comorbidities. While Patient D was registered to another family physician from 2008 onwards, Dr. Aly stated in her interview with the expert that Patient D had only seen that physician once and not returned. Instead, Patient D received primary care from Dr. Aly, beginning in approximately November 2013. This included prescribing Gabapentin, Oxycontin, and, beginning in December 2014, 100 microgram patches of Fentanyl. The care was provided in Patient D's home. Dr. Aly stated that she told Patient D she was not allowed to provide treatment to Patient D, but felt emotional pressure because Patient D wanted to be treated by her and not to travel for care. Dr. Aly did not bill the Ontario Health Insurance Plan for care provided to Patient D.

Dr. Aly failed to have Patient D sign an opioid contract. When initiating Patient D on Fentanyl, she did not have the requisite knowledge to titrate the dose appropriately and instead relied on advice from another relative who was a pharmacist. Dr. Aly states that she then looked up the dose and thought it was "pretty high" and should go down, but her pharmacist relative said that it was appropriate and the dose that "most doctors" would give. Dr. Aly demonstrated a significant lapse in judgement in treating her close personal relative as a primary care physician for several years and in prescribing narcotics to her close personal relative, and failed to meet the standard of practice of the profession in this regard.

Summary

Dr. Aly' s care of the patients noted above did not meet the standard of practice of the profession:

- Dr. Aly's prescribing was not in keeping with the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (2010);
- Dr. Aly did not demonstrate an awareness of how to titrate narcotics safely and progressively;
- Dr. Aly did not use an opioid contract with three of the four patients;
- Dr. Aly used Fentanyl, a potent drug, in high doses with non-compliant patients who were refusing to participate in chronic pain clinics or follow up with chronic pain specialists, in an attempt to reduce their pain;
- Dr. Aly prescribed narcotics to and acted as a primary care provider for two close personal relatives for years despite being aware of the College policy on the topic and despite her relationship with them affecting her objectivity;
- Dr. Aly did not consistently initiate referrals for her patients on high dose opioid therapy to a chronic pain specialist;
- Dr. Aly relied on a relative who is a pharmacist to guide her as to dosages and approach in prescribing potent narcotics such as Fentanyl, rather than familiarizing herself with the appropriate prescribing and monitoring practices.

Disposition

The Discipline Committee ordered that:

- the Registrar suspend Dr. Aly’s certificate of registration for a period of four (4) months, effective immediately.
- the Registrar impose the following terms, conditions and limitations on Dr. Aly’s certificate of registration:

  Prescribing Log

  - Dr. Aly shall keep a log of prescriptions (“Prescribing Log”) until such time as the College has conducted the reassessment described below and has deemed it successfully completed. The Prescribing Log will include all prescriptions for:

  - Narcotic Drugs (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19);
  - Narcotic Preparations (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19);
  - Controlled Drugs (from Schedule G of the Regulations under the *Food and Drugs Act,* S.C., 1985, c. F-27);
  - Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act.,* S.C., 1996, c. 19);
  - (A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached as Schedule "A" to the Order; and the current regulatory lists are attached as Schedule "B" to the Order)
  - All other Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act*, *2010,* S.O. 2010, c. 22 as noted in Schedule "C" of the Order).
- The Prescribing Log shall be in the form set out at Schedule "D" of the Order, which will include at least the following information:
  - the date of the prescription;
  - patient identifier;
  - the medication, dose, direction, number of tablets to be dispensed and frequency (if applicable);
  - the clinical indication for use;
  - whether it is a new prescription; and
  - physician initials.

<u>Education</u>

- Dr. Aly shall, at her own expense, participate in and successfully complete individualized instruction in medical ethics, in accordance with the Individualized Education Plan set out at Schedule "E" of the Order, to the satisfaction of the College. Dr. Aly will initiate contact with the instructor within one (1) month of the date of this Order. Dr. Aly will provide proof of successful completion within six (6) months of the date of this Order. The instruction will involve one-on-one sessions with a College-approved instructor ("the Instructor"), incorporating principles of guided reflection, tailored feedback, and other modalities customized to the specific needs of Dr. Aly as assessed by the Instructor. The Instructor will report to the College regarding Dr. Aly's progress and compliance.

<u>Clinical Supervision</u>

- Prior to resuming practice following the suspension of her certificate of registration described in the paragraph above, Dr. Aly shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor") with

respect to her prescribing of narcotics and controlled substances, who will sign an undertaking in the form attached as Schedule "F" to the Order.
- Dr. Aly shall practice under the guidance of the Supervisor for a period of nine (9) months ("Clinical Supervision").
- Clinical Supervision of Dr. Aly's prescribing of narcotics and controlled substances shall contain the following elements:

Moderate-Level Supervision

- For an initial period of two (2) months, the Clinical Supervisor will engage in a period of moderate-level supervision, during which time the Clinical Supervisor will meet with Dr. Aly every two weeks and will at minimum:
  - review charts and prescriptions for twenty (20) of Dr. Aly's patients, to be selected from the Prescribing Log at the sole discretion of the Clinical Supervisor. If the Prescribing Log contains fewer than twenty (20) patients, the Clinical Supervisor shall review all charts and prescriptions contained in the Prescribing Log. The review shall include charts and prescriptions for all patients to whom Dr. Aly initiated a new prescription for a Narcotic Drug, Narcotic Preparation, Controlled Drug, Benzodiazepine and Other Targeted Substance or other Monitored Drug since the Clinical Supervisor's prior review;
  - evaluate whether the assessment, clinical examination, risk assessment for addiction and on-going management and follow up is appropriate in all cases reviewed;
  - discuss with Dr. Aly any concerns the Clinical Supervisor may have regarding assessment, clinical examination, risk assessment for addiction and on-going management and follow up, and make recommendations for improvement; and
  - submit written reports to the College at least once every two weeks, or more frequently if the Clinical Supervisor has concerns about Dr. Aly's prescribing practices.
- After two (2) months, and only upon recommendation by the Clinical Supervisor and approval of the College, the Clinical Supervision may be reduced to a low level for the remaining seven (7) months.

Low-Level Supervision

- If the transition is recommended by the Clinical Supervisor and approved by the College, for a period of a further seven (7) months, the Clinical Supervisor will engage in a period of low-level supervision, during which time the Clinical Supervisor will meet with Dr. Aly on a monthly basis and will, at minimum:
  - review charts and prescriptions for fifteen (15) of Dr. Aly's patients, to be selected from the Prescribing Log at the sole discretion of the Clinical Supervisor. If the Prescribing Log contains fewer than fifteen (15) patients, the Clinical Supervisor shall review all charts and prescriptions

contained in the Prescribing Log. The review shall include charts and prescriptions for all patients to whom Dr. Aly initiated a new prescription for a Narcotic Drug, Narcotic Preparation, Controlled Drug, Benzodiazepine and Other Targeted Substance or other Monitored Drug since the Clinical Supervisor's prior review;
- evaluate whether the assessment, clinical examination, risk assessment for addiction and on-going management and follow up is appropriate in all cases reviewed;
- discuss with Dr. Aly any concerns the Clinical Supervisor may have regarding assessment, clinical examination, risk assessment for addiction and on-going management and follow up, and make recommendations for improvement; and
- submit written reports to the College at least once every month, or more frequently if the Clinical Supervisor has concerns about Dr. Aly's prescribing practices.

Other Elements of Clinical Supervision

- Throughout the period of Clinical Supervision, Dr. Aly shall abide by all recommendations of her Clinical Supervisor.
- If a person who has given an undertaking in Schedule "F" to the Order is unable or unwilling to continue to fulfill its provisions, Dr. Aly shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.
- If Dr. Aly is unable to obtain a Clinical Supervisor as set out in this Order, she will cease prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and other Monitored Drugs until such time as she has obtained a Clinical Supervisor acceptable to the College.
- If Dr. Aly is required to cease prescribing as a result of the paragraph above, this will constitute a term, condition or limitation on her certificate of registration and that term, condition or limitation will be included on the public register until such time as she has obtained a Clinical Supervisor acceptable to the College.

Reassessment of Practice

- Approximately nine (9) months after the completion of the Education and Clinical Supervision, Dr. Aly shall undergo a reassessment of her practice by a College-appointed assessor or assessors (the "Assessor"). The Assessor shall report the results of the reassessment to the College.
- The reassessment may include (at the College's discretion) a review of a minimum of twenty (20) of Dr. Aly's patient charts, direct observation of Dr. Aly's practice, an interview with Dr. Aly, interviews with colleagues and co-

workers, and any other tools deemed necessary by the College. Dr. Aly shall abide by all recommendations made by the Assessor.
- Dr. Aly shall consent to the sharing of information among the Assessor, the Clinical Supervisor, the Instructor, and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

Monitoring

- Dr. Aly shall inform the College of each and every location where she practices, in any jurisdiction (her "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
- Dr. Aly shall cooperate with unannounced inspections of her practice location(s) and patient charts and to any other activity the College deems necessary in order to monitor her compliance with the provisions of this Order.
- Dr. Aly shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan, the Narcotics Monitoring System and/or any person or institution that may have relevant information, in order for the College to monitor and enforce her compliance with the terms of this Order.
- Dr. Aly shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Aly attend before the panel to be reprimanded.
- Dr. Aly pay costs to the College in the amount of $10,180.00 within thirty (30) days from the date this Order.

2. Dr. R.S. Cameron

Name:	Dr. Robert Stewart Cameron
Practice:	Family Medicine
Practice Location:	Windsor
Hearing:	Agreed Facts and Joint Submission on Penalty Contested Costs
Finding/Penalty Decision Date:	March 26, 2018
Written Decision Date:	May 28, 2018

Allegations and Findings

- Failed to maintain the standard of practice of the profession – **proved**
- Incompetence – **withdrawn**

Summary

Dr. Cameron is a 65-year-old general physician who received his certificate of registration authorizing independent practice in 1978. At the relevant time, Dr. Cameron practised at a walk-in clinic in Windsor, Ontario.

Information from the Narcotics Monitoring System

In July 2016, the College received information from the Ministry of Health and Long-Term Care's Narcotics Monitoring System regarding Dr. Cameron's prescribing of controlled drugs, including narcotics, from January 1, 2015 to December 31, 2015 (the "NMS data"). The NMS data indicated that Dr. Cameron had been identified as a physician who, in 2015, prescribed eight or more patients at least 650 oral morphine equivalents per day and issued at least one prescription exceeding 20,000 oral morphine equivalents.

Investigation of Dr. Cameron's Practice

The College retained an expert, a family physician, to opine on Dr. Cameron's prescribing of controlled drugs including narcotics. The expert reviewed 24 charts, the NMS data, and interviewed Dr. Cameron. At the request of the College, the expert provided an addendum report to the College, containing individual patient reports of the charts he reviewed. The expert opined that Dr. Cameron's care of his patients fell below the standard of practice of the profession in 18 of 24 charts and that Dr. Cameron's care in 16 of 24 charts placed his patients at a risk of harm. In particular, the expert noted that:

- Dr. Cameron had a tendency to prescribe narcotics at doses well in excess of those recommended in the relevant clinical guidelines, for chronic pain, over many years, with few physical exams or other evaluations of the patient's pain or function;
- Dr. Cameron demonstrated questionable and at times very poor judgment in continuing to prescribe large doses of narcotics to patients who had repeatedly demonstrated aberrant behaviour, often at appointments over a period of years, and was too accepting of patients' often questionable explanations for lost, stolen or damaged narcotics;
- Dr. Cameron failed to regularly conduct opioid risk assessments, implement narcotics contracts and/or conduct urine drug screening to address repeated aberrant behaviour;
- In respect of at least six patients, Dr. Cameron failed to refer patients to specialists, including pain and/or addiction specialists, where indicated;
- In respect of at least seven patients, Dr. Cameron failed to react to information from third parties about potential opioid abuse or to follow the advice of consultants who suggested decreasing or discontinuing opioid medications;
- Dr. Cameron continued to prescribe high doses of narcotics to patients who may have sustained accidents or injuries due to these prescriptions;

- Dr. Cameron prescribed benzodiazepines to patients to whom he was also prescribing high doses of narcotics;
- In respect of at least four patients, Dr. Cameron regularly prescribed narcotics to patients also prescribed methadone for addiction without appropriate consultation with the methadone prescriber.

Undertaking

On March 9, 2018, Dr. Cameron has entered into an undertaking with the College, whereby he undertook to resign from the College, effective April 30, 2018 and not to apply or re-apply for registration as a physician to practise medicine in Ontario or any other jurisdiction after the effective date.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar impose the terms of the Inquiries, Complaints and Reports Committee's Order dated June 27, 2017 made pursuant to section 25.4(1) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act*, *1991* (attached as Appendix "B" to the Order) as terms, conditions and limitations on Dr. Cameron's certificate of registration.
- Dr. Cameron attend before the panel to be reprimanded.
- Dr. Cameron pay costs to the College in the amount of $10,180.00 within 60 days of the date this Order becomes final.

3. Dr. Y. Garcia

Name:	Dr. Yelian Garcia
Practice:	Family Medicine
Practice Location:	Greater Toronto Area
Hearing:	Allegation 1 Agreed Facts Contested Allegation 2 Joint Submission on Penalty Contested Costs
Finding/Written Decision Date:	February 15, 2017
Penalty Decision Date:	January 24, 2018
Penalty Written Decision Date:	July 11, 2018

Allegations and Findings

- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **proved**
- Incompetence **– withdrawn**

Summary

Failing to Maintain the Standard of Practice

After graduating from medical school and completing a residency program through McMaster University, Dr. Garcia practised under a restricted certificate of registration between August 18, 2011 and January 12, 2012. During this time, he practised family medicine under the supervision of a physician at Wellington Medical Centre in Aurora, and under the supervision of a second physician at Oak Ridges Medical and Urgent Care Centre in Richmond Hill.

Dr. Garcia obtained his certificate of registration authorizing independent practice in January of 2012. Dr. Garcia continued to provide family medicine and walk-in services at Wellington Medical Centre and urgent care services at Oak Ridges Urgent Care Centre. He also began providing urgent care and walk-in services at One Care Medical Clinic in Scarborough and Woodbridge Urgent Care Centre in Woodbridge, as well as providing medical care to patients at three long-term/residential care facilities.

According to Dr. Garcia, he was seeing on average 10 to 13 patients per hour at the Wellington Medical Centre in 2012. Because of this, Dr. Garcia would chart pertinent information during patient encounters and complete 50 to 70% of his charts at the end of the day. Dr. Garcia tried to be as efficient as possible while ensuring an evidence-based practice. He conducted some patient examinations and assessments very quickly in 2012.

There was a pharmacy located in the same premises as the Wellington Medical Centre. In the summer of 2012, a pharmacist at the pharmacy expressed concern about Dr. Garcia's narcotic prescribing practices to both Dr. Garcia and the physician who had supervised him at Wellington Medical Centre ("the supervising physician").

In the late summer and fall of 2012, the supervising physician reviewed the charts for most of the approximately dozen patients to whom Dr. Garcia was prescribing narcotics or opioids at the Wellington Medical Centre, met with several of these patients, along with Dr. Garcia, and conducted an assessment of each patient's pain and the appropriateness of the narcotics prescriptions given by Dr. Garcia. Following this process, several patients seen together by the supervising physician and Dr. Garcia were referred to a pain clinic, specialist or detoxification program.

In May 2013, the supervising physician contacted the College to report his concerns about the medical care provided by Dr. Garcia.

Following receipt of this information, the College began an investigation into Dr. Garcia's practice. The College obtained medical records with respect to 36 patients. Review by a medical inspector retained by the College concluded that Dr. Garcia

provided very fine medical care to some patients and that Dr. Garcia failed to maintain the standard of practice of the profession in his care of other patients.

Dr. Garcia acknowledged during the College investigation that he should slow down in terms of the manner in which he assessed and communicated with patients. Dr. Garcia also stated that his practice had changed since 2012 and early 2013, and that he had tried to slow down his patient interactions and communicate more effectively with patients. Dr. Garcia acknowledged during the College investigation that he was "duped" by a couple of patients who were engaged in drug-seeking behaviour and that he was too trusting of patients who were seeking narcotics for pain medication. At that time, Dr. Garcia also stated that he had learned to be less trusting of patients and that he no longer had patients with chronic pain in his family practice.

Dr. Garcia failed to maintain the standard of practice of the profession with respect to eleven patients. The deficiencies noted included:

- not obtaining an adequate history or doing a proper physical examination of a patient who complained of "chronic pain";
- for several patients, not recording any physical examination and not recording details about the source or type of pain they experienced;
- prescribing narcotics to pain patients without taking a proper and full history and without doing any physical examination;
- early renewal of narcotic prescriptions without a notation in the chart to explain why the medication was renewed early;
- regarding one patient who was given a typhoid immunization, Dr. Garcia made no notes of this appointment in the chart and no record was kept of the drug identification number or lot number for the vaccine given.
- regarding one patient, Dr. Garcia's charting was moderately below standard. Dr. Garcia's typed note for a visit incorrectly indicated he gave the patient a typhoid shot, although his handwritten note correctly indicated that he gave patient N an allergy shot on that date.

The medical inspector expressed concern that Dr. Garcia's general patient population was put at risk because of his willingness to prescribe narcotics and repeated inability to detect the misuse of opioid medication.

<u>Disgraceful, Dishonourable or Unprofessional Conduct</u>

The Committee also found that Dr. Garcia 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.

First, the Committee found that Dr. Garcia prescribed medications and provided a medical service to Ms. A, a woman who was not a patient and with whom he had a personal and romantic relationship. Dr. Garcia prescribed medications to Ms. A on three

occasions. On one of those occasions, he prescribed an IUD and referred Ms. A to a gynecologist to perform the IUD insertion. There was no record of an assessment, including a history and physical examination, prior to providing any of the prescriptions.

The policy statement on Treating Self and Family Members clearly states when it is permissible to treat a family member or another individual whom the physician has a personal or emotional involvement. As stated in the Policy: "Physicians should not treat either themselves or family members, except for a minor condition or in an emergency situation and when another qualified healthcare professional is not readily available."

These conditions were not present on the occasions when Dr. Garcia chose to prescribe medications, an IUD and provide a medical service to Ms. A. When a physician treats someone with whom they have a personal/emotional relationship, there is a risk that the relationship will affect the doctor's ability to provide quality care. Further, as Ms. A's romantic partner, Dr. Garcia placed himself in a conflict of interest by providing Ms. A with a prescription and a referral for insertion of an IUD for birth control.

Second, during Ms. A's hospitalization, Dr. Garcia used his professional status as a physician in an attempt to persuade or pressure a nurse to provide confidential information in regard to Ms. A without her consent, despite the fact that he, as a physician, had full knowledge that he was not entitled to that information.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Garcia's Certificate of Registration for a period of eight (8) months, to commence at 12:01 a.m. on February 7, 2018.
- the Registrar impose the following terms, conditions and limitations on Dr. Garcia's Certificate of Registration:

Restriction

- Dr. Garcia shall have clinical interactions with no more than a total of forty-eight (48) patients per day, at a rate of no more than six (6) patients per hour within each hour;

Patient Log

- At each of his Practice Locations, Dr. Garcia shall maintain an up-to-date daily log of every patient with whom he has a clinical interaction, which shall include the patient's name, the date, and the hour within which the clinical interaction occurred ("Patient Log"). Dr. Garcia shall maintain the original Patient Log and shall send a

copy to the College at the end of every calendar month;
- At its sole discretion, the College may require Dr. Garcia to implement other measures to ensure the accuracy of the Patient Log, including but not limited to requiring him to have the Patient Log reviewed and/or approved by a person or persons approved by the College;

Prescribing Log

- Dr. Garcia shall keep a log of all prescriptions (the "Prescribing Log") for:
  - *Narcotic Drugs* (from the Narcotic Control Regulations made under the Controlled Drugs and Substances Act, S.C., 1996, c. 19, as amended from time to time);
  - *Narcotic Preparations* (from the Narcotic Control Regulations made under the Controlled Drugs and Substances Act, S.C., 1996, c. 19, as amended from time to time);
  - *Controlled Drugs* (from Part G of the Food and Drug Regulations under the Food and Drugs Act, S.C., 1985, c. F-27, as amended from time to time);
  - *Benzodiazepines and Other Targeted Substances* (from the Benzodiazepines and Other Targeted Substances Regulations made under the Controlled Drugs and Substances Act., S.C., 1996, c. 19, as amended from time to time);

  (A current summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached hereto as Schedule "A"; and the current regulatory lists are attached as Schedule "B" to the Order)
  - *All other Monitored Drugs* (as defined under the Narcotics Safety and Awareness Act, 2010, S.O. 2010, c. 22 as noted in Schedule "C" [to the Order] and as amended from time to time);
- The Prescribing Log shall be in the form set out at Schedule "D" [to the Order], which will include at least the following information:
  - the date of the prescription;
  - the name of the patient with chart / file number;
  - the medication, dose, direction, number of tablets to be dispensed and frequency (if applicable);
  - the clinical indication for use;
  - whether it is a new prescription; and
  - physician initials.
- Dr. Garcia shall keep a copy of all prescriptions written for all Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines/Other Targeted Substances and all other Monitored Drugs, in the corresponding patient chart.

Instruction in Medical Ethics

- At his own expense, Dr. Garcia shall participate in and successfully complete individualized instruction in ethics approved by the College, at the instructor's

earliest availability. Dr. Garcia will provide proof of successful completion within three (3) weeks of completing the instruction. The instruction will involve one-on-one sessions with a College-approved instructor, incorporating principles of guided reflection, tailored feedback, and other modalities customized to the specific needs of Dr. Garcia as assessed by the instructor. The instructor will report to the College regarding Dr. Garcia's progress and compliance.

Instruction in Maintaining Boundaries

- At his own expense, Dr. Garcia shall participate in and successfully complete the next available course on "Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship" offered by Western University, or an equivalent program acceptable to the College, and shall forthwith thereafter provide proof of completion thereof to the College.

Clinical Supervision

- Prior to resuming practice following the suspension of his certificate of registration described above in paragraph 2, Dr. Garcia shall retain, at his own expense, a clinical supervisor or supervisors (the "Clinical Supervisor") acceptable to the College, who will sign an undertaking in the form attached as Schedule "E" to the Order;
- For a period of twelve (12) months, commencing as of the date Dr. Garcia resumes practice following the suspension of his certificate of registration described above in paragraph 2, Dr. Garcia may practice only under the supervision of the Clinical Supervisor ("Clinical Supervision"). Clinical Supervision of Dr. Garcia's practice shall contain the following elements:

  Chart Review:

  - All charts reviewed shall be independently selected by the Clinical Supervisor without the participation of Dr. Garcia.

  Phase 1 of Chart Review
  - For a minimum of two (2) months, Dr. Garcia and the Clinical Supervisor will meet at least once every week to discuss the Clinical Supervisor's review of the elements set out in (v), below.
  - After a minimum of two (2) months of *Phase 1 of Chart Review*, if the Clinical Supervisor is satisfied that Dr. Garcia has the necessary knowledge, skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that the chart review component of supervision be reduced.

Phase 2 of Chart Review

- Upon the recommendation of the Clinical Supervisor and approval of the College, the chart review component of clinical supervision will be reduced. Dr. Garcia and the Clinical Supervisor will continue to meet at least once every month to discuss the Clinical Supervisor's review of the elements set out in (v) below.

Elements of Chart Review

- At each meeting described in (ii) and (iv) above, Dr. Garcia and the Clinical Supervisor will discuss the Clinical Supervisor's review of:
  - The Prescribing Log;
  - 20 charts, selected as follows:
    - 5 charts selected from Dr. Garcia's clinic practice;
    - 5 charts selected from Dr. Garcia's long-term care/retirement home practice; and
    - 10 charts of patients to whom Dr. Garcia has prescribed Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs since the Clinical Supervisor's prior review; or
    - If there are fewer than 10 patients listed in the Prescribing Log to whom Dr. Garcia has prescribed Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs since the Clinical Supervisor's prior review, then the charts of all patients listed in the Prescribing Log and additional charts selected from both Dr. Garcia's clinic and long-term care/retirement home practices, resulting in a total of 10 charts.
    - The chart of every patient to whom Dr. Garcia has issued a new prescription for a Narcotic Drug, Narcotic Preparation, Controlled Drug, Benzodiazepine and Other Targeted Substance or other Monitored Drug since the Supervisor's prior review.

Direct Observation

Phase 1 of Direct Observation

- For a minimum of one (1) month, the Clinical Supervisor shall directly observe Dr. Garcia in practice for ½ day (3.5 hours) at least once per week;
- During *Phase 1 of Direct Observation*, the Clinical Supervisor's observation of Dr. Garcia's practice shall rotate between Dr. Garcia's clinical practice and his long-term care/retirement home practice;
- For greater clarity, during *Phase 1 of Direct Observation*, the Clinical Supervisor shall observe Dr. Garcia in practice at least twice in his clinic setting and at least twice in his long-term care/retirement home practice;
- After a minimum of one (1) month of *Phase 1 of Direct Observation*, if the Clinical Supervisor is satisfied that Dr. Garcia has the necessary knowledge,

skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that the direct observation component of supervision be reduced;

Phase 2 of Direct Observation

- Upon the recommendation of the Clinical Supervisor and approval of the College, the direct observation component of Clinical Supervision will be reduced and will take place on the following terms: For a minimum of two (2) months, the Clinical Supervisor shall directly observe Dr. Garcia in practice for ½ day (3.5 hours) at least once per month in Dr. Garcia's clinic practice and at least once per month in his long-term care/retirement home practice;
- After a minimum of two (2) months of *Phase 2 of Direct Observation*, if the Clinical Supervisor is satisfied that Dr. Garcia has the necessary knowledge, skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that the direct observation component of supervision be reduced;

Phase 3 of Direct Observation

- Upon the recommendation of the Clinical Supervisor and approval of the College, the direct observation component of Clinical Supervision will be reduced and will take place on the following terms: For the remainder of the Clinical Supervision, the Clinical Supervisor shall directly observe Dr. Garcia in practice for ½ day (3.5 hours) at least once every three (3) months in Dr. Garcia's clinic practice and at least once every three (3) months in his long-term care/retirement home practice;

Meetings

- As set out above in (ii) and (iv), Dr. Garcia and the Clinical Supervisor will meet at least once every week, for a minimum of two (2) months, and at least once every month thereafter. In addition to the elements of chart review described above, meetings will include the following:
  - Prior to meeting with the Clinical Supervisor, Dr. Garcia shall provide the Clinical Supervisor with the audit trail for each patient whose chart is to be reviewed at that meeting, if the chart is maintained in an Electronic Medical Record;
  - The Clinical Supervisor shall discuss with Dr. Garcia any concerns the Supervisor may have arising from the direct observations or review of charts, Prescribing Log or audit trail;
  - The Clinical Supervisor shall make recommendations to Dr. Garcia for practice improvements and shall follow up on same;
  - The Clinical Supervisor shall make recommendations to Dr. Garcia for ongoing professional development and inquire of Dr. Garcia to determine compliance with same;

- Dr. Garcia shall review and discuss with the Clinical Supervisor the educational resources and College policies set out below in section (k); and
- Any other activities which the Clinical Supervisor deems necessary to Dr. Garcia's Clinical Supervision.

Reporting

- The Clinical Supervisor will keep a log of all patient charts reviewed along with patient identifiers; and
- The Clinical Supervisor will provide reports to the College:
  - At least once every two (2) weeks for the first two (2) months;
  - If the Clinical Supervisor so recommends and subject to the approval of the College, at least once every month thereafter; or
  - More frequently if the Clinical Supervisor has concerns about Dr. Garcia's standard of practice or conduct.
- Dr. Garcia will review and discuss with his Supervisor the following resources:
  - CPSO Policy "Prescribing Drugs": http://www.cpso.on.ca/Policies-Publications/Policy/Prescribing-Drugs;
  - 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain: http://nationalpaincentre.mcmaster.ca/guidelines.html;
  - CMPA advice regarding preventing the misuse of opioids: https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2015/preventing-the-misuse-of-opioids;
  - the Centre for Effective Practice Management of Chronic Non-Cancer Pain Tool: https://thewellhealth.ca/cncp
  - CPSO Policy "Medical Records": http://www.cpso.on.ca/Policies-Publications/Policy/Medical-Records;
  - CPSO Policy "Maintaining Appropriate Boundaries": http://www.cpso.on.ca/Policies-Publications/Policy/Maintaining-Appropriate-Boundaries-and-Preventing
- Dr. Garcia shall abide by the recommendations of the Clinical Supervisor;
- If a Clinical Supervisor who has given an undertaking as set out in Schedule "E" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Garcia shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a person who is acceptable to the College and ensure that it is delivered to the College within that time;
- If Dr. Garcia is unable to obtain a Clinical Supervisor in accordance with this Order, he shall cease to practice until such time as he has done so;
- Dr. Garcia shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and Dr. Garcia's compliance with this Order;

- Dr. Garcia shall consent to the Clinical Supervisor and/or the College making inquiries of any staff/employees at any of his practice locations in relation to any of the terms of this Order and any aspect of the Clinical Supervision, and shall consent to staff/employees providing information and/or documentation to the Clinical Supervisor and the College, including but not limited to information regarding Dr. Garcia's charting practices;

Assessment

- Approximately twelve (12) months after the completion of the period of supervision as set out above, Dr. Garcia shall undergo an assessment of his practice (the "Assessment") by a College-appointed assessor (the "Assessor(s)"). The Assessor(s) shall report the results of the Assessment to the College;
- The Assessment shall include both Dr. Garcia's clinic and long-term care/retirement home practices. The Assessment may include chart reviews, direct observation of Dr. Garcia's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. Dr. Garcia shall abide by all recommendations made by the Assessor(s), and the results of the Assessment will be reported to the College and may form the basis of further action by the College;
- Dr. Garcia shall consent to the disclosure to the Assessor(s) of the reports of the Clinical Supervisor arising from the supervision, and shall consent to the sharing of all information between the Clinical Supervisor, the Assessor(s) and the College, as the College deems necessary or desirable;

Other

- Dr. Garcia shall comply with the College Policy on Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation in respect of his period of suspension, a copy of which forms Schedule "F" to this Order;
- Dr. Garcia shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and again prior to resuming practice following the suspension of his certificate of registration described above in paragraph 2, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location, until the report of the Assessment has been provided to the College;
- Dr. Garcia shall co-operate unannounced inspections of his Practice Location(s) and patient charts and to any other activity the College deems necessary for the purpose of monitoring and enforcing his compliance with the terms of this Order and shall provide his irrevocable consent to the College to make appropriate enquiries of any person or institution who may

have relevant information for the purposes of monitoring and enforcing his compliance with the terms of this Order;
- Dr. Garcia shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan, the Narcotics Monitoring System and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with this Order;
- Dr. Garcia shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Garcia appear before the Committee to be reprimanded.
- Dr. Garcia pay to the College costs in the amount of $49,000.00 within 45 days of the date of this Order.

4. Dr. S.C. Huebel

Name:	Dr. Stephen Charles Huebel
Practice:	Emergency Medicine
Practice Location:	Scarborough
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	June 7, 2018
Written Decision Date:	August 3, 2018

Allegations and Findings

- Failed to maintain the standard of practice of the profession – **proved**
- Incompetence – **withdrawn**

Summary

Dr. Huebel failed to maintain the standard of practice of the profession in his care and treatment of patients in the seven cases described below. He also consistently failed to maintain the standard of practice of the profession in his documentation and charting, as demonstrated in 12 cases reviewed by the College.

At the relevant times, Dr. Huebel practised emergency medicine at the Hospital. As a result of his certificate of registration being subject to interim terms and conditions since May 3, 2017, Dr. Huebel has not practised since July 31, 2017.

<u>Patient A</u>

In October 2016, the College received a complaint from Patient A's family member regarding Dr. Huebel's care of Patient A, who was a teenager at the time. Dr. Huebel attended to Patient A when she presented to the Hospital emergency department with

shortness of breath. It was documented at triage that she also had a grossly elevated heart rate of 148. Dr. Huebel diagnosed her with an upper respiratory tract infection and discharged her home with a Flovent™ inhaler. Patient A was returned to the emergency department on the following day with a decreased level of consciousness and was diagnosed with acute severe Diabetic Ketoacidosis (DKA).

An emergency medicine expert retained by the College opined that Dr. Huebel's care of Patient A fell below the standard of practice, in that:

- Dr. Huebel's charting is mostly illegible, with minimal history and physical exam documented. The standard of practice was not met in both the legibility and content of his charting;
- Dr. Huebel should have recognized, assessed and addressed Patient A's grossly elevated heart rate. Even at the peak of flu season with upper respiratory tract infections being at the top of his differential diagnoses, Dr. Huebel should have recognized that this heart rate was out of keeping with his diagnosis and treatment plan for Patient A;
- Given patient A's high heart rate, Dr. Huebel should not have ordered medications that further elevate the heart rate to treat the wheeze that he had heard in her respiratory exam;
- Dr. Huebel did not address Patient A's grossly elevated heart rate at all in his contemporaneous patient records or narrative, despite him stating that he reviewed the triage vitals himself and with the patient and her family member.

The expert further noted that it is the standard of care in emergency medicine to assess, investigate and treat someone with an abnormal vital sign such as this prior to their discharge from the emergency department and that Dr. Huebel fell below that standard of care in both what he did and what he did not do. The expert concluded that Dr. Huebel's clinical practice exposes his patients to harm as it clearly did so in the case of Patient A.

<u>Reassessment Pursuant to Discipline Committee Order</u>

On January 19, 2015, the Discipline Committee imposed terms and conditions on Dr. Huebel's certificate of registration, which required him to undergo a12-month period of supervision followed by two reassessments of his practice. The expert retained by the College to conduct the reassessment of Dr. Huebel's practice reviewed 13 of Dr. Huebel's patient charts. She opined that Dr. Huebel failed to meet the standard of practice of the profession in 11 of the 13 charts.

Dr. Huebel's charting and documentation failed to meet the standard of practice in 11 of the charts reviewed, the expert observed were largely illegible with minimal history and physical exam documented. In a response to the College dated April 5, 2017, Dr. Huebel conceded that his recordkeeping remains inadequate and requires improvement. Dr. Hubel's care and treatment of patients fell below the standard of

practice in the following six cases, which were included in the expert's reassessment of his practice:

Patient B

Patient B, a man in his 90s, was transported by paramedics to the Hospital emergency department after falling down an unknown number of stairs. He was not placed on a board and collar. He had a hematoma on the side of his head that had been bandaged by paramedics and had a past medical history of a subdural hematoma requiring surgical removal. Dr. Huebel ordered a CT scan of Patient B's head, read it as negative and discharged the patient home. Formal radiological interpretation of the CT scan the next morning indicated that Dr. Huebel had missed an acute subdural haemorrhage.

The expert opined that Dr. Huebel's care of Patient B fell below the standard of practice, in that:

- although Dr. Huebel properly ordered the CT scan, he missed a very important diagnosis of an acute subdural haemorrhage, when the patient had a history of same, making the index of suspicion for this disease entity quite high;
- there was no evidence on the chart that Dr. Huebel conducted a complete and systematic trauma survey, which would be the standard in this case, given visible injuries such as a parietal hematoma was indicated on the paramedic record;
- Dr. Huebel's charting is illegible, with minimal history and physical exam documented.

Patient C

Patient C, a woman in her 70s, presented to the Hospital emergency department with right hip pain radiating to her lower leg and calf. She had fallen onto her right hip three months prior and had x-rays taken at that time, which were negative. She had visited the emergency department three times in the intervening period for the same pain. Dr. Huebel treated Patient C with medication, ordered a Doppler ultrasound of the right leg, and ordered a blood test for D-dimer, which assists in diagnosing Deep Vein Thrombosis (DVT).

The expert opined that Dr. Huebel's care of Patient C fell below the standard of practice, in that:

- the Doppler ultrasound ordered by Dr. Huebel was not the appropriate choice of imaging to rule out DVT in Patient C given her age, history of trauma to the region and symptoms of this duration. Rather, the CT scan ordered by a subsequent physician was more appropriate. Both the ultrasound and CT scan revealed no acute findings.

- Dr. Huebel's assessment intentions were not indicated in his charting and his documentation of the physical exam was incomplete for the consideration of DVT as a potential cause for the patient's pain.

Patient D

Patient D, a woman in her 20s, presented to the Hospital emergency department with suicidal thoughts and worsening depression, low mood, decreased sleep and daily use of marijuana and alcohol. She was seen by the crisis team and an on-call psychiatrist, who discharged her with a prescription for Cipralex and follow up with the Psychiatry outpatient clinic. She was then seen by Dr. Huebel, who documented her assessment time as 9:45 and her discharge time as 9:50.

The expert opined that Dr. Huebel's care of Patient D fell below the standard of practice, in that:

- Dr. Huebel's charting was illegible, with minimal history and physical exam documented;
- there was no legibly documented justification for the assessment of depression or the statement "medically clear", which was written in the body of the chart;
- there was no documentation of any medical issues that may have been considered, nor any clinical toxicologic assessment given the patient's daily use of drugs and alcohol, which is standard for this patient group.

Patient E

Patient E, a man in his late 20s, was trauma patient who presented to the Hospital emergency department after he was involved in a motor vehicle accident on Highway 401. He complained of a headache, dizziness and mid-back/neck pain; he was ambulatory with normal vital signs. Dr. Huebel's assessment time is documented as 01:55 and the discharge time is documented as 02:00.

The expert opined that Dr. Huebel's care of Patient E fell below the standard of practice, in that:

- Dr. Huebel's chart was illegible;
- Dr. Huebel failed to clear Patient E for cervical spine injuries by applying a decision rule such as the Canadian C Spine Rules to determine if imaging was necessary, despite the fact that neck pain was included in the triage notes;
- there was no documentation of the speed of the cars or assessment as to the degree of injury predicted;
- the patient was only seen for 5 minutes, and it is extremely difficult to conduct an appropriate trauma assessment in that timeframe.

Patient F

Patient F, a man in his 50s, presented to the Hospital emergency department with heart palpitations, flushing and dizziness. His vital signs, EKG and blood work were normal, including levels of the cardiac enzyme troponin. Patient F was seen by Dr. Huebel at 22:05 and was discharged by him at 22:15. Dr. Huebel never ordered a second blood test for troponin levels.

The expert opined that Dr. Huebel's care of Patient F fell below the standard of practice, in that:

- Most of his chart was illegible, with minimal history and physical exam documented;
- while appropriate bloodwork and an EKG were done, there was no legible documented timeframe for the onset of the patient's symptoms, which made it impossible to know whether the appropriate time delay for testing of cardiac enzymes was met.

Patient G

Patient G, a man in his 80s, presented to the Hospital emergency department with bilateral shoulder aching pain. He had checked his blood pressure and heart rate at home and they were elevated. He had undergone an angiogram 2 weeks prior at a different facility but the Hospital did not have the results. Patient G was on an extensive list of medications and had a history of atrial fibrillation, hypertension and other comorbidities. He was placed on a cardiac monitor.

Dr. Huebel ordered an EKG and bloodwork. The EKG showed atrial fibrillation. The bloodwork was drawn, but then had to be redrawn half an hour lated due to hemolysis. The blood showed elevated troponin levels, which necessitated a subsequent assessment of cardiac enzymes such as troponins after a prescribed interval of time to rule out cardiac ischemia.

Dr. Huebel left the Hospital for several hours, assuming that Patient G would be transferred to another emergency physician and would receive an IV of Procainamide to encourage normal heart rhythm. Upon his return, he learned that Patient G had not been transferred to another physician in his absence. He was still in atrial fibrillation and had not yet received Procainamide. Dr. Huebel ordered an IV of Procainamide intended to convert the patient to a normal heart rhythm. Approximately an hour later, the nurses informed Dr. Huebel, who was working in a different area of the emergency department, that Patient G had converted to normal sinus rhythm. Dr. Huebel discharged Patient G home with a family member.

The expert opined that Dr. Huebel's care of Patient G fell below the standard of practice, in that:

- Dr. Huebel's chart was illegible;
- a second set of cardiac enzymes (troponins) was never drawn in order to rule out cardiac ischemia. Aching shoulder pain is recognized as a potential symptom of cardiac ischemia, which should have been considered in a patient with a known cardiac history and recent angiogram;
- a post-cardioversion EKG to document Patient G's return to normal sinus rhythm was not completed before discharge;
- after being told that he had converted to normal sinus rhythm, Dr. Huebel failed to personally reassess Patient G before discharging him.

The expert noted that it is highly unusual for an emergency physician to be working two shifts in different locations, such that he would need to leave and return a few hours later.

Expert's Conclusion

After reviewing the above cases in detail, the expert concluded that Dr. Huebel does not meet the standard of care expected of a competent physician practicing emergency medicine in the majority of cases; his poor documentation is not up to the standard expected of emergency medicine practitioners; and he displays a lack of knowledge and judgment with respect to the assessment and management of cardiac, trauma, psychiatric and toxicological patients. In the expert's opinion, this combination has the potential to cause harm to his patients.

Dr. Huebel's Prior History with the College

In 2004, the Complaints Committee of the College ordered Dr. Huebel to be cautioned in person regarding the importance of performing and documenting a thorough assessment in the emergency department of a patient with symptoms suggestive of myocardial ischemia.

In 2006, the Complaints Committee ordered Dr. Huebel to be cautioned in writing regarding the importance of assessing patients thoroughly to justify his clinical decisions, documenting his assessments and treatment plan in the chart, and reassessing patients prior to discharge to answer questions and provide follow-up instructions.

In 2008, following receipt of complaints regarding Dr. Huebel's assessment and treatment of two patients in the emergency department, one of whom had suffered a cardiac event and the other was involved in a motor vehicle accident, the College commenced investigation. In the course of the investigation, Dr. Huebel completed the College's record-keeping course. As a result of the 2008 complaints and investigation, Dr. Huebel entered into an Undertaking with the College in September 2010 ("the 2010 Undertaking"), pursuant to which he was subject to supervision for a period of six months, followed by reassessment.

In October 2010, in response to a patient complaint, the Inquiries, Complaints and Reports Committee (the "ICRC") issued a verbal caution to Dr. Huebel regarding his inadequate and cursory examination and making a referral too quickly before properly assessing the urgency level of the patient.

On February 1, 2013, following the reassessment pursuant to the 2010 Undertaking, College inspector reviewed 27 charts selected from Dr. Huebel's emergency medicine practice and reported that:

- Dr. Huebel's charting was illegible;
- there was a consistent pattern of deficiencies in Dr. Huebel's documentation of patient history, physical exam, working or provisional diagnosis and reassessments prior to discharge;
- significant results for investigations and lab tests were not documented; and
- Dr. Huebel's use of consultants was problematic as he relied on them to assume care of his patients with no further management by him.

As a result of this report, Dr. Huebel was subject to a preceptorship, with a preceptor acceptable to the College meeting with Dr. Huebel every one to two months to review charts selected by the Chief of Emergency Medicine and who would also supervise Dr. Huebel's ongoing education.

As a result of reassessment as well as a complaint received by the College in 2013 regarding "Patient AA", the College commenced another investigation of Dr. Huebel's Emergency Medicine practice. An expert retained by the College reviewed 21 charts selected from Dr. Huebel's emergency medicine practice, observed Dr. Huebel's assessment and treatment of 14 patients and conducted an interview of Dr. Huebel. In his report, dated February 6, 2014, the expert found Dr. Huebel's documentation regarding his clinical encounters to be "cursory and incomplete", concluding that it did not meet the expectation for record keeping as set out in the College Policy on Medical Recordkeeping. The expert further opined that Dr. Huebel's clinical handling of Patient BB did not meet the standard of practice of emergency medicine.

In March and November 2014, allegations of failing to maintain the standard of practice of the profession with respect to Patient AA and Patient BB were referred to the Discipline Committee. In May 2014, Dr. Huebel entered into an undertaking with the College in lieu of an interim order of the ICRC and was subject to the undertaking from May 2014 until his discipline matter was disposed of in January 2015. Pursuant to this undertaking, Dr. Huebel retained a clinical supervisor who met with him once each month, and reviewed at least 10 charts selected by the emergency department Chief or his designate. Dr. Huebel also reviewed at least 50 questions that he had completed from the Emergency Medicine examination preparation handbook or similar web-based program.

Prior Discipline Committee Finding

On January 19, 2015, the Discipline Committee of the College found that Dr. Huebel committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession in his care and treatment of two patients. The Discipline Committee found that:

- Dr. Huebel failed to adequately investigate, diagnose and manage the care of Patient AA, who presented with classical symptoms of aortic dissection, and who subsequently died.
- Dr. Huebel failed to adequately evaluate and care for Patient BB, an insulin-dependent diabetic woman who presented with hypoglycaemia and was seven months pregnant.
- Dr. Huebel's documentation with respect to Patient BB was cursory and incomplete; it did not meet the standard of care for record-keeping.

The Discipline Committee ordered a reprimand and directed the Registrar to impose the terms of the 2015 Undertaking as terms, conditions and limitations on Dr. Huebel's certificate of registration, which provided that Dr. Huebel was to undergo a further period of clinical supervision for 12 months, to be followed by two reassessments of his practice.

Subsequent Events

The reports of the clinical supervisor who supervised Dr. Huebel over the following 12 months, meeting with him to review 10 charts selected by the emergency department Chief or his designate, and submitting quarterly reports to the College, were generally positive, though he did consistently note problems with illegibility and insufficient documentation. The clinical supervisor's final report to the College was dated December 11, 2015.

The misconduct currently at issue occurred between February and May 2016. It came to the College's attention in late 2016 and was referred to the Discipline Committee on April 10, 2017. On May 2, 2017, the ICRC made an interim order imposing a number of terms, conditions and limitations on Dr. Huebel's certificate of registration, pending this hearing. The Order required Dr. Huebel to engage a Clinical Supervisor who shall attend in person at all of Dr. Huebel's encounters with patients and review all patient charts. Dr. Huebel retained a Clinical Supervisor, who supervised him from May 2017 until July 2017. Dr. Huebel has not practised medicine since July 31, 2017.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Huebel's Certificate of Registration for a period of three (3) months, effective immediately.

- the Registrar impose the following terms, conditions and limitations on Dr. Huebel's Certificate of Registration:

Practice Restrictions

- Dr. Huebel shall not engage in the practice of medicine as the Most Responsible Physician for any patient(s) whatsoever.
- The entirety of Dr. Huebel's scope of practice shall be limited in the following ways:
  - He shall only practise medicine in a hospital setting as a surgical assistant of a surgeon:
    - certified by the Royal College of Physicians and Surgeons or recognized as a surgical specialist by the College; and
    - who has been approved by the College,(collectively, a "Qualified Surgeon"); and
  - for further clarity, but without limiting the generality of the above:
    - Dr. Huebel shall not provide any pre-operative or post-operative care whatsoever; and
    - a Qualified Surgeon must always be physically in attendance when Dr. Huebel is engaging in practice as a surgical assistant.
  - Dr. Huebel shall not engage in any practice of medicine that is not expressly and specifically listed above.

Monitoring

- Dr. Huebel shall inform the Collge of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
- Dr. Huebel shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and patient charts by a College representative for the purposes of monitoring and enforcing his compliance with the terms of this Order.
- Dr. Huebel shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
- Dr. Huebel shall consent to the College providing all Qualified Surgeon(s) and Chief(s) of Staff with any information relevant to this Order and/or arising from the monitoring of his compliance with the terms of this Order.
- Dr. Huebel shall consent to any Qualified Surgeon and any Chief of Staff disclosing to the College, and to one another, all information relevant to this Order and/or relevant for the purposes of monitoring his compliance with the terms of this Order.

General

- Nothing in this Order shall be construed as preventing Dr. Huebel from seeking to vary this Order in the future.
- Dr. Huebel shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Huebel appear before the panel to be reprimanded.
- Dr. Huebel pay to the College its costs of this proceeding in the amount of $10,180.00 within thirty (30) days from the date of this Order.

5. Dr. N. Syed

Name:	Dr. Naseeruddin Syed
Practice:	Family Medicine
Practice Location:	Peterborough
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date	March 5, 2018
Written Decision Date:	May 8, 2018

Allegations and Findings

- Failed to maintain the standard of practice of the profession – **proved**
- Incompetence – **withdrawn**

Summary

Investigation One

On August 2014, Dr. Syed's former nurse contacted the College expressing concern regarding various aspects of Dr. Syed's practice, including his prescribing practices. Based on the information requested by the College in April 2015 regarding claims for all monitored drugs made by Dr. Syed's patients, the College commenced an investigation.

The College retained an expert who reviewed 25 of Dr. Syed's patient charts, pharmacy records, narcotic monitoring system data and conducted an interview with Dr. Syed. He opined that Dr. Syed's dedication to the practice of medicine and his belief that he is truly acting in the best interests of his patients are not questioned, but he had concerns about Dr. Syed's knowledge and judgment which may expose his patients to possible harm. He also was of the view that Dr. Syed's skill was difficult to determine due the extremely poor and woefully sparse documentation on the charts reviewed. He concluded that 24 of 25 charts reviewed failed to meet standards; 6 out of 25 patient charts displayed a lack of knowledge, the majority regarding dosing of psychoactive drugs; 4 out of 25 patient charts displayed a lack of judgment, the majority regarding

prescriptions of benzodiazepines, narcotics and antidepressants; and 6 of 25 patient charts reveal exposure of Dr. Syed's patients to harm or injury, specifically relating to his general prescribing practices.

Investigation Two

The College received information from two physicians who practise in a methadone maintenance practice at the Ontario Addiction Treatment Centres ("OATC") in Peterborough, outlining concerns regarding Dr. Syed's prescribing of high doses and large amounts of benzodiazepines to several methadone patients. Concerns regarding serious or fatal respiratory depression were relayed. 6 patients were identified and concerns were raised about an admission to the local hospital's Intensive Care Unit in the group of patients due to recent benzodiazepine overdose.

Dr. Syed stated to the College investigator that he was not aware that the 6 patients were being prescribed methadone.

The manager of the pharmacy located at the same address as Dr. Syed's practice, relayed to the College investigator concerns regarding the early release of medications in patients claiming to have lost their prescriptions and regarding the maximum dosages of benzodiazepines being prescribed. By letter dated July 5, 2015, one of the physicians who contacted the College expressing concerns regarding Dr. Syed's prescribing provided a further report with respect to his concerns about specific patients.

The College retained an expert who reviewed Dr. Syed's general medicine practice, including his prescribing practice. After reviewing 10 patient charts, pharmacy records and interviewing Dr. Syed the expert concluded among other things, that despite the guidelines for documentation afforded by the EMR, in not a single case during this chart review of these 6 patients was the record of treatment properly populated with adequate detail to meet College standards. In fact, there were glaring absences of documentation in the vast majority of charts reviewed, such that not one met record-keeping standards. The latter case is similar to that of the five previous, in that these patients were all prescribed psychoactive drugs, many in excessive quantities, despite all being on methadone and followed by a physician managing their addictions. While Dr. Syed maintained in his interview that he was unaware that these patients were on methadone, he acknowledged that many of the clientele of this walk-in clinic were drug addicts with poor social support. The expert noted that with this knowledge the physician managing these patients should be extremely diligent in assessing and treating these patients, including careful history taking and thorough physical examination to ensure the safety of the patient. According to the expert, in 6 patients whose charts were reviewed, Dr. Syed has failed to meet the standard of practice of the profession and at times may have exposed his patients to potential harm.

Dr. Syed advised the College that he did not know the patients to whom the two physicians referred were on methadone. However, during the investigation, the College reviewed Dr. Syed's charts for these patients, which revealed that:

- Dr. Syed had received a fax from the pharmacy indicating that Patient A, who was identified by the two physicians, was on methadone in January, 2015. Despite this, he prescribed benzodiazepines to Patient A in February, 2015.
- Dr. Syed continued to prescribe narcotics and benzodiazepines to Patient B throughout February, March and April, 2015 and prescribed benzodiazepines to Patient C in March 2015 in two cases after being told by both physicians that they were methadone patients.
- Patient D identified by both physicians was seen in the emergency department for overdose of sedatives (specifically having taken many of the 2mg tablets of Clonazepam prescribed by Dr. Syed at once). The patient was admitted to the ICU for overdose of sedatives. Five days later, there was no patient visit in his chart, yet Dr. Syed prescribed Ativan to Patient D. About ten days later, Dr. Syed discussed the recent overdose and admission to hospital with Patient D as well as the recent letter from the physician and again prescribed Ativan to patient D.

Complaint of Patient E

In March 2015, the College received a complaint from Patient E expressing concerns that Dr. Syed failed to provide appropriate care when ordering medications for him during a walk-in visit. Specifically, Dr. Syed prescribed a medication that patient E was allergic to, prescribed high doses of benzodiazepines, knowing that Patient E is on methadone and has a general lack of knowledge concerning mental health patients and is over-prescribing to them.

The College retained an expert who reviewed the standard of care provided by Dr. Syed to Patient E. The expert opined, in part, that not one of the patient's eight visits in 2015 contained the required elements to meet the standards of record keeping of the College: the histories were incomplete, the physical exams often undocumented and the diagnoses usually only represented by OHIP billing codes. The plans for management were prescriptions only with rare advice as to how to specifically manage the patient's presenting complaints. Dr. Syed demonstrated lack of knowledge concerning the management of drug-seeking, habituated methadone patients. Dr. Syed demonstrated lack of skill in advising tapering of benzodiazepines without specific instructions. Dr. Syed demonstrated lack of judgment by allowing himself to be manipulated into repeat prescriptions of such a class of drugs and his prescriptions of narcotics, including Nucynta, in this patient. The pharmacist brought to light Dr. Syed's lack of knowledge of a potentially serious drug interaction between Nuycynta and Cymbalta. Dr. Syed demonstrated a lack of judgment by stopping the antidepressant instead of the narcotic in this instance. The clinical practice of Dr. Syed with regard to Patient E had the potential in several instances to expose his patient to harm.

Complaint of Patient F

In May 2016, the College received a complaint from Patient F expressing concerns that Dr. Syed failed to provide appropriate assessment, diagnosis and treatment when she attended the walk-in clinic with gynaecological concerns about a growth. Dr. Syed did not conduct a physical examination of the patient and proceeded to prescribe her medication without adequate explanation. The patient consulted a pharmacist, who expressed some disagreement with the prescription. As a result, the patient did not fill the complete prescription.

The College retained an expert who reviewed the standard of care provided by Dr. Syed to Patient F. The expert concluded, in part, that the care provided by Dr. Syed did not meet the standard of the profession.

The expert noted that the patient's concern was of the lesion on her labia, and it is standard practice to examine this lesion. According to the expert, sometimes a physician may defer exam, but this would be based on agreement with the patient, which was not the case in this instance. Regarding the concern about the prescription provided, the expert noted that for a typical yeast infection, a patient may potentially be prescribed Diflucan 150mg for one day and/or a topical treatment (such as the Terazol 7), while Dr. Syed prescribed Diflucan for seven days along with a repeat. According to the expert, this is a definite concern, as it is not the standard treatment for a common yeast infection (as Dr. Syed implied it was in his letter). The expert further noted that Patient F's short visit demonstrated concerns regarding the knowledge, skill and judgment provided by Dr. Syed. According to the expert, there is reason to believe that Dr. Syed's clinical practice may expose patients to harm or injury, as examination of patients is vital to the correct diagnosis and that the prescription provided in the case of Patient F appears to be excessive and may cause harm to the patient. However, the expert noted that this is one short encounter, and may not be indicative of Dr. Syed's overall practice style.

The Interim Order of the the Inquiries, Complaints and Reports Committee (ICRC)

On February 14, 2017, the ICRC directed the Registrar to impose terms, conditions and limitations on Dr. Syed's certificate of registration, which remain in effect until April 15, 2018.

Disposition

The Discipline Committee ordered that:

- the Registrar suspend Dr. Syed's certificate of registration for two (2) months, to commence at 12:01 a.m. on April 15, 2018.

- the Registrar impose the following terms, conditions and limitations on Dr. Syed's certificate of registration upon his return to practice at the conclusion of his suspension:

Prescribing Log

- Dr. Syed, shall keep a Log of all prescriptions for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs (as set out in Schedule "A"), in the form attached as set out in Schedule "B", which will include at least the following information (the "Prescribing Log"):
    - the date of the appointment;
    - the name of the patient and chart/file number;
    - the name of the medication prescribed, dose, direction, number of tablets to be dispensed and frequency;
    - the clinical indication;
    - whether the prescription is for a new medication and/or different dose or frequency than currently prescribed to the patient (Y/N);
    - Dr. Syed's signature;
    - the date of the Clinical Supervisor's review (if applicable, as set out below); and
    - the Clinical Supervisor's signature (if applicable, as set out below).
- Dr. Syed is to keep a copy of all prescriptions he writes for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs, in the corresponding patient chart.

Clinical Supervision re: Narcotic Practice

- Dr. Syed is to practise under the guidance of a clinical supervisor acceptable to the College (the "Clinical Supervisor"), for a minimum of nine (9) months on the terms set out below (the "Clinical Supervision").
- The Clinical Supervisor shall sign an undertaking in the form attached hereto as Schedule "C".
- Dr. Syed shall cooperate fully with the Clinical Supervision and abide by all recommendations of his Clinical Supervisor with respect to practice improvements and education.
- Dr. Syed shall consent to the disclosure by the Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and to monitor Dr. Syed's compliance with this Order. This shall include, without limitation, providing the Clinical Supervisor with any reports of any assessments of Dr. Syed's practice in the College's possession.
- If the Clinical Supervisor who has given an undertaking in Schedule "C" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Syed shall, within

seven (7) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.

- Dr. Syed shall not prescribe any narcotics or controlled substances unless and until the Clinical Supervision is in place.
- If Dr. Syed is unable to obtain a Clinical Supervisor on the terms set out in sections 4.B, he will cease prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs until such time as he has obtained a Clinical Supervisor acceptable to the College.
- If Dr. Syed is required to cease prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs as a result of section 4.B(vii) above this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the Public Register.

Phase 1 of Clinical Supervision ("Phase 1")

- Dr. Syed is to engage in Phase 1 of Clinical Supervision for a minimum of two (2) months on the terms set out below.
- During Phase 1, Dr. Syed is to meet with the Clinical Supervisor once a week to discuss the Clinical Supervisor's review of a minimum of twenty (20 charts for patients to whom Dr. Syed has prescribed:
    - Narcotic Drugs, or
    - Narcotic Preparations; or
    - Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs where the patient is also prescribed a Narcotic Drug and/or Narcotic Preparation.
- If there are not twenty (20) charts for patients to whom Dr. Syed has prescribed the above substances, the Clinical Supervisor shall review the charts of all patients listed in the prescribing log since his prior review.
- During Phase 1, the Clinical Supervisor must sign and date the Prescribing Log to confirm the charts that the Clinical Supervisor has reviewed and discussed with Dr. Syed.
- During Phase 1, the Clinical Supervisor will provide a report to the College at least once a week.
- After a minimum of two (2) months of Phase 1, if the Clinical Supervisor is satisfied that Dr. Syed has the necessary knowledge, skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that supervision be reduced.

Phase 2 of Clinical Supervision ("Phase 2")

- Upon the recommendation of the Clinical Supervisor and approval by the College, Dr. Syed shall engage in Phase 2 of Clinical Supervision for a minimum of three months on the terms set out below.

- During Phase 2, Dr. Syed is to meet with the Clinical Supervisor at least once every two (2) weeks to discuss the Clinical Supervisor's review of a minimum of fifteen (15) charts for patients to whom Dr. Syed has initiated a new prescription for:
    - Narcotic Drugs, or
    - Narcotic Preparations; or
    - Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs where the patient is also prescribed a Narcotic Drug and/or Narcotic Preparation.
- If there are not fifteen (15) charts for patients to whom Dr. Syed has initiated a new prescription for the above substances, the Clinical Supervisor shall review the charts of all patients listed in the prescribing log since his prior review.
- During Phase 2, the Clinical Supervisor must sign and date the Prescribing Log to confirm the charts that the Clinical Supervisor has reviewed and discussed with Dr. Syed.
- During Phase 2, the Clinical Supervisor will provide a report to the College at least once every two (2) weeks.
- After a minimum of three (3) months of Phase 2, if the Clinical Supervisor is satisfied that Dr. Syed has the necessary knowledge, skills and judgment to practice in a less highly supervised environment, the Clinical Supervisor may recommend to the College that supervision be reduced.

Phase 3 of Clinical Supervision ("Phase 3")

- Upon the recommendation of the Clinical Supervisor and approval by the College, Dr. Syed, shall engage in Phase 3 of Clinical Supervision for a minimum of four (4) months on the terms set out below.
- During Phase 3, Dr. Syed shall mee with the Clinical Supervisor at least once a month to discuss the Clinical Supervisor's review of a minimum of fifteen (15) charts for patients to whom Dr. Syed has initiated a new prescription for:
- Narcotic Drugs, or
    - Narcotic Preparations; or
    - Controlled Drugs, Benzodiazepines and Other Targeted Substances and All other Monitored Drugs where the patient is also prescribed a Narcotic Drug and/or Narcotic Preparation.
- If there are not fifteen (15) charts for patients to whom Dr. Syed has initiated a new prescription for the above substances, the Clinical Supervisor shall review the charts of all patients listed in the prescribing log since his prior review.
- During Phase 3, the Clinical Supervisor must sign and date the Prescribing Log to confirm the charts that the Clinical Supervisor has reviewed and discussed with Dr. Syed.
- During Phase 3, the Clinical Supervisor(s) will provide a report to the College at least once every month.

- After a minimum of four (4) months of Phase 3, if the Clinical Supervisor is satisfied that Dr. Syed has the necessary knowledge, skills and judgment to practice without supervision, the Clinical Supervisor may recommend to the College that the Clinical Supervision cease.

Clinical Supervision re: Non-Narcotic Practice

- By June 15, 2018, Dr. Syed shall obtain a clinical supervisor acceptable to the College, who will supervise Dr. Syed's general practice upon completion of his suspension for a period of nine (9) months, and who will sign an undertaking in the form attached hereto as Schedule "D" (the "General Practice Clinical Supervisor").
- Dr. Syed shall cooperate fully with the Clinical Supervision and abide by all recommendations of his General Practice Clinical Supervisor with respect to practice improvements and education.
- Dr. Syed shall consent to the disclosure by the General Practice Clinical Supervisor to the College, and by the College to his General Practice Clinical Supervisor, of all information the General Practice Clinical Supervisor or the College deems necessary or desirable in order to fulfill the General Practice Clinical Supervisor's undertaking and to monitor Dr. Syed's compliance with this Order. This shall include, without limitation, providing the General Practice Clinical Supervisor with any reports of any assessments of Dr. Syed's practice in the College's possession.
- If the General Practice Clinical Supervisor who has given an undertaking in Schedule "D" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Syed shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.
- If Dr. Syed is unable to obtain a General Practice Clinical Supervisor in accordance with paragraphs 4(C)(i) or 4(C)(iv) of this Order, he shall cease practising medicine until such time as he has done so, and the fact that he has will constitute a term, condition or limitation on his certificate of registration until that time.

Reassessment of Practice

- Approximately three (3) months after each aspect of the Clinical Supervision set out above has ceased, Dr. Syed will submit to a comprehensive reassessment of his entire practice by an assessor or assessors selected by the College (the "Assessor(s)"). The Reassessment may include a chart review, direct observation of Dr. Syed's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the College. Dr. Syed shall abide by all recommendations made by the Assessor(s), and the

results of the Reassessment will be reported to the College and may form the basis of further action by the College.

Compliance

- Dr. Syed shall co-operate with unannounced inspections of his office practice and patient charts for the purpose of monitoring and enforcing his compliance with the terms of this Order.
- Dr. Syed shall inform the College of any and all new practice locations including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction five (5) days in advance of commencing practice at that location.
- Dr. Syed shall give his irrevocable consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the *Narcotics Safety and Awareness Act*, *2010* and/or any person or institution who may have relevant information, in order for the College to monitor my compliance with the provisions of this Order.
- Dr. Syed shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Syed attend before the panel to be reprimanded.
- Dr. Syed pay costs to the College in the amount of $10,180.00 within 30 days of the date of this Order becomes final

6. Dr. R.H.C. Wu

Name:	Dr. Raymond Hon Chuen Wu
Practice:	Family Medicine
Practice Location:	Markham
Hearing:	Uncontested Facts and Joint Submission on Penalty
Finding/Penalty Decision Date	May 1, 2018
Written Decision Date:	June 28, 2018

Allegations and Findings

- Failed to maintain the standard of practice of the profession – **proved**
- Disgraceful, dishonourable or unprofessional conduct – **proved**

Summary

Dr. Raymond Wu is a general physician who received his certificate of registration authorizing independent practice in 1987. At the relevant time, Dr. Raymond Wu was acting as a locum at a family medicine practice in Markham and also has his own family medicine practice in Markham.

Dr. Raymond Wu's locum in Dr. Howard Wu's practice

Dr. Raymond Wu acted as a locum in the practice of his nephew, Dr. Howard Wu, from June 2013 to December 2013, where he practised two days a week, seeing 60-70 patients per day, while Dr. Howard Wu's certificate of registration was suspended. In his capacity as a locum in Dr. Howard Wu's practice, Dr. Raymond Wu supervised employees of Dr. Howard Wu who were international medical graduates (the "IMGs"). In accordance with the office procedures established by Dr. Howard Wu, the IMGs saw patients on their own and discussed their findings, assessments and management plans with Dr. Raymond Wu. Dr. Raymond Wu then signed prescriptions and any notes the patients required.

Some patients seen by the IMGs and for whom Dr. Raymond Wu completed medical device claims and prescribed medical devices were referred by the physiotherapy clinic next door for assessment of their musculoskeletal complaints.

College Investigation

The College commenced investigation, after Sun Life Assurance Company of Canada ("Sun Life"**)** contacted the College, expressing concerns that Dr. Raymond Wu had been inappropriately completing medical device claims and prescribing medical devices for patients where there was no medical necessity. The College retained an expert to provide an opinion on Dr. Raymond Wu's standard of practice.

The expert reviewed the charts of six patients identified by Sun Life as having prescriptions signed by Dr. Raymond Wu for whom he prescribed medical devices while he was acting as a locum in Dr. Howard Wu's office. The expert opined that Dr. Raymond Wu's documentation fell below the standard of care expected of a family physician in the six charts reviewed, including a lack of detailed history of the patients' presenting complaints, a lack of relevant past medical history, a lack of a detailed and clinical exam relevant to the patients' presenting complaints and a lack of assessments and diagnoses. The expert pointed out the following concerns regarding Dr. Raymond Wu's documentation and patient care:

- The history of the presenting complaint is similar in all six charts reviewed: "pain in the low back and neck (off and on chronic)". No further details specific to each patient is documented.
- The clinical exam findings are similar on all six charts reviewed: "paravertebrae tenderness reduce ROM, Neuro Neg" and in some patents a comment that a particular joint "was tender to palpation".
- No exam findings documented of other joints that the patients were complaining of as being painful.
- No investigations were ordered to aid in the diagnoses of the patient complaint (x-ray, ultrasound, MRI or EMG).
- Lack of documented assessment or diagnoses.

- Recommendations for treatment are similar: “RICE Posture Better Support Shoes Strengthening, PT and meds as needed”.
- For a patient that Dr. Raymond Wu has counselled there are four phrases that he uses. There is no information documented that is specific to the patient who was seen.
- Dr. Raymond Wu documents “and meds as needed”. There is no information regarding the name and dosage of the medications or the duration of the treatment.
- The documentation for follow-up visits lacks information regarding the patients response to treatments recommended.
- No documentation to support the use of support stockings, TENS machine, back brace, knee braces, ankle braces, elbow braces and wrist braces.
- Concern regarding the use of multiple braces per patient.
- Inappropriate use of braces for pain control and that the duration of brace use is for one year.

The expert further opined that bracing can be used as an adjunct to other treatment modalities for patients presenting with musculoskeletal complaints. However, the expert noted that for the six patients, whose charts were reviewed, there was insufficient documentation of history, clinical examination and investigations to support their use. Also, the expert noted that, it is not the standard of clinical practice to use multiple bracing at one time and for the duration of one year and that these patients did not receive follow-up care to assess if the bracing was of clinical benefit in reducing their pain. The expert further opined that during the six months Dr. Raymond Wu was a locum of Dr. Howard Wu, he showed a lack of skill and knowledge with respect to his documentation of patient encounters. According to the expert, Dr. Raymond Wu lacked judgement, in that he either saw patients or supervised the International Medical Graduates seeing patients sent from the physiotherapy clinic next door for the purpose of receiving prescriptions for bracing, support stockings and TENS machines.

The expert also reviewed five further patient charts received from Dr. Raymond Wu’s own family practice clinic and noted no concerns with regard to these five charts and patient care. The expert opined that Dr. Raymond Wu met the standard of care expected of a family physician in a busy urban setting.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Wu’s certificate of registration for a period of one (1) month, commencing May 4, 2018 at 11:59 p.m.
- Dr. Wu attend before the panel to be reprimanded.
- Dr. Wu pay costs to the College in the amount of $6,000.00 within 30 days of the date this Order becomes final.

Disgraceful, Dishonourable, or Unprofessional Conduct – 8 cases

1. Dr. A.A. Abdurahman

Name:	Dr. Adel Abduselam Abdurahman
Practice:	General Surgery
Practice Location:	Sault Ste Marie
Hearing:	Agreed Facts, Contested Penalty
Finding Decision Date:	February 9, 2018
Penalty/Written Decision Date:	August 13, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Abdurahman is a general surgeon practising medicine in Sault Ste Marie, Ontario. He received his medical degree in Ontario in 2004 and his certificate of registration authorizing independent practice and specialist qualification in general surgery in Ontario in 2009.

Alternative Payment Plan ("the Agreement")

Effective in 2005, the Ministry of Health and Long-Term Care entered into an Alternative Payment Plan ("the Agreement") with physicians, local hospitals and the Ontario Medical Association for funding of general surgery services in the district of Kenora and Rainy River. One of the goals of the Agreement is to provide surgical services in the under-serviced regions of northern Ontario. The physicians are members in a group known as the Regional Surgical Network, ("the Group") and are required to sign a declaration and consent confirming that they are bound by the Agreement. Under the terms of the Agreement, a physician member of the Group receives an annual payment in return for providing surgical services in one of the hospitals named in the Agreement. The Agreement specifically prohibits physicians who are members of the Group from submitting claims or accepting payment from the Ontario Health Insurance Plan ("OHIP").

Disgraceful, Dishonourable or Unprofessional Conduct

In September 2014, Dr. Abdurahman was appointed as one of two General Surgeons to Riverside Health Care Facilities, La Verendrye Hospital, in Fort Frances, Ontario (Fort Frances Hospital), with courtesy privileges at the Emo and Rainy River Health Centres – the hospitals covered by the Agreement. On January 1, 2015, Dr. Abdurahman signed

declaration and consent forms, confirming that he is a member of the Group and is bound by the terms of the Agreement. Between January 1, 2015 and October 6, 2016, Dr. Abdurahman was providing general surgery services at Fort Frances Hospital under the terms the Agreement, pursuant to which he received lump sum payment in exchange for providing general surgery services and was specifically prohibited from submitting claims or accepting payment from the Ontario Health Insurance Plan ("OHIP").

During the time he held privileges with Fort Frances Hospital, Dr. Abdurahman held privileges at five other hospitals in Ontario, which are outside the service area covered by the Agreement and are located within 950-2000km from Fort Frances Hospital.

In October 2016, the College received information from Fort Frances Hospital that Dr. Abdurahman had breached the terms of the Agreement by:

- practising outside the geographic area covered by the Agreement;
- billing OHIP for services provided, contrary to the terms of the Agreement, on a fee-for –service basis; and
- providing locum coverage and services at hospitals up to 2000 km away from Fort Frances Hospital at the same time that he was paid to be first General Surgeon on-call at the Fort Frances Hospital.

Specifically, during the period that he was bound by the Agreement, Dr. Abdurahman:

- submitted claims for services provided and accepted payment from OHIP in the amount of $204, 959.74, in violation of the agreement;
- rendered and billed for services at hospitals that are not parties to the agreement and are between 1000 to 2000 km away from Fort Frances on thirty-three (33) dates. On at least thirty (30) of these dates, he was also first General Surgeon on-call at Fort Frances Hospital and it was physically impossible for him to attend at Fort Frances Hospital within any reasonable time period;
- on the same dates when he was being paid to be on-call at Fort Frances Hospital, he submitted claims and received payment from OHIP in the amount of $37, 827.34 for services rendered at other hospitals, an amount included in the total amount of $204, 959.74, referred to above;
- used vacation days from Fort Frances to provide fee-for-service coverage, and submit claims to OHIP, at hospitals in Ontario not party to the agreement;
- upon learning that Fort Frances Hospital had received information that he was providing services and billing OHIP outside the terms of the agreement, Dr. Abdurahman provided inaccurate information to Fort Frances Hospital regarding the number of dates he was providing services at other hospitals. He also contacted the Chief of Staff of Fort Frances Hospital to ask him to retroactively falsify the Fort Frances Hospital on-call schedule so that the schedule would not reflect conflicts when Dr. Abdurahman was in fact providing services elsewhere.

Resignation and Repayment Plan

Dr. Abdurahman resigned his privileges with Riverside Health Care on October 6, 2016, and is no longer a member of the Group. Dr. Abdurahman entered into a promissory note, dated October 27, 2016, in the amount of $46,944.87, payable to the Group in four instalments. The promissory note reflects money the Group owes to the Ministry of Health and Long-Term Care as a result of Dr. Abdurahman's breach of the Agreement. The amount of $46,944.87 is comprised of the amount paid to Dr. Abdurahman for being the first General Surgeon on-call at Fort Frances on dates when he was also billing OHIP for services rendered in other hospitals, as well as a recruitment bonus he was paid to work in Fort Frances and to which he was no longer entitled due to his breach of the Agreement.

Under the terms of the promissory note, Dr. Abdurahman was scheduled to pay the entire amount by March 17, 2017. To date, Dr. Abdurahman has repaid $6,000.00.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Abdurahman's Certificate of Registration for a nine (9) month period, effective immediately.
- The Registrar impose the following terms, conditions and limitations on Dr. Abdurahman's Certificate of Registration, effective immediately:

    - Dr. Abdurahman will successfully complete the PROBE course in ethics and professionalism, at his own expense, within 6 months of the date of this Order, or any alternate course in ethics and professionalism approved by the College. Dr. Abdurahman will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College;
    - Prior to resuming practice after the period of suspension of his certificate of registration. Dr. Abdurahman shall retain a College-approved clinical supervisor, who will sign an undertaking in the form attached as Schedule "A" to the Order (the "Clinical Supervisor"), to review Dr. Abdurahman's Ontario Health Insurance Plan(OHIP) claims and billings, any other billing submitted to or paid out by the Ministry of Health and Long-Term Care (MOHLTC) and the corresponding patient records;
    - For a period of five (5)years, Dr. Abdurahman may practice only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to review of OHIP billings and corresponding patient charts, and may also include practice management, and continuing education. The period of Clinical Supervision will commence on the expiry of the period of suspension, or on the date that the Clinical Supervisor is approved, if one is not approved during the period of suspension;

- The Clinical Supervisor will conduct the review once every month and the review will consist of at least twenty (20) patient charts, selected in the sole discretion of the Clinical Supervisor, and the corresponding claims and billings submitted to OHIP and/or the MOHLTC;
- The Clinical Supervisor will provide a report to the College once every month, or more frequently if the Clinical Supervisor has concerns about Dr. Abdurahman's standard of practice or conduct.
- If, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason. Dr. Abdurahman shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Schedule "A". If Dr. Abdurahman fails to retain a Clinical Supervisor on the terms set out above within thirty (30) days of receiving notification that his former Clinical Supervisor is unable or unwilling to continue in that role, he shall cease practicing medicine until such time as he has obtained a Clinical Supervisor acceptable to the College. If Dr. Abdurahman is required to cease practice as a result of this paragraph, this will constitute a term, condition and limitation on his certificate of registration and such term, condition and limitation shall be included on the public register;
- After a minimum period of one year of Clinical Supervision, and only upon receipt of approval from the College, the frequency of supervision may be reduced from time to time thereafter as recommended by the Clinical Supervisor and only as approved by the College;
- Upon completion of the five (5) year period of Clinical Supervision, as described above, within approximately six (6) months. Dr. Abdurahman shall undergo a re-assessment of his practice by a College-appointed assessor (the "Assessor"). This re-assessment by the Assessor will include a review of Dr. Abdurahman's office charts and corresponding OHIP billings and an interview with Dr. Abdurahman. Dr. Abdurahman shall abide by all recommendations made by the College-appointed Assessor. The Assessor shall report the results of this re-assessment to the College;
- Dr. Abdurahman shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location;
- Dr. Abdurahman shall consent to the sharing of information between the Clinical Supervisor, Assessor and the College as any of them deem necessary or desirable in order to fulfill their respective obligations;
- Dr. Abdurahman shall consent to the monitoring of his OHIP billings and cooperate with inspections of his practice and patient charts by the Clinical Supervisor and College representatives for the purpose of monitoring and enforcing his compliance with this term of the Order. Monitoring this term shall include making enquiries of the Ministry of Health and Long- Term Care regarding Dr. Abdurahman's billings;
- Dr. Abdurahman 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 shall provide his irrevocable consent to the College to make appropriate enquiries of any person or institution who may have relevant information for the purposes of monitoring and enforcing his compliance with the terms of this Order; and
- Dr. Abdurahman shall be responsible for any and all costs associated with implementing the terms of this Order.

- Dr. Abdurahman shall, within three (3) months, pay a fine to the Minister of Finance in the amount of $35,000.00, and Dr. Abdurahman shall provide proof of this payment to the Registrar of the College.
- Dr. Abdurahman appear before the panel to be reprimanded within three (3) months of the date this Order becomes final.
- Dr. Abdurahman pay to the College its costs of this proceeding in the amount of $5,500 within thirty (30) days from the date this Order becomes final.

Appeal

On August 15, 2018, Dr. Abdurahman appealed the penalty decision of the Discipline Committee to the Divisional Court. Pursuant to s. 25(1) of the *Statutory Powers Procedure Act*, the appeal operates as a stay of the decision pending the outcome of the appeal. Therefore, the penalty decision of the Discipline Committee is not in effect.

2. Dr. R.K.T. Chan

Name:	Dr. Richard Kok Tiong Chan
Practice:	Neurology
Practice Location:	London, ON
Hearing:	Agreed Facts and Joint Submission Penalty
Finding/Penalty Decision Date:	April 23, 2018
Written Decision Date:	May 10, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Richard Kok Tiong Chan (“Dr. Chan”) is a neurologist with the Department of Clinical Neurological Sciences, London Health Sciences Centre. His date of birth is December 22, 1961.

Between 2011 and 2015, Dr. Chan on numerous occasions prescribed Fentanyl patches to his relative (Relative 1) who lives abroad. On each of these prescriptions the ID of the relative was her passport number and the address was Dr. Chan’s home

address. Dr. Chan prescribed to another relative (Relative 2) who also lives abroad. In July 18, 2014, this relative filled a prescription, which was written by Dr. Chan, for 150 tabs of hydromorphone. The prescription bore this relative's passport number, and indicated her address to be Dr. Chan's home address.

Dr. Chan went personally to the drug store himself to have each of the prescriptions he wrote for both of his relatives filled. The Fentanyl patches he prescribed to Relative 1 and the hydromorphone tabs he prescribed to Relative 2were provided to him by the pharmacy.

On January 13, 2016, Dr. Chan wrote a prescription for Relative 1 for 180 Fentanyl patches. As with the previous prescriptions, it bore her passport number and indicated her address to be Dr. Chan's home address. On the prescription he submitted to the Shoppers Drug Mart ("SDM") pharmacy, Dr. Chan wrote "Patient leaving town, OK to release all supplies now".

When in January, 2016, the SDM pharmacist telephoned a number believed to be for the patient, Dr. Chan answered the pharmacist's call and confirmed that he was the prescribing physician, and that he had written the prescription for Relative 1. The pharmacist advised Dr. Chan that the prescription he had written would not be filled because it was for his relative. In a separate conversation with the pharmacy owner, it was suggested to Dr. Chan that he have the patient's family physician write the prescription.

Several days later, Dr. Chan asked Dr. X, a clinical fellow working under his supervision, to write a prescription for Fentanyl for Relative 1. Dr. Chan approached Dr. X during clinic hours and when she was between patients, he told her that his relative had been using the medication and he had been prescribing to her for years. Dr. Chan also told Dr. X that he would have asked another colleague to write the prescription, but that there were no other staff doctors around and that he needed it right away. He told her what medication to prescribe, and he specified the dose and quantity. Dr. Chan told Dr. X that he had already presented a prescription for Fentanyl to the pharmacy, but the pharmacy requested that he have another physician issue the prescription.

Dr. X did not assess Dr. Chan's relative. She did not feel she could refuse Dr. Chan's request, as Dr. Chan was her supervisor and wrote the prescription as requested by Dr. Chan. The same day Dr. Chan submitted the prescription written by Dr. X to the SDM pharmacy to be filled. The pharmacy did not fill the prescription written by Dr. X.

Over January 18 and 19, 2016, Drs. Chan and X exchanged the text wherein Dr. Chan wrote Dr. X that he ended up not sending the prescription to the pharmacy as the pharmacy returned the stocks, that he is glad that he didn't have to use it as he feels awkward for asking her to write the script, and stated that he will bring his relative to the doctor when he gets home. Several days later, the pharmacy

telephoned Dr. X to confirm whether the prescription she had written was valid. Dr. X confirmed having written it, but stated that she had not seen the patient.

In the course of the College's investigation into Dr. Chan's prescribing, Dr. Chan provided conflicting or inaccurate information regarding:

- Dr. Chan's contact with a physician who treated Dr. Chan's Relative 1in the foreign country where she resides;
- The length of time for which he had been prescribing Fentanyl to Relative 1;
- The number of pharmacies at which he had filled Relative 1's Fentanyl prescriptions;
- Where and how he treated and examined Relative 1; and
- How he got the Fentanyl to Relative 1.

In the course of the College's investigation into Dr. Chan's prescribing, Dr. Chan provided some information that conflicted with information provided to the College by the pharmacist and/or pharmacy owner.

Disposition

The Discipline Committee ordered that:

- the Registrar suspend Dr. Chan's certificate of registration for a five (5) month period, to commence at 12:01 a.m. on May 1, 2018.
- the Registrar impose the following terms, conditions and limitations on Dr. Chan's certificate of registration:

  Prescribing Privileges

  - Dr. Chan shall issue new prescriptions or renew existing prescriptions for any of the following substances only to patients whom Dr. Chan is treating in a hospital setting (including in-patients, clinic patients, and emergency department patients):
    - Narcotic Drugs (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19); and
    - Narcotic Preparations (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19).

    A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached as Schedule "A" to the Order dated April 23, 2018; and the current regulatory lists are attached as Schedule "B" to the Order dated April 23, 2018.

Prescription Log

- Dr. Chan shall record all prescriptions he writes for the substances set out in paragraph 4.(1), and other specified information, in a prescription log or logs containing the information set out in the attached Schedule “C” to the Order Dated April 23, 2018, which shall be made available to the College at the College’s request.
  A copy of each prescription written by Dr. Chan for a drug set out in paragraph 4(1) shall be maintained either in the appropriate hospital records or Dr. Chan’s office chart.

Coursework

- At his own expense, Dr. Chan shall participate in and successfully complete by the end of 2018:
  - A prescribing course acceptable to the College; and
  - The PROBE course in ethics and professionalism by obtaining an unconditional pass, or any alternate course in ethics and professionalism approved by the College. Dr. Chan will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College.

Compliance

- Dr. Chan must inform the College of each and every location at which he practices or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within fifteen (15) days of commencing practice at that location.
- Dr. Chan shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the terms of this Order.
- Dr. Chan shall co-operate with unannounced inspections of his Practice Location(s) and patient charts by the College and to any other activity the College deems necessary in order to monitor his compliance with the terms of this Order.
- Dr. Chan shall provide his irrevocable consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the *Narcotics Safety and Awareness Act*, *2010* and any person or institution that may have relevant information, in order for the College to monitor his compliance with the terms of this Order.
- The College may provide this Order to any Chief(s) of Staff, or a colleague with similar responsibilities, at any Practice Location where he practices or has privileges ("Chief(s) of Staff"), or other person or individual as necessary for the implementation of this Order and shall consent to the College providing to said Chief(s) of Staff, person or organization with any information the College has

that led to this Order and/or any information arising from the monitoring of his compliance with this Order.

- Dr. Chan appear before the panel to be reprimanded.
- Dr. Chan pay to the College its costs of this proceeding in the amount of $6,000 within thirty (30) days from the date of this Order.

3. Dr. R.K. Chandra

Name:	Dr. Ranjit Kumar Chandra
Practice:	Pediatrics
Practice Location:	Mississauga, Scarborough, Brampton
Hearing:	Contested
Finding Decision Date:	December 8, 2017
Penalty/Written Decision Date:	June 18, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- failed to respond appropriately or within a reasonable time to a written inquiry from the College **- proved**

Summary

Dr. Ranjit Chandra is a pediatrician who has been a member of the College since 1994. He has been practising in the field of allergy medicine in six locations.

Scheme to Defraud OHIP

In March 2016, while investigating another physician, College investigators noted unusual billing patterns and referral sources regarding Dr. Chandra's billings. Several weeks later, the College received a complaint from a patient, Patient A, who had seen Dr. Chandra on one occasion. Patient A testified that Dr. Chandra asked her to participate in a fraudulent billing scheme using her health card number and those of her family for services he had not provided. Patient A also heard Dr. Chandra approach other patients to the same effect. She contacted the police and then notified the College. Three other patients testified at the hearing and the Committee considered detailed documentary evidence including OHIP records, Dr. Chandra's banking records from the Royal Bank of Canada, Dr. Chandra's records from Roger Communications and Bell Canada, as well as e-mail correspondence from computers that were seized by the College.

The evidence demonstrated that Dr. Chandra recruited approximately 300 people to this scheme and $2,056,342 in OHIP fees were paid to Dr. Chandra over four years.

The Committee concluded that Dr. Chandra had engaged in a fraudulent scheme to defraud OHIP. It had direct evidence from Patient A who had been approached by Dr. Chandra to participate in the scheme and had been offered money to allow the fraudulent use of her OHIP card and that of her family members. The Committee also had direct evidence from two patients (Patients B and C) who had received payments from Dr. Chandra for their participation in this scheme, both of whom testified that they had received no treatment at all for the vast majority of the services for which Dr. Chandra billed OHIP. The Committee also heard from Patient D, who testified that Dr. Chandra had billed OHIP for many services for which he received no treatment.

The evidence of the investigator and the documentary evidence demonstrated that these incidents were part of a pattern of conduct by Dr. Chandra, over at least a four-year period, with significant sums of money being paid by Dr. Chandra to patients he designated as “leaders” or as receiving “extras.” The Committee found the evidence demonstrated that Dr. Chandra used these terms to refer to patients who permitted the use of their health cards in return for a portion of Dr. Chandra’s OHIP billings. The evidence indicated that the largest payments were made to employees or former employees of Dr. Chandra. The evidence also demonstrated that Dr. Chandra billed for audiometry and pulmonary function tests, despite there being no such equipment in his offices. There were no charts for multiple patients for whom he billed, and even for those patients with charts, the medical notes did not support the vast majority of the billings. There were suspicious bundling of billing codes of increasing frequency, an unusual pattern of billing for services in bulk going back up to six months, and an unusual cluster of billings by household. The evidence further demonstrated that Dr. Chandra had billed OHIP for services ostensibly performed on dates when Dr. Chandra was not in the country. Also, there were Royal Bank of Canada records including cheques made out to specific individuals from Dr. Chandra’s medical professional corporation, who were participating in the recruitment of individuals who were to be billed as patients, classified as “leaders”, who were to bring in others, classified as “extras”, with lower levels of recruits. There were also regular patients who were unaware that their OHIP numbers were used to bill for multiple services that did not take place. While much of the evidence in this regard was circumstantial, the Committee was satisfied that it demonstrated a fraudulent scheme by Dr. Chandra to defraud OHIP, a conclusion supported by the direct evidence of Patients A to D and the documentary evidence.

The Committee concluded that Dr. Chandra engaged in a systematic scheme to defraud OHIP by submitting false claims and that he enlisted some of his patients in this scheme. The Committee found that such conduct constitutes an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Failed to Respond to Written Inquiry from the College

The Committee found that during its investigation, the College wrote to Dr. Chandra over a six-month period from July 5 to December 12, 2016, requesting that he attend for an interview, either in person or by telephone, and provide certain information and reminded him of his duty to cooperate with the College's inquiries. Dr. Chandra declined to attend an interview and to provide the requested materials.

Paragraph 1(1) 30 of O. Reg. 856/93 provides that failing to respond appropriately or within a reasonable time to a written inquiry from the College is an act of professional misconduct. Subsection 76 (1.1) of the Code states that an investigator may make reasonable inquiries of any person, including the member who is the subject of the investigation, on matters relevant to the investigation. In addition, subsection 76 (3.1) of the Code provides that a member shall cooperate fully with an investigator.

The Committee found that Dr. Chandra's willingness to "consider" the College's request for an interview only after he received a complete copy of the documents in the College's possession is a position which overtly challenges the authority conferred upon the College and undermines the College's ability to safeguard the public. It is not for the subject of the investigation to dictate the manner in which the College gathers information or to otherwise control the sequence or timing of the investigatory process. The College has a duty to serve and protect the public interest, and in doing so, to choose the timing and means of investigation that are most likely to determine the truth and protect the public.

The duty of members to respond is a statutory one and there are no exceptions. It is an essential tool for the College to fulfill its primary objective of protecting the public interest. There is no statutory requirement for the College to release investigative material at the interview stage. The Committee notes that by the time the interview was being requested, there was a high degree of suspicion of fraudulent behaviour and the investigator needed to be able to address specific questions at an interview. The Committee concluded that it was reasonable for the College to refuse further disclosure before conducting an interview with Dr. Chandra. Accordingly, the Committee did not accept the position advanced by Dr. Chandra's counsel at the time in correspondence that Dr. Chandra was entitled to refuse to be interviewed by the College until his demands for full disclosure were met. The Committee found that Dr. Chandra was required to meet with the College investigator and provide the information requested, and that his failure to do was a breach of his obligation to respond appropriately or within a reasonable period of time to a written inquiry of the College.

The Committee also concluded that a pending criminal proceeding is no basis for a member to refuse to be interviewed or to otherwise refuse to co-operate with the College's investigation. The case law demonstrates that the criminal courts are sensitive to the fact that members of a regulated health profession are required to provide statements to their regulators and can and do protect the member's *Charter* rights.

The Committee found that Dr. Chandra failed to respond appropriately or within a reasonable time to a written inquiry from the College.

The Committee also found that Dr. Chandra's failure to respond within a reasonable time to the College's written inquiry was an abrogation of his professional duty and constitutes an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar revoke Dr. Chandra's certificate of registration, effective immediately.
- Dr. Chandra pay a fine to the Minister of Finance in the amount of $35,000.
- Dr. Chandra shall appear before the Committee to be reprimanded.
- Dr. Chandra pay to the College costs in the amount of $16,500 within 30 days of the date of this Order.

4. Dr. P.D. Davison

Name:	Dr. Peter Diarmuid Davison
Practice:	Family Medicine
Practice Location:	Ottawa
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date:	May 1, 2018
Written Decision Date:	June 6, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**

Summary

Dr. Davison is a family physician practising in Ottawa. He received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario in 1975.

<u>Patient A</u>

Patient A, a man in his 90s, has been a patient of Dr. Davison since mid-1990s. Dr. Davison has followed Patient A for his general primary care needs, including with respect to hypertension, osteoarthritis, coronary artery disease, B12injections,

respiratory concerns, situational mood issues related to the passing of his family member and ongoing sleep issues.

In 2015, a general evaluation was conducted of Patient A at the Hospital by a geriatric nurse. The outcome of the evaluation was “suspected dementia” and “probable mixed mild dementia”. Following this, Dr. Davison completed an assessment for Patient A in support of his application for admission into a long-term care home and completed an Ontario Pharmacist Association Notification Form in April 2016, which was provided in support of a more frequent medication dispensing interval for Patient A. Dr. Davison described that Patient A “forgets to take his medications” and is late for refills “up to 1 month sometimes”.

In July of 2016, Dr. Davison was experiencing acute financial difficulties, both of a professional and personal nature, including with respect to paying office rent. He turned to a close friend for help, who was unable to provide him with financial assistance. He petitioned his office landlord to come to a workable solution and the landlord partially agreed, but some funds were still needed in order to get back into the office. Given his age and stage of career, he was also deeply embarrassed by the circumstances. Aside from his wife and close friend, he did not share details of his financial difficulties with other family members, including his children, nor did he seek support from additional friends or family.

Dr. Davison visited Patient A at his condominium, where he lives alone, and requested financial assistance from Patient A. No-one besides Dr. Davison and Patient A was present for this discussion. Patient A agreed and provided a cheque for $10,000 to Dr. Davison. Dr. Davison indicated he would return the money once he was in a position to do so and cashed Patient A’s cheque on July 28, 2016. In August 2016, Dr. Davison attended at Patient A’s condominium again to advise that he was not yet in a position to return the money. He expected to receive a payment from OHIP in mid-August which had not yet arrived as expected. No-one besides Dr. Davison and Patient A was present for this discussion.

The College received a complaint about Dr. Davison on September 1, 2016 from a close friend of Patient A, Ms. B. Dr. Davison was verbally notified of the complaint on September 12, 2016 and in writing on September 19, 2016. On September 20, 2016 Dr. Davison received a payment from OHIP. That same day, Dr. Davison provided a cheque, dated September 20, 2016 to Patient A in the amount of $10,000, together with a thank you card. The cheque was cashed on September 22, 2016.

In November of 2016 College Investigator spoke with Patient A, who indicated that Dr. Davison had repaid him and that he had deposited the cheque. When the Investigator requested confirmation that the cheque was deposited, Patient A responded that as far as he was concerned the matter was closed.

In his response to the College, dated October 31, 2016, Dr. Davison indicated that the decision to approach Patient A was made while he was under a considerable amount of stress, which he acknowledged and understood was misguided. While he believed at the time that he and Patient A were on equal footing and that Patient A was not a vulnerable person, he appreciated that he put Patient A in a difficult position and he apologized to Patient A.

The College commenced investigation on March 12, 2017. Dr. Davison cooperated with the College's investigation. He has no prior history of any discipline proceeding.

Disposition

The Discipline Committee ordered and directed that:

- The Registrar suspend Dr. Davison's certificate of registration for a three month period, to commence at 12:01 a.m. on May 2, 2018.
- The Registrar impose the following term, condition and limitation on Dr. Davison's Certificate of Registration: Dr. Davison will successfully complete one on one instructions in medical ethics with an instructor approved by the College, at his own expense, within six months of the date of this Order, and shall provide proof of completion to the College.
- Dr. Davison appear before the panel to be reprimanded.
- Dr. Davison pay to the College its costs of this proceeding in the amount of $5,500 within thirty (30) days from the date of this Order.

5. Dr. T.C. Drone

Name:	Dr. Troy Christie Drone
Practice:	Anaesthetics
Practice Location:	Kitchener
Hearing:	Agreed Facts and Joint Submission Penalty
Finding/Penalty Decision Date:	June 25, 2018
Written Decision Date:	July 25, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Conduct unbecoming a physician **– withdrawn**

Summary

Dr. Drone is a physician who currently practises as an anesthetist in Kitchener. He received his certificate of registration authorizing independent practice in Ontario in 1994. At the time of the incidents described below, Dr. Drone was a member of the

Ontario Medical Association ("OMA"), the association that represents the political and economic interests of physicians in Ontario. It is the exclusive representative of Ontario physicians in negotiations with the Province of Ontario.

Tentative Physician Services Agreement ("tPSA")

On July 11 2016, the OMA and the Ontario government reached a tentative agreement dealing with government funding for physician services and changes to the physician fee schedule, among other issues, tPSA. The tPSA was to have a term of four years, and would have replaced a previous agreement, which terminated in 2014. The tPSA was endorsed by the OMA's Board, including by Dr. Virginia Walley, who was President of the OMA at the time. The OMA promoted the agreement in the weeks leading up to a General Meeting, which took place on August 14, 2016. On August 14, 2016, the OMA membership voted to reject the tPSA.

Dr. Drone's emails between June 21 and August 11, 2016

Between June 21 and August 11, 2016, in response to the OMA's support of the tPSA, Dr. Drone sent a series of emails to Dr. Walley's personal email address, as well as to an email address used by OMA staff, including Dr. Walley, to communicate publicly about the tPSA.

The following are excerpts from the emails:

- June 21, 2016: "… do your paid job and stop letting this horrible government fuck us around!!! Enough already!! Listen to everyone!! Holy fuck. For fucks sake??? Fuck!!!"
- June 28, 2016: "… You suck!!! SUCK!!"
- August 1, 2016: "Dr. Walley, you are a cunt. Crash and burn as you deserve to do!! … Sincerely, FUCK YOU and the OMA!!! Dr. Drone"
- August 10, 2016: "Fuck you!"
- August 11, 2016: at 6:06 pm: "Fuck-off Virginia"; 6:08 pm: "Fuck-off!"; 6:09 pm: "Fuck-off!"

The emails sent by Dr. Drone were viewed by Dr. Walley as well as OMA staff who monitored the tPSA email address.

Dr. Drone's prior history and response during investigation

Dr. Drone has no prior disciplinary history before the Discipline Committee. He provided two responses during the investigation, in which he apologized to Dr. Walley and acknowledged that his conduct was unacceptable. He also undertook Professional Communication coaching with Dawn Martin, Communications Specialist and Educational Consultant, to develop skills related to professional communication in challenging scenarios, specifically with colleagues. Dr. Drone and Dr. Martin met on six occasions between July 2017 and June 2018. In October 2017, Dr. Drone successfully completed the PROBE Ethics and Boundaries Course for physicians.

Disposition

The Discipline Committee ordered that:
- the Registrar suspend Dr. Drone's certificate of registration for a period of one (1) month, commencing at 12:01 a.m. on July 2, 2018.
- Dr. Drone appear before the panel to be reprimanded.
- Dr. Drone pay to the College its costs of this proceeding in the amount of $6,000 within thirty (30) days from the date of this Order.

6. Dr. D.M. Goodwin

Name:	Dr. David Michael Goodwin
Practice:	Family Medicine
Practice Location:	Niagara Falls
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date	July 19, 2018
Written Decision Date:	August 16, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Conduct unbecoming a physician **– withdrawn**

Summary

Dr. Goodwin is a physician who received his certificate of registration authorizing independent practice in Ontario in 1975. Dr. Goodwin's certificate of registration with the College expired on May 31, 2018. Dr. Goodwin practiced family medicine in Ontario until November 2015. He also acted as the Medical Director of a long-term care facility in Ontario. Dr. Goodwin resigned from this role effective January 1, 2018. At the time of the incidents described below, Dr. Goodwin was a member of the Ontario Medical Association ("OMA"), in addition to being a Council member of the OMA and a member of the Executive of the OMA's Section on General and Family Practice ("SGFP").

The OMA is the association that represents the political and economic interests of physicians in Ontario. It is the exclusive representative of Ontario physicians in negotiations with the Province of Ontario.

At the relevant times, Dr. Virginia Walley was President of the OMA and the Minister of Health for Ontario was Dr. Eric Hoskins. On July 11, 2016, the OMA and the Ontario government reached a tentative agreement dealing with government funding for physician services and changes to the physician fee schedule, among other issues

("tPSA"). The tPSA was endorsed by the OMA's Board, including by Dr. Walley. The OMA promoted the agreement in the weeks leading up to a General Meeting, which took place on August 14, 2016. In the lead-up to the General Meeting, the OMA Board promoted the agreement as providing "stability" and "predictability".
On August 14, 2016, the OMA membership voted to reject the tPSA.

On July 29, 2016, Dr. Goodwin posted a letter to "Virginia" signed by "Santa" on a physician-only forum which requires registration and a password to access and which is accessible to the approximately 13,000 OMA members who practice general or family medicine. Dr. Goodwin also emailed the letter to approximately 20 colleagues in the Executive of the SGFP and copied it to an editor at the Medical Post. In addition, Dr. Goodwin forwarded the letter directly to Dr. Walley's personal email address.

The letter signed by "Santa" was written by Dr. Goodwin. It read, in part:

> Dear Virginia
> Thank you for writing me with your existential question.....So yes, Virginia, you can have STABILITY… if you just bend a little further forward and get those hands firmly on the ground. You can also have PREDICTABILITY, but you'll have to keep letting that nice Eric have his way with you. And yes, Virginia, it is ok to vote yes. But it's also ok to vote no.
> Yours in perpetuity
> Santa

Dr. Goodwin's email to Dr. Walley, which included the forwarded letter, read:

> V
> Thought I should share this with
> you....
> Mike

After the letter was posted to the SGFP online forum, the Chair of the SGFP Executive wrote to Dr. Goodwin stating, "There have been some serious concerns brought forward regarding your post. Would appreciate if you can refrain from further private distribution of this message."

Dr. Goodwin responded, stating:

> I'm sorry that you feel that satire is unacceptable at sgfp.net, and that you saw fit to order [D.B.] to remove my post from the website. Unfortunately I had already copied the message to Dr. Walley at her personal email and to [R.C.] Editor at the Medical Post, so any attempt at censorship will likely only highlight the issue [...]

On the same day, another physician on the SGFP Executive wrote to Dr. Goodwin

stating:

> "I am surprised and dismayed by the tone of emails from members of this exec [...] I think it would be valuable for all of us to step back and take a moment to reflect: How would I feel if I was on the receiving end of one of these emails? What am I upset/angry about? Who am I upset/angry at?"

Dr. Goodwin responded, copying the SGFP Executive, stating:

> "Just for the record, I consider Dr. Walley a friend [...] I doubt she would be upset by my now censored post, though she would certainly see the point of the satire […]

It is Dr. Goodwin's position that his email of July 29, 2016 was modeled on an 1897 editorial in the New York Sun known as "Yes, Virginia, there is a Santa Claus".

Dr. Goodwin's certificate of registration with the College expired on May 31, 2018. Dr. Goodwin has advised the College that he does not intend to renew his certificate of registration.

Disposition

The Discipline Committee ordered that:

- the Registrar suspend Dr. Goodwin' s certificate of registration for a period of one (1) month, commencing at 12:01 a.m. on July 20, 2018.
- the Registrar impose the following as a term, condition and limitation on Dr. Goodwin's certificate of registration:
  - Dr. Goodwin will successfully complete the PROBE course in ethics and professionalism by obtaining an unconditional pass, at his own expense, or any alternate course in ethics and professionalism approved by the College, by January 31, 2019. Dr. Goodwin will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College.
- Dr. Goodwin appear before the panel to be reprimanded.
- Dr. Goodwin pay to the College its costs of this proceeding in the amount of $10,180 within thirty (30) days from the date of this Order.

7. Dr. E. Tamari

Name:	Dr. Erez Tamari
Practice:	Family Medicine
Practice Location:	Mississauga
Hearing:	Agreed Facts, Uncontested Facts,

	Joint Submission on Penalty
Finding/Penalty Decision Date	June 13, 2018
Written Decision Date:	August 16, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Failed to maintain the standard of practice – **withdrawn**

Summary

Dr. Tamari is a family physician. For approximately 30 years, Dr. Tamari operated a family medicine practice in Mississauga, and held hospital privileges at a Hospital in Mississauga.

Conduct with Patients

Patient A

Patient A and his family were Dr. Tamari's patients for more than 20 years. In May 2014, Patient A complained to the College about Dr. Tamari's conduct and practice management in relation to him and to his family in 2013 and 2014, including concerns about having to physically attend at Dr. Tamari's office to schedule appointments because of blocked/restricted telephone access to his office. As a result, the family found a new family physician. By letter dated March 10, 2014, Patient A advised Dr. Tamari of the decision to leave his practice and requested copies of medical records, providing signed consents. Patient A and his family's records were provided to the College on July 25, 2014, after Patient A's contact with the College.

Patient B

Patient B, a woman in her 50s, who had been a long-standing patient of Dr. Tamari has a past medical history of a workplace injury in late 2013. At an appointment in May 2014, Patient B requested Dr. Tamari to complete a medical report for her disability insurance claim. In August 2014, Dr. Tamari provided partial copies of select test results to insurance company; however, medical information remained outstanding at the time of Patient B's complaint to the College in February 2015, despite repeated requests. In August 2014, Patient B requested transfer to another family doctor's practice. This doctor made written requests for Patient B's medical records from Dr. Tamari in August and October 2014; no response was received. In January 2015, after telephoning Dr. Tamari's office again, Dr. Tamari faxed 115 pages of Patient B's medical records, but the records did not include any clinical encounter notes. In June 2015, upon request of the College investigator, the insurance company confirmed that requested documentation was still missing, including clinical/chart notes, recent specialist consultation reports and tests/investigations. On February 18, 2015, the College

investigator notified Dr. Tamari of the complaint and requested Dr. Tamari's response and Patient B's original office records for 2014-2015. On April 16, 2015, Dr. Tamari's counsel advised that Patient B's paper chart was destroyed after Dr. Tamari's conversion to an electronic medical record-keeping system, and that the electronic file containing Patient B's recent records was corrupted and could not be opened. The available records were provided to the College.

Patient C

Patient C was a long-standing patient of Dr. Tamari until August 2015, when he relocated to another country. In June 2016, Patient C complained to the College of his concerns regarding Dr. Tamari's failure to provide his medical records to his physician in another country in order to obtain medical insurance and life insurance there. Despite Patient C's and the insurance company's repeated requests between September 2015 and May 2016, Dr. Tamari failed to provide Patient C's records. In the course of the College investigation, a detailed chronology was received setting out multiple attempts made between September 2015 and October 2016 by the third party retained by Patient C's insurer to obtain the required medical information. The Attending Physician's Statement requested by the insurer was received from Dr. Tamari on November 16, 2016. On January 3, 2017, Patient C advised that Dr. Tamari had provided his medical records in December 2016.

Mr. Y

In May 2016, Mr. Y, whose children were patients of Dr. Tamari, complained to the College of the difficulties he experienced over the past year in attempting to arrange an appointment with Dr. Tamari to discuss and receive updated information regarding his children's health. Specifically, Dr. Tamari had not responded to repeated telephone calls by Mr. Y between March 22 and May 15, 2016. Dr. Tamari's office contacted Mr. Y in mid-June 2016, after receiving notification of his complaint to the College, and provided an appointment with Dr. Tamari on June 24. Mr. Y expressed concerns about Dr. Tamari's aggressive communications during that appointment. Despite multiple requests made by the College in August, October, and December 2016, Dr. Tamari did not respond to the complaint.

Patient D

Patient D and her four family members were patients of Dr. Tamari. In March 2017, Patient D complained to the College that Dr. Tamari failed to transfer her family's medical records to their new doctor (Dr. X) after numerous requests and failed to respond to a request by Patient D's family member's insurer for an Attending Physician's Statement. In April 2017, the College received information from the insurer regarding the Attending Physician's Statement; Dr. X also informed the College that she sent written requests for the complainants' medical records, including authorization to release forms, to Dr. Tamari in June 2016.

In March 2017, the College investigator notified Dr. Tamari of the complaint and requested a response and a copy of the complainants' records for 2015-2017. Reminder letters were sent in May 2017. Dr. Tamari's counsel requested an extension to respond in May and again in June. After the second deadline, Dr. Tamari was requested to respond by July 4, 2017. On July 13, 2017, Dr. Tamari's counsel provided a CD with the medical records for Patient D and two of her family members, indicating that the records for the other two family members would follow as Dr. Tamari had challenges providing the records, including computer problems. The received records could be viewed, but they could not be printed without a password, which was unknown. Test results and lab reports for the two remaining family members were provided on July 24, 2017. The clinical notes were not provided as Dr. Tamari's computer had been infected with a virus, which prevented retrieval of the electronic medical records. On August 23, 2017, the College investigator requested copies of all medical records and the Cumulative Patient Profile for each family member. On September 28, 2017, Dr. Tamari's counsel provided a further copy of medical records for Patient D, and her two family members. On October 27, 2017, a further request was made. On November 2, 2017, Dr. X advised that as of that date, no records were received from Dr. Tamari. On November 7, 2017, Patient D's family member's insurance application was denied because the insurer did not receive all of the information they required.

Patient E

In July 2017, Patient E, Dr. Tamari's patient of 24 years, complained to the College that Dr. Tamari failed to provide a necessary form to her insurer within 90 days, as they had discussed. In late July 2016, she became ill and needed to apply for mortgage insurance benefits. In September 2016 she asked Dr. Tamari to complete a form for her insurer. In early January 2017, Dr. Tamari advised Patient E that he had faxed the form to the insurer. When she contacted Dr. Tamari's office several days later, she was told that Dr. Tamari would be re-faxing the forms from his home office. According to Patient E, the insurer never received the necessary documentation and her file was closed. In April 2017, Patient E requested a copy of her medical records from Dr. Tamari. As of January 4, 2018, Patient E confirmed that she had not received her medical records. Dr. Tamari was notified of the complaint on August 8, 2017 and was requested to respond on August 16, 2017. Upon his counsel's request, he was granted an extension to respond by September 22, 2017. On October 27, 2017, College investigator again requested Dr. Tamari's response to Patient E's complaint. On December 8, 2017, the records were provided to the College.

Patient F

Patient F, who was a patient of Dr. Tamari since the early 1990's, was a pedestrian involved in a motor vehicle accident in May 2016 when he was struck by a truck. Patient F saw Dr. Tamari a few times in a six-month period, but needed to see Dr. Tamari more frequently to address his health issues. Despite attempts, he was not able to do so

owing to Dr. Tamari's availability. Patient F found a new family doctor (Dr. Y) in May 2017. Patient F and Dr. Y requested that Patient F's medical records be transferred to Dr. Y. Dr. Y advised the College that a release of records request was completed on May 23, 2017 and faxed to Dr. Tamari's office the following day. After repeated verbal and written requests, a copy of Patient F's chart was provided to him on July 28, 2017 and Patient F brought the records to Dr. Y on August 3, 2017. In July 2017, Patient F complained to the College and Dr. Tamari was notified of the complaint on August 8, 2017. On August 16, 2017, College investigator requested a response and, on August 22, 2017, Dr. Tamari's counsel requested an extension to provide the response to September 22, 2017, which was granted. The College received a copy of Dr. Tamari's clinical notes and records for Patient F on September 28, 2017.

Patient G

In August 2017, Patient G and his wife, Dr. Tamari's patients since 1987, were notified by Dr. Tamari that he had closed his family practice. In January 2018, Patient G complained to the College that on August 23, 2017 he sent a letter to Dr. Tamari's office, as per the instructions in Dr. Tamari's letter, requesting copies of his and his wife's medical records. Patient G called both Dr. Tamari's old office and his new office on numerous occasions from September 2017 to January 2018 and was told by Dr. Tamari's staff that Dr. Tamari had received his request and was working on it. The College investigator notified Dr. Tamari of the complaint in January 2018 and requested his response and a copy of the medical records. Dr. Tamari's counsel advised that she was working on obtaining his response. Reminder letters were sent on April 2 and 24. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue, and will provide records as soon as he is able.

Patient H

In July 2017, Patient H and his wife, Dr. Tamari's patients since 1990, were notified that Dr. Tamari had closed his family practice. They found a new family physician, Dr. Z, in August and release forms were faxed to Dr. Tamari's office that month. In October 2017 Patient H complained to the College that no response was received from Dr. Tamari's office and the release forms were re-faxed by Dr. Z on two different dates in October 2017. As of February 20, 2018, Dr. Z had not received Dr. Tamari's medical records. In his complaint, Patient H stated that his wife has suffered from migraines for many years and, as a result, it is important for her new physician to know what tests have been conducted and what treatments have been attempted. The College investigator notified Dr. Tamari of the complaint in November 2017 and, in February 2018, requested Dr. Tamari's response and a copy of the complainants' medical records. Reminder letters were sent in March and April. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue and will provide records as soon as he is able.

Patient I

In August 2017, Patient I and his family, Dr. Tamari's patients since approximately 1987 and 1990s, were notified that Dr. Tamari had closed his family practice. Patient I had left Dr. Tamari's practice in May 2017 due to repeated cancelled appointments by Dr. Tamari and, as a result, poor management of Patient I's health. On August 17, shortly after receiving Dr. Tamari's letter, Patient I hand-delivered 4 written requests for the family's medical records to Dr. Tamari's receptionist, made numerous monthly calls and left messages with Dr. Tamari's receptionist over the following months. Patient I suffers from a chronic condition and his new family physician, believes that a request for medical records was sent by her office in May 2017, when he first became a patient. As of May 2018, records had not been received by Dr. the new family physician or by Patient I. In February 2018, Patient I complained to the College. The College investigator notified Dr. Tamari of the complaint and requested Dr. Tamari's response and a copy of the complainants' medical records in March 2018. A reminder letter was sent in April. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue and will provide records as soon as he is able.

Patient J

In July 2017, Patient J, Dr. Tamari's patient since 1993, was notified that Dr. Tamari had closed his family practice. Patient J found a new family physician in August and a release form was faxed to Dr. Tamari's office that month requesting a summary of his medical records, relevant consult and lab reports and immunization records. Following the written request, Patient J made numerous calls to Dr. Tamari in September, October, December, January and March. On each of these calls, Dr. Tamari's staff confirmed that the messages were being relayed to Dr. Tamari. In March 2018, Patient J complained to the College. The College investigator notified Dr. Tamari of the complaint and requested Dr. Tamari's response and a copy of the complainant's medical records on March 28, 2018. Dr. Tamari's response, received on May 8, indicated that his efforts to obtain the records have been complicated owing to a corrupted EMR, that he is attempting to resolve this issue and will provide records as soon as he is able.

<u>Administration and Management of Practice</u>

Except Patient F, all the complainant's medical records that Dr. Tamari provided to the College were incomplete and/or illegible. Dr. Tamari failed to take appropriate measures to back up his medical records when he converted from paper charts to electronic medical records. As a result, when a number of patient charts were corrupted the records were lost in their entirety. Several of the patients listed above described difficulties in scheduling appointments with Dr. Tamari's office, issues with the messaging service and that staff was not available or unresponsive to inquiries for records or booking appointments. Particularly important were communication and

coverage, since Dr. Tamari was absent, intermittently, from his practice over the years. This mismanagement impacted his patients' access to care.

Breach of Discipline Committee Order

In May 2012, following the Discipline Committee's finding that Dr. Tamari committed professional misconduct, terms, conditions and limitations were imposed on Dr. Tamari's certificate of registration, requiring, among other things, that Dr. Tamari maintain a log of all requests received for third party reports and medical records indicating when such requests were made and when they were fulfilled. The College's investigations revealed that Dr. Tamari had failed to maintain a complete and accurate Log of all requests for third party reports and medical records, and responses to such requests with respect to Patients B, C, D, E, F, G, H, I and J and their families.

Provision of Information to Hospital

In January 2017, Dr. Tamari completed and submitted his re-appointment application to the Hospital, where he had held hospital privileges for several decades. He answered "No" to the question of whether he was the subject of any complaint, investigation, or review by a licensing body, despite the fact that he was the subject of at least four College investigations as of January 2017 and other College investigations in 2016.

Previous College History

In May 2012, the Discipline Committee found and Dr. Tamari admitted that he had engaged in disgraceful, dishonourable or unprofessional conduct, in that he failed to respond in a timely manner to repeated requests by an insurance company for his patient's medical records in order to process her travel insurance claim in 2009. The Committee ordered a one-month suspension of his certificate of registration. He was also required to undergo a preceptorship in practice management for no less than six months, followed by a reassessment, and to maintain a log of requests for third party reports and medical records, indicating when such requests were made and when they were fulfilled.

In April 2000, Dr. Tamari's certificate of registration was suspended for one month after the Discipline Committee found that he engaged in professional misconduct, in that Dr. Tamari:

- failed to provide a report of an examination or treatment performed by him to his patient within a reasonable time after the patient had requested such a report;
- failed to respond to repeated requests for a patient's medical records from an insurance company, the patient, the patient's employer and the College over a period of fourteen months; and

- failed to respond appropriately or within a reasonable time to a written inquiry from the College.

Upon review of the College investigation results, which revealed that Dr. Tamari had failed to transfer the medical records of a patient and her children to their new physician despite several requests for over four months, the Complaints Committee required that Dr. Tamari attend in person to be cautioned about his disregard for his patients requests for their medical records. After his failing to respond to numerous attempts to schedule this attendance, a date was selected without his input. As a result, the Discipline Committee found that Dr. Tamari failed to attend at the College at the appointed time which, according to the Discipline Committee, showed blatant disregard for the self-governance of the medical profession.

In March 1996, following the College investigation of Dr. Tamari's former patient's complaint that he failed to transfer her and her children's medical records to her new physician in a timely manner and that as a result of his inappropriate transfer, the original medical records were lost, the Complaints Committee:

- cautioned Dr. Tamari in person about his failure to cooperate with the College during the investigation;
- cautioned Dr. Tamari in writing about the importance of patient records and the need to respond to requests for the transfer of records in a timely and professional manner; and
- counselled Dr. Tamari about his obligation to retain patient records for at least 10 years and to transfer only copies of records, while maintaining originals in a secure location for the prescribed period of time.

In May 1991, following a complaint by a patient that he failed to maintain the standard of practice and failed to provide a record, the Complaints Committee counselled Dr. Tamari in writing. Upon further investigation, directed by the Health Disciplines Board following the complainant's appeal, the Complaints Committee:

- counselled Dr. Tamari in writing about the importance of effective communication with patients following discharge from hospital; and
- directed that Dr. Tamari be admonished in person about the importance of undertaking and his personal responsibility to ensure the transfer of requested records within reasonable time, and to do so on an urgent priority basis, where there is indication that records are required for imminent treatment purposes.

<u>Dr. Tamari's Health and Change in Scope of Practice</u>

Since March 2017, Dr. Tamari has been under the care of a new psychiatrist, who reached a new primary diagnosis with respect to Dr. Tamari, which was different from Dr. Tamari's past diagnosis. The psychiatrist started a new treatment regime and Dr. Tamari has been under this treatment for approximately one year.

In January 2018, Dr. Tamari entered into a four-year health monitoring contract with the Ontario Medical Association's Physician Health Program (PHP) which requires, among other things: meetings with his new psychiatrist and compliance with clinical advice and guidance; regular meetings with a PHP Monitor; monitoring of his behaviour in the workplace by a workplace monitor; and remaining under the care of a designated family physician. On January 29, 2018, Dr. Tamari signed an undertaking with the College agreeing to abide by the terms of the January 2018 PHP contract.

In March 2018, Dr. Tamari's new psychiatrist reported that Dr. Tamari's repeated pattern of behaviour, which continued unabated for a number of years, had a significant impact on his work that is necessary to run his day-to-day operation (i.e. patients' correspondence, paperwork, and practice organization) and that Dr. Tamari has displayed significant improvement as evidenced by his ability to cope with unforeseen circumstances in his interpersonal life. In a letter dated April 19, 2018, the PHP notes satisfaction with Dr. Tamari's progress in the monitoring program and with his commitment to his ongoing well-being, confirming that he has been completely compliant with all aspects of his monitoring program.

Dr. Tamari advises that he has put in measures with a view to preventing recurrence of his unprofessional behaviour, including: a structure and routine for addressing his administrative tasks during a part of each day; adherence to a limited, regular exercise routine; and a change in his work structure. In July 2017, Dr. Tamari closed his solo family medicine practice and now shares office space and administrative support with a family physician. His scope of practice is limited to minor surgical procedures and surgical assisting which, according to Dr. Tamari, reduces the administrative tasks in his practice that were primarily responsible for his previous conduct.

Dr. Tamari acknowledges that, throughout the time in which he practised family medicine, as well as in the closing of his family practice, he has repeatedly failed to provide medical records and reports/forms to patients and to third parties in a timely manner, including with respect to patients other than those specified above and has taken steps to rectify these issues.

Disposition

The Discipline Committee ordered and directed that:

- the Registrar suspend Dr. Tamari's certificate of registration for a period of six (6) months commencing immediately.
- the Registrar impose the following terms, conditions and limitations on Dr. Tamari's certificate of registration:

    - Dr. Tamari shall not engage in the practice of general family medicine or be the primary care provider for any patient whatsoever;

- Dr. Tamari's practice shall be restricted to:
    - performing minor surgical procedures in an office-based setting. This includes assessing and preparing a patient for the minor procedure, as well as providing follow-up and treatment of related complications stemming from those procedures; and
    - surgical assisting in a hospital-based setting, provided that a member of the College of Physicians and Surgeons of Ontario is in attendance and performing the surgery;
- Commencing immediately, Dr. Tamari shall maintain a log of all requests for medical records and third party reports made by patients, other physicians or third parties. The log shall indicate when such requests were made and when they were fulfilled (the "Log"), and Dr. Tamari shall submit this Log to the College on a monthly basis for an indefinite period of time. For greater clarity, Dr. Tamari is responsible for maintaining the Log and submitting it to the College during the time that his certificate of registration is suspended;
- Within sixty (60) days of the date of the receipt of valid patient consent, Dr. Tamari shall deliver all existing medical records to all patients and/or third parties included in the Notice of Hearing, including the medical records of those family members referenced in the underlying complaints of the patients included in the Notice of Hearing. The receipt of patient consents and delivery of medical records to the patients and family members addressed in this paragraph, shall be included in the Log, referenced in paragraph above;
- Dr. Tamari shall retain and employ an administrative assistant who will be present at all times that Dr. Tamari is practising in his office;
- Dr. Tamari shall participate in and successfully complete one-on-one individualized educational instruction in ethics with an instructor approved by the College, and provide proof thereof to the College within six (6) months of the date of this Order;
- Upon his return to practice, Dr. Tamari shall practise under the supervision of a College-approved supervisor or supervisors (the "Supervisor(s)") who will sign an undertaking in the form attached as Schedule "A" to the Order. For a period of twelve (12) months thereafter, the Supervisor shall supervise the management of Dr. Tamari's practice. The supervision of his practice management shall contain the following elements:
    - The Supervisor will meet with Dr. Tamari in person a minimum of once a month;
    - The Supervisor will review the Log and corresponding charts, as necessary, to ensure the timely provision of complete records and reports, and, in addition, ten (10) current patient charts selected on a random basis by the Supervisor to ensure accessibility, legibility and completeness;
    - Dr. Tamari shall fully cooperate with, and shall abide by any recommendations of his Supervisor, including any recommended practice management improvements and ongoing professional development;

  - The Supervisor will submit written reports to the College, at minimum, once per month, for the first three (3) months, and every other month thereafter;
  - If a Supervisor who has given an undertaking in the form attached at Schedule "A" to the Order is unwilling or unable to continue to fulfill its terms, Dr. Tamari shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time;

- Dr. Tamari shall inform the College of each and every location where he practises in any jurisdiction (his "Practice Location(s)") within five (5) days of returning to practice and shall inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.
- Dr. Tamari shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and patient charts by a College representative for the purposes of monitoring and enforcing his compliance with the terms of this Order.
- Dr. Tamari shall be responsible for any and all costs associated with implementing the terms of this Order.
- Dr. Tamari shall consent to the College making enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, including his administrative assistant, in order for the College to monitor and enforce his compliance with the terms of this Order.

- Dr. Tamari attend before the panel to be reprimanded.
- Dr. Tamari pay to the College costs in the amount of $10,180.00, within ninety (90) days of the date of this Order.

8. Dr. M.C. Tjandrawidjaja

Name:	Dr. Michael Clarence Tjandrawidjaja
Practice:	Cardiology
Practice Location:	Brampton
Hearing:	Agreed Facts and Joint Submission on Penalty
Finding/Penalty Decision Date	June 25, 2018
Written Decision Date:	August 1, 2018

Allegations and Findings

- Disgraceful, dishonourable, or unprofessional conduct – **proved**
- Conduct unbecoming – **withdrawn**

Summary

Dr. Tjandrawidjaja is a physician who currently practises as a cardiologist in Brampton. He received his certificate of registration authorizing independent practice in Ontario in 2012. At the time of the incidents described below, Dr. Tjandrawidjaja was a member of the Ontario Medical Association ("OMA"), the association that represents the political and economic interests of physicians in Ontario. It is the exclusive representative of Ontario physicians in negotiations with the Province of Ontario.

Tentative Physician Services Agreement ("tPSA")

On July 11, 2016, the OMA and the Ontario government reached a tentative agreement dealing with government funding for physician services and changes to the physician fee schedule, among other issues, tPSA. The tPSA was to have a term of four years, and would have replaced a previous agreement, which terminated in 2014. The tPSA was endorsed by the OMA's Board, including by Dr. Virginia Walley, who was President of the OMA at the time. The OMA promoted the agreement in the weeks leading up to a General Meeting, which took place on August 14, 2016. On August 14, 2016, the OMA membership voted to reject the tPSA.

Dr. Tjandrawidjaja's emails of July 31 and August 8, 2016

On July 30, 2016, OMA members received an email providing information regarding an upcoming vote to ratify the tPSA. The email encouraged members to vote in favour of the agreement. It was sent from an email address used by OMA staff to communicate publicly about the tPSA, and was signed by Dr. Walley. On July 31, 2016, Dr. Tjandrawidjaja replied by sending the following email to Dr. Walley: "You are a turd". On August 8, 2016, Dr. Tjandrawidjaja sent the following email directly to Dr. Walley's personal email address: "Virginia, how much are the liberals bribing you? It will likely come out at some point." The emails sent by Dr. Tjandrawidjaja were viewed by Dr. Walley as well as OMA staff who monitored the tPSA email address.

Dr. Tjandrawidjaja's response during investigation

Dr. Tjandrawidjaja provided a response during the investigation, acknowledging the emails were inappropriate, stating that he regretted sending them, and indicating he wished to apologize to Dr Walley, among other things. In November 2017, Dr. Tjandrawidjaja completed 4.5 hours of one-on-one Professional Communication coaching with Dawn Martin, Communications Specialist and Educational Consultant, to develop skills related to professional communication and collaboration with colleagues.

Disposition

The Discipline Committee ordered and directed that:

- Dr. Tjandrawidjaja appear before the panel to be reprimanded.

- Dr. Tjandrawidjaja pay to the College its costs of this proceeding in the amount of $6,000 within thirty (30) days from the date of this Order.

Motion to Vary – 1 case

1. Dr. A.W.W. Lau

Name:	Dr. Alvin Wah Wing Lau
Practice:	Family Medicine
Practice Location:	Sarnia
Motion to Vary:	Proceed on Consent of the College
Order Date:	May 2, 2018
Reasons for Order Date:	August 14, 2018

Summary

On December 2, 2013, the Discipline Committee found that Dr. Alvin Wah Wing Lau, a family physician, committed an act of professional misconduct, 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 by members as disgraceful, dishonourable or unprofessional.

On August 21, 2007, the Discipline Committee found that Dr. Lau had committed an act of professional misconduct and failed to maintain the standard of practice of the profession in that he failed to conduct a physical examination of four obstetrical patients and did not take a history of three of those patients, but noted on the patient record that he had done so.

On August 21, 2007, the Discipline Committee ordered that:

3. Dr. Lau appear before the panel to be reprimanded.

4. The Registrar suspend Dr. Lau's certificate of registration for a period of twelve (12) months. The suspension shall commence at 12:01 am on September 1, 2007.

5. Four (4) months of the suspension referred to in paragraph 2 shall be suspended provided Dr. Lau meets the following conditions:

    (a) Dr. Lau will successfully complete, at his own expense, a Medical Ethics Course organized through the College's Quality Management Division;
    (b) Dr. Lau will successfully complete, at his own expense, the Physician-Patient Communication Skills Course offered by the College or, in the alternative, a comparable course organized through the College; and

(c) Dr. Lau will continue to abide by the following terms, conditions and limitations, which are set out in the s. 37 Order dated August 8, 2006:

i. Dr. Lau, at his own expense, shall cause a monitor to be present during his appointments with all patients at his office practice and walk-in clinic;
ii. That 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 as amended, who is acceptable to the College of Physicians and Surgeons (the "College");
iii. That monitor shall review each of Dr. Lau's chart entries to ensure that they accurately represent the appointment proceedings and will countersign the entry with Dr. Lau;
iv. At all times, Dr. Lau shall ensure that the monitor keeps a log of each patient seen. The log shall contain the name of the patient and the date of the encounter;
v. Dr. Lau shall ensure that the monitor provides to the College a copy of the log during the previous month, by facsimile on the 1st of each and every month;
vi. Dr. Lau, at his own expense, shall cause a member of the College of Physicians and Surgeons, who is acceptable to the College, to review his patient charts on a daily basis (the "Chart Review");
vii. The physician conducting the Chart Review shall provide to the College a monthly update on Dr. Lau's charts and the appropriateness of the care provided to Dr. Lau's patients by Dr. Lau as indicated in the charts;
viii. Dr. Lau shall co-operate with the monitor and the physician conducting the Chart Review and not interfere with their abilities to perform their respective functions, including allowing them free access to his charts;
ix. Both the monitor and physician conducting the Chart Review shall report to the Registrar of the College immediately any and all irregularities they may encounter;
x. Dr. Lau shall provide a signed consent allowing the College to have access to his OHIP billings; and,
xi. Dr. Lau shall co-operate with, unannounced inspections of his office(s) and practices(s) and patient charts by a College representative for the purposes of monitoring and enforcing his compliance with the terms of this Order.

6. The Registrar impose the terms, conditions and limitations set out in paragraph 3(c) above on Dr. Lau's certificate of registration. Dr. Lau may apply for the terms of this Order to be varied as of August 21, 2012. If Dr. Lau makes such an application, he will provide the results of a practice assessment arranged by and acceptable to the College to be completed at Dr. Lau's expense. Dr. Lau may request such a practice assessment any time after February 21, 2012 and the College agrees to make reasonable efforts to arrange and complete the practice assessment within the six month period after Dr. Lau initiates the request.

7. Dr. Lau pay to the College costs in the amount of $2,500.00 within thirty (30) days of the date of this Order.
8. The results of this proceeding be included in the register.

At the discipline hearing on December 2, 2013, Dr. Lau admitted that he failed to comply with the terms, conditions and limitations imposed by the Discipline Committee on his certificate of registration on August 21, 2007, in that he permitted the monitor to be absent from the room in response to specific patient requests. Dr. Lau admitted that such conduct was unprofesssional and thereby constituted an act or omission relevant to the practice of medicine that, having regard to all of the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional by members of the profession. The parties agreed that the conduct should be characterized as unprofessional. Dr. Lau also admitted that he did not seek guidance or advice from the College regarding compliance with the 2007 Order of the Discipline Committee where a patient requested that the monitor not be present and he did not apply to vary the terms of the Order of the Discipline Committee to address situations where a patient requested that the monitor not be present.

The Discipline Committee accepted Dr. Lau's admission and found that his conduct constituted professional misconduct.

On December 2, 2013, the Discipline Committee reserved its decision on penalty. On February 5, 2014, the Discipline Committee ordered and directed that:

- Dr. Lau appear before the panel to be reprimanded.
- Dr. Lau pay costs to the College in the amount of $4,460 within thirty (30) days from the date of this Order

On December 2, 2013, Dr. Lau made a motion to vary the Committee s Order of August 21, 2007. The Discipline Committee reserved its decision on the motion. On February 5, 2014, the Discipline Committee denied Dr. Lau's motion to vary the Committee s Order of August 21, 2007.

Motion to Vary

On May 2, 2018, Dr. Lau made a further motion to vary the Committee's Order of August 21, 2007. The College consented to the order sought based on the evidence presented and an undertaking by Dr. Lau to the College.

Disposition

On May 2, 2018, the Discipline Committee ordered and directed that:

- the Order of the Discipline Committee dated August 21, 2007 be varied, removing the terms, conditions and limitations on Dr. Lau's Certificate of Registration set out at paragraph 5(c).

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

2019 Council and Executive Committee Meeting Dates

Meeting	Date
Executive Committee	Tuesday, January 15
Council - Strategic Planning	Thursday, Feb. 28
Council	Friday, March 1
Executive Committee	Tuesday, March 19
Executive Committee	Tuesday, April 23
Council	Thursday, May 23 Friday, May 24
Executive Committee	Tuesday, June 18
Executive Committee	Tuesday, August 13
Council	Friday, September 20
Executive Committee	Tuesday, October 15
Executive Committee	Tuesday, November 12
Council	Thursday, December 5 Friday, December 6