Dr. Lalitha Shankar, a Toronto radiologist, performs assessments for the Independent Health Facilities program.

A Culture of Care
Working together to provide quality care to our patients

- Treating Self and Family
- Meet the New President
- Patient Safety Recommendations
is the official publication of the College of Physicians and Surgeons of Ontario. The objective of this magazine is to provide clear policy direction and review pertinent legislative and disciplinary information, consult with the profession on issues of concern, and provide a forum for discussion and exchange of information and ideas. This publication does not accept unsolicited manuscripts.

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The College of Physicians and Surgeons of Ontario is the licensing and regulatory body governing the practice of medicine in Ontario. The College is responsible for setting and maintaining medical standards, licensing physicians, investigating complaints about physicians on behalf of the public, and disciplining doctors found to have committed act(s) of professional misconduct.

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Dear Editor:

Re: Member Information, Dialogue, Issue 3, 2013

Thank you for the recent edition’s theme on “information”, especially about members, and the importance of “protecting the public.” Apart from details of how our patient’s feel about us (i.e., the number of complaints lodged against us), and how the College feels about us (the number of validated concerns from the previous list), I’m not sure how even more information will be helpful, until we get to the point of total information disclosure.

By way of example, let us presume that the public has information that Physician A has a 10% mortality rate (or adverse outcome rate) for a certain procedure/intervention, Physician B has a 1% rate and Physician C has a 0.1% rate. Who would you choose?

The “back story” is that Dr. A only provides services to the terminally afflicted – he starts with patients who are facing certain death by regular standards. He is tremendously successful and an outstanding physician. Dr. B is a “regular” guy – he takes all comers and has the global average success rate with them. Dr. C takes only minimally complicated cases, those in fact with almost no risk of adversity whatsoever, but one in a thousand of his patients dies due to poor risk management. Who would you choose now?

Until we have FULL disclosure – MCAT scores, full academic transcripts, access to ITER ratings, scores on postgraduate activities, peer rankings, and ADJUSTED odds ratios for standardized cases (including “the complex patient”), simulator performance ratings, as well as all the usual College information (and yes it has to be readily accessible) – how can the public make an informed decision? Lest you feel that I am giving too many points of information on any one physician – could anyone explain what point of information would NOT be useful for an informed public to use to optimize their decision of physician choice? Religion, gender, income, race, cultural affiliation?

Of course, there would also be a large number of medico-legal problems – since the standard is currently “a prudent physician in the same circumstances” – but we know some prudent physicians are much more prudent than others. Would we be judged according to our peers – our average peers, or our lowest acceptable peers, or the standard our best peers could (easily) attain?

If the “Privacy train has left the station” perhaps we had better check that all the carriages are connected. As Einstein said – “There’s no point in getting excited or vexed – you’re always late for the previous train and always in time for the next.” I hope health-care literacy, and its associated health-care practitioner selection skills, is the next train.

Mark Voysey, MD
Toronto
Dear Colleagues

We have developed a revised draft policy that addresses the provision of physician services during job actions.

Now, we want to hear what you think. Does it adequately protect the public interest? Is it reasonable and practical for physicians? Let us know.

The Providing Physician Services During Job Actions draft acknowledges that there may be rare instances when physicians may consider withdrawing their services as part of a job action.

It, however, states that physicians must fulfill their professional responsibilities and uphold the reputation of the profession by providing services to those in need during job actions. Given the significant negative implications that a withdrawal of services can have on patients and the public, the decision to participate in a job action cannot be made lightly. The draft makes it clear that physicians must first explore all alternative options that may be available to resolve the concern that has motivated the desire to withdraw services. If the concern cannot be resolved, physicians must consider several patient safety factors before making the decision to withdraw services.

If after doing that, physicians still believe that proceeding with a withdrawal of services is not contrary to their professional responsibilities, they must mitigate the withdrawal on patients and/or the public.

Ultimately, the College expects that during a job action, physicians will provide patients with medical care that is urgent, or otherwise necessary to prevent harm, suffering and/or deterioration. This will include ensuring patients’ health-care concerns are assessed and appropriately triaged so that urgent and/or necessary medical care can be obtained.

I urge you to read the full draft policy at www.cpso.on.ca under Consultations and provide comment. I can assure you that your feedback is important to the development of policy. We also have developed a Q&A about the revised draft policy and urge you to read that on page 29.
This is my last letter to you as President of the College. Serving the public and my colleagues in this capacity over the past year has been one of the most rewarding experiences of my professional life, and I am grateful I’ve had this opportunity.

I’d like to express my sincere appreciation to my fellow Council members for their support over the last year. I also acknowledge the dedication of Dr. Rocco Gerace and thank College staff members for their valuable assistance.

I’d also like to thank my family and colleagues for their support during my Presidential year.

Dr. Marc Gabel now has the privilege of serving as your President, and I wish him every success.

Early in 2013, Council approved a bylaw that requires physicians to have an email address for College communications. Please note that email is now the primary vehicle for the circulation of proposed bylaw and regulation notices. The consultation period begins the day the College emails the notice to its members.

Using email to circulate regulations and bylaws will save time, reduce costs, promote efficiency and improve communications with the membership.

If you have not provided an email address to the College, please do so immediately. You are required to do so under the College’s bylaws. Please ensure that your spam filters do not block messages from the College.

We will continue to publish notices about all consultations, including contact information and deadlines, in Dialogue.
Spousal exception bill doesn’t recognize power imbalance

As you may be aware, a Bill was passed recently that creates an exception to the sexual abuse provisions in the RHPA.

Bill 70, the Regulated Health Professions Amendment Act (Spousal Exception) Act gives a health regulatory college the option of submitting a regulation that, if approved by government, would exempt treatment of members’ spouses from the sexual abuse provisions of the RHPA.

This College has no plans to submit such a regulation. We have been clear from the beginning that we did not think any legislative changes were required in this area. In fact, our new president, Marc Gabel, explained why we wanted to maintain the status quo in front of the Standing Committee in October.

Of most concern to the CPSO is the existence and implications that stem from the power imbalance between patients and their doctors. While some health practitioner groups have advanced arguments in favour of a spousal exemption because they feel it would be convenient and appropriate to treat their spouse, this is not the case for physicians.

Of all of the Ontario health colleges, the College of Physicians and Surgeons of Ontario has conducted by far the greatest number of disciplinary hearings related to sexual abuse. This has included cases involving patients who have been sexually abused by their “spouses.” Vulnerability to sexual abuse can and does exist both within and outside spousal relationships.

While we acknowledge that more than 20 very different health professions are subject to the same legislation, it is never good medicine for physicians to treat themselves or their family members. A personal relationship can impede the provision of quality medical care, because the physician risks losing clinical objectivity and judgment. I urge you to read our Practice Points article on page 49 to see exactly where physicians can run into trouble when they cross that boundary.

...In this issue of Dialogue, we acknowledge the contribution of those many physicians who keep medical self-regulation healthy and thriving. I am happy to report that 1,367 physicians participated in College activities last year. This is the highest number ever. These doctors sit on committees, do case reviews, assess peers, participate in policy development and make decisions about the quality of medical care delivered in this province.

The regulation of the profession by its own members remains the best way to ensure that patients in Ontario receive the best possible health care.

I thank all of them for their hard work.

Rocco Gerace, MD Registrar
From our Twitter page

Below are some tweets pulled from our Twitter page.

OMSA Communications @OMSA_Executive
Great meeting & discussion w/the @CPSO_ca on improving outreach & education in the future to Med students #meded #professionalism

Scott Wooder @ScottWooder
It was my pleasure to attend @CPSO_ca dinner with President Eric Stanton, Pres-Elec Marc Gabel and newest council member Brenda Copps

GTA Top Employers @GTATopEmployers
#FF Congratz #GTATopEmployers #winners @Canadian Tire @AskCapital-One @CarswellHREvent @CAPM_Toronto @cibc @cocacola_ca @cpsso_ca @CorusPR

Second Harvest @2ndHarvestTO
@cpsso_ca Wow! Thank you SO much! Happy to be part it. Your support will help us rescue enough excess food for 10,000+ meals. #holidaygiving

Pat Rich @cmaer
Timely tweet RT @cpsso_ca: Policy on “Decision-making for the EOL” up for review. Accepting feedback til Fri: bit.ly/1dhSz0 #hcsmca

OMSA Communications @OMSA_Executive
Pay attention for posts rom @cpsso_ca later today for their Trivia challenge! #meded #onhealth

Wendy Stewart @3ndySt3wart
@cpsso_ca – Yay! Great job keeping docs, healthcare workers and the people of Ontario informed!

Reed Smith @reedsmith
Great to hear from @cpsso_ca on physician use of #hcsm – Interesting to see their TOU and Policy. #smHealth

We welcome your feedback on any issue raised in Dialogue.

Please send your comments by email to Dialogue’s Managing Editor at editor@cpsso.on.ca, or send your letters to:

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We reserve the right to edit letters for length and clarity.
New President, Vice-President

Dr. Marc Gabel and Dr. Carol Leet elected to lead Council for 2013-2014 year

**DR. MARC GABEL, PRESIDENT**

Dr. Marc Gabel, a Toronto general practitioner practising in psychotherapy, is the College’s new President.

Dr. Gabel attended medical school at the State University of New York, (SUNY-Downstate).

He came to Council in 2002 for a three-year term and was re-elected in 2008, and again in 2011.

Before arriving at Council, Dr. Gabel was a peer assessor for several years.

Dr. Gabel has participated on the Executive, Finance, Governance, Methadone, Outreach and Quality Assurance Committees.

Between 2005-2008, Dr. Gabel co-chaired the Discipline Committee as a non-Council member.

Dr. Gabel also chaired the working group that updated the Medical Records policy.

In the coming year, Dr. Gabel will sit on the Finance and Governance Committees as well as chair the Outreach Committee and the Executive Committee.

Find out more about Dr. Gabel in our Q&A on page 31.

**DR. CAROL LEET, VICE-PRESIDENT**

Dr. Carol Leet, a Brampton pediatrician, is the College’s new Vice-President.

Dr. Leet attended medical school at Queen’s University and is currently affiliated with William Osler Health Centre, Brampton.

Dr. Leet was returned to Council in 2011 for a second term. She arrived at the College 12 years ago as a member of the Complaints Committee. Eventually she assumed the role of chair of the committee, which has since been renamed the Inquiries, Complaints and Reports Committee (ICRC).

In addition to chairing the ICRC, Dr. Leet has also participated on the Executive, Finance, Governance, and Outreach Committees.

In 2010, Dr. Leet chaired the working group on the Test Results Management policy.

In the coming year, Dr. Leet will participate in the Executive, Finance, Governance and Outreach Committees. She will also chair the working group on the End of Life policy review.
A Culture of Care

Working together to provide quality care to patients

Dr. Kathleen Ferguson, pictured here, is one of the more than 1,367 Ontario doctors who participated in the activities of self-regulation last year.

When physicians participate at the College – whether sitting on a College committee, or assessing their peers, or providing clinical opinions – they keep self-regulation healthy. It is a service that benefits the College, the profession, patients and the public.

Fortunately, it is also time well spent for the participating doctor.

Dr. Kathleen Ferguson, a respirologist from London, says her experience as a member of the Inquiries, Complaints and Reports Committee has made her a better doctor. The Committee’s mandate is to serve and protect the public by fairly and appropriately evaluating complaints about physicians.

“I have learned a tremendous amount in my time on the Committee. Certainly, my clinical notes are the best they have ever been. I am also more sensitive to the moods and concerns of my patients and to the types of behaviour and situations that may increase the likelihood of a complaint,” said Dr. Ferguson, who has sat on the Committee for two years.

Dr. Ferguson said she will continue working on the Committee because she finds the work both interesting and challenging.

She noted that she enjoys working alongside the public members of the Committee and is impressed with the valuable input they bring to the consideration of cases.

Dr. Ferguson believes it is crucial that physicians participate in self-regulation in order to maintain the privilege.

“I cannot imagine a better system than self-regulation,” she said. “Doctors understand all aspects of the medical care that we provide better than anyone else. It is helpful that there are specialty panels at the ICRC so that the assessment of complaints involves peers from both academic and community practice.”
The medical profession has self-governed more than 147 years in Ontario; it is easy to take it for granted that it will always be the case. But self-governance can be weakened or even abolished if it doesn’t have a strong College that is supported by its members, said Dr. Rocco Gerace, College Registrar.

In these pages, you will see the names of 1,367 physicians who gave of their time to ensure that regulation of the profession by its own members remains the very best way to ensure that patients in Ontario receive the best possible health care.

“Self-regulation survives and indeed thrives because of such physicians,” said Dr. Gerace. That is why we have taken the opportunity to provide some much-deserved recognition to these physicians.

Active, engaged and responsible

More than 1,300 physicians participated in CPSO activities last year

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Dr. Emmanuel H. Tadross
Dr. James W.L. Tam
Dr. David W.Y. Tam
Dr. Sara M. Taman
Dr. Christine E. Tang
Dr. David F. Tang-Wai
Dr. Tina M.M. Tao
Dr. Osman A. Tarabain
Two new members at Council table

Election returns three incumbents to Council

The results of an election held in mid-October will see the return of several incumbents as well as two new physicians to the Council table in December. Dr. Ronald Wexler, of District 2, had been earlier acclaimed. This was the first election held online and it appears to have increased voter engagement. Most districts saw at least a 10% increase in voter participation. Terms are effective for three years.

THE FOLLOWING PHYSICIANS WERE NAMED TO COUNCIL IN THE ELECTION HELD ON TUESDAY, OCTOBER 15TH

**District 1**
Counties of Essex, Kent and Lambton

**Dr. Peter Tadros**
TECUMSEH
MD, FRCP
Graduated from: University of Saskatchewan
Principal area of practice or specialty: Diagnostic Radiology
Current hospital appointments: Honorary Staff, Hotel-Dieu Grace Hospital
Dr. Tadros returns to his third term at Council. Over his previous terms, he has worked on the Discipline and Finance Committees.

**District 2**
Counties of Elgin, Huron, Middlesex, Oxford and Perth

**Dr. Ronald Wexler**
LONDON
MD, FRCP
Graduated from: University of Western Ontario
Principal area of practice or specialty: Anesthesia
Current hospital appointments: St. Joseph’s Healthcare, Hamilton Health Sciences Centre
Dr. Wexler was acclaimed. This is Dr. Wexler’s third term as a Council member. During his previous terms, he served on the Inquiries, Complaints and Reports Committee and the Outreach Committee.

**District 3**
Counties of Bruce, Dufferin, Grey, Wellington and Regional Municipality of Waterloo

**Dr. Jerry Rosenblum**
WATERLOO
MD, FRCP
Graduated from: University of Toronto
Principal area of practice or specialty: Anesthesia
Current hospital appointments: Grand River Hospital, St. Mary’s Hospital
Dr. Rosenblum is new to Council. He has, however, served on the College’s Patient Relations Committee, and the Inquiries, Complaints and Reports Committee. Until 2010, he had been a peer assessor for the College.

**District 4**
Counties of Brant, and the Regional Municipalities of Haldimand-Norfolk, Halton, Hamilton-Wentworth and Niagara

**Dr. Brenda Copps**
HAMILTON
MD, CCFP, FCFP
Graduated from: McMaster University
Principal area of practice or specialty: Family Medicine
Current hospital appointments: St. Joseph’s Healthcare, Hamilton Health Sciences Centre
Dr. Copps is new to Council, although she has been a peer assessor for the College. She has been Chief of Family Medicine at St. Joseph’s Hospital.

**Dr. Eric Stanton**
HAMILTON
MD, FRCP
Graduated from: McMaster University
Principal area of practice or specialty: Cardiology
Current hospital appointments: St. Joseph’s Healthcare, Hamilton Health Sciences Centre
Dr. Stanton has just finished his term as President of the College. In his previous two terms, he has served on the Executive Committee, the Governance Committee, and was a long-time chair of the Quality Assurance Committee.
REPORTS from Council

Draft policy sets out expectations for MD services during job actions

This is a brief overview of the discussions and decisions made at the December Council meeting.

Council reviewed the revisions to a draft policy that specifies College expectations for physicians who may be contemplating and/or undertaking job actions and approved it for release for external consultation.

The changes include a revised title, Providing Physician Services During Job Actions, which more accurately captures the essence of the policy – that the provision of physician services is important, and in fact expected, during job actions. The draft now clarifies that physicians are expected to provide patients with medical care that is urgent, or otherwise necessary to prevent harm, suffering and/or deterioration during job actions.

Please participate in the current consultation on this draft policy. You can read the entire draft on our website at www.cpso.on.ca under Consultations.

Transparency Principles: A Foundation for Discussion

After an extensive consultation, Council approved, in principle, a document that outlines principles that will inform discussions about transparency.

This does not constitute formal approval of the document, only an agreement that the principles are a reasonable way to start discussions about potential options.

In September, the College discussed a multi -staged initiative that will see us examine our information -sharing practices and determine if and how we might make more information available about decisions and processes.

At that meeting, Council reviewed a set of draft transparency principles intended to guide discussions as we consider making more information publicly available.

The principles were developed by a small group of health professional regulators, including this College. After the meeting, the profession, the public and other stakeholders were invited to comment on these draft principles and we received sig-
nificant feedback from each group. Members of the public were in favour of greater transparency, but many physicians expressed concerns.

There will be further opportunities for the profession and the public to provide feedback on more specific recommendations as we move forward.

The feedback received on the principles will inform further work on the initiative, both on the Ontario health regulatory level and for the College.

**Revised “Guidelines for College-Directed Supervision”**

Council approved the revised Guidelines for College-Directed Supervision after an external consultation.

The guidelines set out the College’s general expectations with regard to the role/responsibilities of supervisors and supervised physicians to each other, as well as to the College, when participating in a supervisory arrangement borne out of a College process.

The most significant changes following the final external consultation were: re-wording the principles to address issues unique to College-directed supervision; emphasizing the onus on supervisors and supervised physicians to disclose pre-existing relationships to the College; making it clear that the College decides whether to approve or refuse a supervisor, and; adding a new paragraph to recognize that despite a possible financial relationship between parties in a supervisory arrangement, the supervisor’s ultimate accountability is to the College. The new guidelines are posted on our website.

**Medical Marijuana Preliminary Consultation**

The College is currently reviewing its Medical Marijuana policy. As part of this review, the College will be considering new federal regulations that will significantly alter the process for accessing dried marijuana for medical purposes. Through the policy review process, the College will ensure that any updates made to the policy reflect current practice issues, embody the values and duties of medical professionalism, and are consistent with the College’s mandate to protect the public.

As part of the early stage of the policy review process, the College is inviting feedback from the profession, the public and other stakeholders on the current policy. The feedback obtained will be used to inform the policy review process.

**Medical Student Engagement**

Council was provided with information on an ongoing initiative to engage undergraduate medical students in ethics and professionalism issues.
The CPSO Professionalism and Practice Program: Undergraduate Medical Education is intended to ensure active and substantive engagement with medical students in Ontario by partnering with faculty and students in the development and delivery of medical school curricula.

To date, the College has developed draft educational modules on several issues: medical professionalism; medical records; and social media and professionalism.

In coming months, the College will be meeting with Ontario faculties of medicine to have further conversations on the program and to obtain feedback on the draft modules.

Consent to Medical Treatment

The Consent to Medical Treatment policy is currently under review. Council was invited to participate in an education and discussion session regarding policy and the general legal principles and framework for consent.

The discussion acknowledged that issues surrounding consent are extremely complex. Council identified a number of issues the Working Group should consider addressing in the revised policy. When a revised policy has been developed, all stakeholders, including physicians and members of the public, will be invited to participate in the consultation to better inform the policy.

College’s Request for Change: Bill 117

Council was updated on Bill 117, which was recently introduced by government and contains amendments to the Regulated Health Professions Act (RHPA), and other Acts in response to the College’s request for legislative change.

The areas included in the Bill are essentially the government’s response to what we consider to be the four highest priority areas in our January 2012 request for change. They include:

- Greater discretion for Colleges in the investigation of complaints. Specifically, Colleges would be able to focus investigations of complaints to matters that could constitute professional misconduct, incompetence or incapacity;
- An enhanced ability to more readily share information with public health;
- An ability for Colleges to share complaints-related information obtained by a College investigator with a hospital;
- A requirement for a hospital or employer to report to Colleges if a regulated health professional has voluntarily restricted his or her practice or privileges because of concerns regarding the member’s conduct or practice.

We continue to analyze the Bill to ensure that we are satisfied that it will help us achieve our desired objectives. We anticipate that we will be bringing forward amendments. We have been in regular discussion with government officials, other health regulators and others.

Dr. Robin Richards is the University of Toronto’s new academic appointment to Council. He replaces Dr. Bob Byrick.

Dr. Richards is an orthopedic surgeon and was Head of the Department of Surgery and Co-Director of the Operating Room and Related Services at Sunnybrook Health Sciences Centre from 2001–2012. Dr. Richards maintains an active surgical practice focusing on arthroplasty of the shoulder and elbow, upper extremity reconstruction following trauma, soft tissue procedures to control joint instabilities in the upper extremity and the surgical treatment of irreparable brachial plexus injury.
The College honoured Dr. Abbyann Lynch, one of Canada’s pioneers in the field of bioethics. Dr. Lynch was recognized for her many years of dedication to this discipline, and specifically, her work with doctors. Dr. Lynch, a founding director of the Department of Bioethics at the Hospital for Sick Children, has worked with several of the health colleges to offer their members one-on-one instruction in ethics. At the CPSO, Dr. Lynch has provided dozens of physicians with instructions over the years, applying her unique mix of intelligence, patience, wisdom and forward focus in often complex and challenging matters. Dr. Lynch retired in July.

Learn more about upcoming Council meetings

The upcoming Council meeting agenda and background materials are posted on our website (www.cpso.on.ca) up to two weeks prior to Council meetings. These materials remain posted until we report on the major actions taken and issues discussed at the meeting in Council Update.

2014 Council meeting dates:
March 6 and 7; May 29 and 30; September 4 and 5; December 4 and 5
Dr. Anne-Marie Guerguerian presented with Council Award at the December meeting

Dr. Anne-Marie Guerguerian, who works in the field of pediatric critical care medicine, was presented with the Council Award at the December meeting.

Dr. Guerguerian received her medical degree at the Université de Montréal after graduating in 1993. She also did her postgraduate training in pediatrics there.

She is an intensivist on staff at the Hospital for Sick Children in Toronto where she leads multidisciplinary teams to care for extremely ill children. She is also the hospital’s medical director of the Extra Corporial Membrane Oxygenation (ECMO) Program, which cares for children who require portable cardiopulmonary bypass support because of respiratory or cardiac failure or both.

While working full time at SickKids, Dr. Guerguerian completed a PhD at Johns Hopkins University School of Public Health in 2009. Her PhD thesis, which was accepted without revisions – the highest category of success - focused on care practices in traumatic brain injury.

Dr. Guerguerian is a world renowned expert in the field of neurocritical care and has published many articles on the subject. She also helped to develop the first pediatric neurocritical care fellowship program in Canada.

In addition to her clinical duties, Dr. Guerguerian is a scientist in the Neuroscience and Mental Health Research Program at SickKids and also mentors medical fellows.

Her leadership and collaboration skills along with the devotion and compassion she shows to her tiny patients and their parents, has garnered her admiration and respect of her colleagues.

“People always judge a doctor by asking whether you would be happy for them to treat a member of your family. Well, Anne-Marie is definitely one of those doctors – the favourite physician of almost every parent who comes through the intensive care unit,” says Dr. Briseida Mema of SickKids who nominated Dr. Guerguerian for the award.

“Theyir eyes shine with admiration and recognition for the care that she provided to their loved ones and there are so many thank you cards in the staff lounge that specifically mention Anne-Marie as an outstanding physician,” says Dr. Mema.

“People who work in this field tend to be intense and present”

Tell us about your childhood and how that influenced your choosing medicine as a career.

I was born and grew up in Montreal in a family of three girls. I am the eldest, my sisters are twins. Medicine is something I always wanted to do. My father was a physician – a pediatric ear, nose and throat surgeon – and my mother worked as an operating room nurse. My grandfather was also a doctor. It was a happy childhood.

What is your role as an intensivist at a hospital for children?

As an intensivist, I spend my entire day in the intensive care unit caring for children who are critically ill with traumatic brain injury or acute lung injury and require mechanical ventilation and other technology so it’s a very technology driven specialty.

This is probably the worst time in a parent’s life – to have their child in the critical care unit. I really see my role to make sure the best expertise is provided. People who work in this field tend to be intense and present.

Describe a typical day for you.

I start off doing bedside rounds in the pediatric critical care unit (PICU). When I’m on, I work several days in a row and do not have a break. That work schedule
allows me to see the trajectory of illness of a child, which is delicate and rapidly changing. Intensive care in adults is also very intense but the speed in children because of their physiology and their metabolism being different, the pace is different. I sometimes stay overnight at hospital when I’m on and even if I go home I’m still on call. So it’s essentially a week at a time in the PICU. The following week, I do administrative duties, teaching and research. We recently hired someone to cover for us a couple of nights a week.

You were praised by your nominators for your ability to quarterback a multidisciplinary team to care for patients. Why is it crucial that you all work in harmony?

I lead the team. Depending on people’s perspective, I’m either in the control tower or I’m the pilot. The patient is under my care so there’s that sense of complete responsibility. There are at least eight people on the team - pharmacists, nurses, respiratory therapists, dieticians, physiotherapists, surgeons, and other specialties. As much as it’s a very technology-driven specialty, patients need minute-to-minute care and it’s only by utilizing the expertise and judgment of the entire team that we bring the quality of care that is expected or desired for these children. It’s only by making people engaged and making them accountable and responsible that you can achieve that. We are fortunate at SickKids to have an environment that promotes the autonomy of judgment of the professionals.

In my research world, I’m very into technology monitoring and computer interfaces. But ultimately if we want the patient to get the best care, we need the health-care providers to have the capacity to use their judgment, to get along and work as a team. It’s a lot like being on a sports team.

How do you cope with the stress of the job?

I’m always a glass half-full person. The children and families lead us and we’re just there to make sure they fulfill whatever recovery and potential they have. Several times a day I tell myself I’m so lucky to work at SickKids. We were just at a ceremony with a child survivor and their parents – there’s a tremendous feeling like you served people and it was meaningful. Unfortunately, we don’t always have a good outcome, and in those cases candour and honesty with families is essential.

You developed a new tool to improve the classification and care for children with traumatic brain injury. What can you tell us about it and why is it important?

It essentially allows us to quantify injury and categorize severity of injury in young children using non-invasive imaging and monitoring technology. There’s a gap in care. Younger children are short-changed compared to tools and therapies geared to adults because we are unable to quantify and classify the injury severity early in younger children because either they are non-verbal or they are anesthetized or they cannot undergo MRI. That delays interventions and therapies. In Canada, Ontario classifies injuries but there is no federal registry or federal data similar to what there is in the U.S. with the Centers for Disease Control and Prevention to quantify injuries or even other illnesses. It makes it very difficult without that data to measure the burden of illness specifically related to traumatic brain injury. It’s listed under injury as a big lump. Injuries are the major cause of death from the age of 1 to age 30.

How do you relax on your time off?

I’m fortunate to have an amazing husband. He’s a PhD in philosophy. We’re huge music fans – we enjoy jazz and contemporary music. We’re also huge nature lovers. We love to canoe and hike in the back country – Killarney and Algonquin Parks are two of our favourite places. No children - no time and no plans. In my field, we have to make choices.
In September, Council passed a by-law amendment that added certain information about applications made to the Discipline Committee for reinstatement to the public register.

Most applications for reinstatement are made to the Discipline Committee. The legislation, however, also provides for a second route to seek reinstatement, which is by a written process to the Executive Committee or Council.

At its December meeting, Council was in favour of adding information regarding Executive Committee or Council decisions on reinstatement applications to the public register.

For more information, please go to our website at www.cpso.on.ca under Consultations.

In order to effect these changes, the by-law amendment below is being circulated externally.

**By-Law No. 91**

1. Subsection 49(1) of By-law No. 1 (the General By-Law) is amended by adding the following paragraph:

   17.2 If an application for reinstatement has been made to the Council or the Executive Committee under s. 74 of the *Health Professions Procedural Code*, the date on which the Council or the Executive Committee will consider the application, and the decision of the Council or Executive Committee.

Council approved the budget for 2014 and agreed to circulate to the profession a proposed 1.3% increase in membership fees. This amounts to $20 a member, bringing the annual fee from $1,550 to $1,570.

For more information, please go to our website at www.cpso.on.ca under Consultations.

The proposed by-law amendment is as follows:

**By-law No. 89**

1. Subsection 4(a) of By-Law No. 2 (the Fees and Remuneration By-Law) is revoked and the following is substituted:

   **Annual Fees**

   4. Annual fees for the year beginning June 1, 2014, are as follows:

   - (a) $1570 for holders of a certificate of registration other than a certificate of registration authorizing postgraduate education and other than a certificate of registration authorizing supervised practice of a short duration;
Council has decided to pursue an amendment to the College’s general regulation that would see some clinics subject to oversight from both the Out of Hospital Premises Inspection Program (OHPIP) and the Independent Health Facilities (IHF) program. Currently, the regulation exempts IHFs from the OHPIP. The decision followed a discussion of the ramifications of a joint regulatory regime.

The proposed amendment is a response to the provincial government’s proposal to make changes that would see colonoscopy procedures moved out of hospitals into community specialty clinics and making them IHFs to allow them to receive facility-based funding. To date, colonoscopy clinics have fallen within the scope of the College’s OHPIP.

The College is of the view, however, that the OHPIP model functions more efficiently and quickly to protect patients than the IHF model. Therefore, the College would like to continue to have clinics that meet the OHPIP requirements regulated under that regime.

Accordingly, the College is proposing an amendment to its general regulation that would allow facilities to be inspected and assessed under the OHPIP even when they are IHFs.

There is more information about this proposed amendment on our website under Consultations and you are welcome to provide your feedback.

Ontario Regulation 114/84

The Council approved in principle and circulates to the membership and other interested parties and stakeholders for feedback the following proposed amendments to Ontario Regulation 114/94 (“O. Reg. 114/94”) made under the Medicine Act, 1991:

1. That subsection 44(1)5 of O.Reg. 114/94 be revoked, which would result in “premises” being defined as follows:

44. (1) In this Part,

…

“premises” means any place where a member performs or may perform a procedure on a patient but does not include a health care facility governed by or funded under any of the following Acts:

1. The Long-Term Care Homes Act, 2007.
2. The Developmental Services Act.
3. The Homes for Special Care Act.
4. REVOKED: O. Reg. 134/10, s.1(2).
5. The Independent Health Facilities Act.
6. The Ministry of Community and Social Services Act.
8. The Ministry of Health and Long-Term Care Act.
9. REVOKED: O. Reg. 134/10, s.1(2).

PROVIDING FEEDBACK:

Email: OHPIP_IHF@cpso.on.ca
Mail:
CPSO
80 College St, Toronto, ON M5G 2E2
Att: Policy Department
Deadline for comments: Feb. 7, 2014
A draft policy that addresses expectations of physicians as it pertains to job actions is now being circulated for comment to the profession, the public and other interested parties.

The Providing Physician Services During Job Actions draft is a revision of the College's current Withdrawal of Services During Job Actions policy and can be found on our website at www.cpso.on.ca under Consultations.

Below are some Q & As that highlight the expectations of the proposed policy.

What revisions have been made and why?
The key components of the current policy have been retained; however, a number of revisions have been made to emphasize the protection of the public interest and clarify expectations for physician conduct.

The changes include a revised title which more accurately captures the essence of the policy – that the provision of physician services is important and, in fact, expected during job actions. The draft also now clarifies that during job actions, physicians are expected to provide patients with medical care that is urgent, or otherwise necessary to prevent harm, suffering and/or deterioration.

What types of job actions does this policy apply to?
The policy applies to job actions that occur for various reasons. These include those related to patient safety, practice environments (e.g., concerns about work environments and/or conditions, such as on-call schedules, available resources, hospital administration, etc.) and/or compensation (e.g., fee negotiations between the Ministry of Health and Long-Term Care and the Ontario Medical Association).

Does the revised draft policy restrict the profession’s ability to withdraw their services during job actions?
The revised draft policy does not categorically prohibit job actions, but it does set out a number of requirements physicians must meet when contemplating and/or undertaking a withdrawal of services. The College has established these expectations to protect and serve the public interest.

The College believes it is important to be clear about the fact that it would never be acceptable for physicians to completely abandon their patients and communities en masse, as it would leave patients and the public without access to urgent and/or necessary medical care.

Does the revised draft policy prevent physicians from advocating for changes that benefit both physicians and patients in the province?
No. Advocating for patients is one of the principles of medical professionalism set out in the College’s Practice Guide. Physicians have a crucial role to play in shaping and improving the health-care system.

There are many ways for physicians to advocate for change without withdrawing their services. The policy expects physicians will explore these other options when contemplating a withdrawal of services.

What if a physician believes that withdrawing services is the only way to achieve necessary changes?
If that is the case, the policy does not prevent physicians from withdrawing their services, provided that the adverse impact on patients and/or the public is mitigated.

In any event, the policy states that physicians must provide patients with medical care that is urgent, or otherwise necessary to prevent harm, suffering and/or deterioration. This will include ensuring patients’ health-care concerns are assessed and appropriately triaged so that urgent and/or necessary medical care can be obtained.
The revised draft policy refers to physicians’ collective responsibility to the public. Does this mean physicians have a duty to care for all Ontarians?

No. Collective responsibility and duty of care are different. Collective responsibility refers to the ethical and professional obligations physicians have, as a group, to the public, as articulated in the Practice Guide.

This is distinct from the legal duty of care a physician has to a patient. The policy refers to collective responsibility as set out in the Practice Guide: the commitment that all physicians have to provide quality care to their patients, and to uphold the reputation of the medical profession.

The revised draft policy contains a number of terms like ‘best interests’ of patients, ‘abandoned’, ‘deprived of access’ to medical care, ‘risk of harm’, and ‘mitigate the adverse impact’. How will the College interpret these terms?

Council did not set out concrete definitions of these terms because their meaning will differ, depending on the circumstances and context in which the withdrawal of physician services occurs or is contemplated.

In applying these terms to specific situations, the College will be guided by the values and principles of professionalism, as set out in the Practice Guide, the spirit of the policy (to ensure patients are not harmed by physician job actions) and the College’s and the professions’ shared commitment to protect and serve the public.

For example, it may not be in the ‘best interests’ of patients if physicians in a remote community participate in a job action for reasons related to physician compensation where patients are prevented from accessing necessary medical care.

For example, some steps physicians may take to “mitigate the adverse impact” could include: transferring the care of patients to other physicians and/or facilities, ensuring sufficient coverage is provided for emergency situations, regularly monitoring the impact of the withdrawal on patients and/or the public, etc.

What does the College consider to be medical care that is ‘urgent’, or otherwise necessary to prevent harm, suffering and/or deterioration?

What is urgent or necessary medical care would depend on the specific circumstances of each case, as mentioned earlier.

The revised draft policy specifies that what constitutes urgent and/or necessary medical care to prevent harm, suffering and/or deterioration is a matter to be determined by a physician’s clinical judgment, and will be informed by the existing health status and specific needs of individual patients, and physicians’ collective ethical responsibility to care for their patients.

For example, patients and/or the public would likely be unable to access necessary medical care if every single physician in a rural community or every single anesthesiologist stopped treating patients for a significant amount of time.

What will happen if a complaint is made about a physician who withdraws their services during a job action?

As with any complaint we receive, it will be investigated. A panel consisting of physicians and members of the public will consider the circumstances of the case and determine whether the physician’s conduct or the care provided was appropriate.

The College will consider any concerns regarding the provision of services, or lack thereof, during job actions in accordance with our duty to serve and protect the public interest.
In December, Dr. Marc Gabel, a Toronto general practitioner practising in psychotherapy, became President of the College of Physicians and Surgeons of Ontario. Recently, we spoke to Dr. Gabel about his expectations for the coming year.

What issues of self-regulation are on your radar now as you become President?
Professionalism is top of mind, for sure.

How do you define professionalism?
I like the definition of Epstein and Hundert: Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served.1

Everything we regulate, from registration of new doctors to encouraging quality medicine, to remediation, to complaints, and including dealing with unprofessional behaviour, can fit under the overarching concept of professionalism.

If we have that set of values guiding our members, the College can fulfill our mandate of serving the public with competency, compassion and care. And dream of all dreams, perhaps we can reduce our complaints to a negligible number.

The Committee that you are most closely associated with has been the Discipline Committee, in which you served as co-chair for several years. What did you learn from your time on that Committee?
The law is very different from medicine! My challenge was how to “judge” – not so easy a task after working so hard in my practice and my life to be discerning rather than judgmental.

There were many sleepless nights, sifting evidence and having to make decisions on the evidence allowed. But I always figured that if I were ever comfortable on the road to a decision, I was not doing my job.

I also learned that the vast majority of doctors are ethical and professional, and that most of the unprofessional behaviour we dealt with could have been avoided if physicians had remembered the tenets of professionalism.

You recently spoke to the Standing Committee on Bill 70, the Regulated Health Professions Amendment Act (Spousal Exception). You were very clear that the College is in favour of the continued application of a zero tolerance approach to sexual abuse and does not endorse a “spousal exception” for physicians. Given

your experience on the Discipline Committee, this must have been significant for you.

It was good experience to be able to work with the representatives of the public and have the opportunity to express the considered views of the College. And it was important to be there, before the Committee, to respond to their concerns and question.

I was also able to bring to bear on the issue my time as a board member of Women in Transition and a founding board member of the Assaulted Women’s Help Line, which sensitized me to the spousal abuse issue. I felt positive knowing my answers to questions concerning this issue came from a regulatory, medical, and socially informed background.

Speaking of background, you’ve had an interesting, somewhat peripatetic career in medicine.

Yes, I have been fortunate to have an opportunity to practise in many areas of medicine. I trained as a pediatrician and was on faculty at UCLA, I did military general medicine in southeast Asia, I then earned a MPH, and did public health in that same area.

And before I came to Ontario, I did a very rural solo general practice in BC. My nearest hospital and all its specialists were more than 50 miles away.

And what led you to focus your general practice in psychotherapy?

It was all those experiences, especially the latter, that led me to realize that I had to deal with many facets of illness, socio-economic and psychiatric, as well as physical.

When I moved to Ontario, my interest in psychotherapy deepened as it became clear to me that many of the health issues affecting my patients appeared to be tied up in psychosocial issues that needed to be addressed. So I sought additional training and supervision, and slowly my practice evolved into a practice focused on psychotherapy.

Is there an area within psychotherapy that you specifically address in your practice?

No. I see patients ranging from schizophrenia to personality disorders to common problems that occur throughout the life cycle. And I make sure to stay connected, working regularly with a peer group and attending as much CPD as I can fit in.

Aside from your medical practice, you also officiate at weddings. How would you describe your style as an officiant? Have you had any off-the-wall moments while conducting ceremonies?

Well, any good wedding has off the wall moments, the fun is riding with them and using them. I started to officiate at marriages at the request of my children’s friends (which made my heart sing) and I found it a wonderful escape into moments of happiness, unlimited possibility, and fine dress-up time. I centre any ceremony around the concept of kindness. And I love the sense of community at such ceremonies.
You appear to be quite tech-savvy. What do you think of the College’s efforts to embrace social media?

Every generation is faced with changing modes of mobility and communication. This time its penetration has been much faster. While I acknowledge the downside of the way technology can change culture, I also know that by joining it, we reap its benefits and shape its development.

I worked on the College’s Social Media guidelines because, like any form of social discourse, knowing the boundaries, pleasures and possible missteps is essential. I imagine the change from direct conversation to the telephone caused immense social changes and professional dangers and advantages. Once we all learned the ways, it became part and parcel of improving (most of the time) our lives. And so it is with the present. And I do admit to a glee in newness and the chance to widen my communication and contacts.

What do you hope your legacy is, as College President?

I would like there to be a greater understanding that the relationship of members with the College is a conversation, not an argument. We all are the College, and what we do, as one, has to serve the public.

And because we are living in different times, and part and parcel with the technological information revolution, we have different societal expectations. It is no longer enough to simply know we are acting in the public interest. We must demonstrate that we perform that mandate by becoming more transparent with our processes and decisions.

My expectation is that a move to greater transparency will lead to an increase in the public’s trust in this organization and its members. It won’t be easy, and much analysis and consultation with the profession and the public will need to happen as we work together on the nuts and bolts of transparency. But it is an important initiative and I hope to be able to contribute to this effort and other issues of the coming year with equanimity and grace.

New address?

Let us know within 30 days!

The College’s register must contain your current mailing address, email address and your primary practice address.

At the back of each issue of Dialogue, and on the College’s website, a change of address form is provided. Please mail, fax or email it to the College.

Your MAILING ADDRESS is the address you would prefer the College use to communicate with you and may be different from your practice address.

It is NOT available to the public, unless you decide to use your primary practice address as your mailing address. Your PRIMARY PRACTICE ADDRESS is available to the public.

Your EMAIL ADDRESS is NOT available to the public.

If you change your mailing, email or practice address, you must notify the College in writing within 30 days of the change.
The College is currently reviewing its Medical Marijuana policy. As part of this review, the College will be considering new federal regulations that will significantly alter the process for accessing dried marijuana for medical purposes. This review will also help to ensure that any updates made to the policy reflect current practice issues, embody the values and duties of medical professionalism, and are consistent with the College’s mandate to protect the public.

We are now inviting feedback from the profession, the public and other stakeholders on the current policy. Until March 31, 2014, federal regulations will allow for two means for patients to obtain marijuana for medical purposes. These routes are:

- Under the Marihuana Medical Access Regulations, where patients must apply to Health Canada; or
- Under the new Marihuana for Medical Purposes Regulations, where patients submit a document, signed by their doctor directly to a licensed producer.

The Marihuana Medical Access Regulations will be repealed on March 31, 2014. Accessing marijuana for medical purposes under the system established by these regulations will no longer be available.

The new regulations mark a significant shift in the medical marijuana program in Canada, with Health Canada no longer authorizing applications for medical marijuana.

Under the new regulations, the physician’s role has changed to providing a ‘medical document’ to authorize patient use of marijuana. This is effectively the same as a prescription: the medical document will require physicians to list the amount of marijuana the patient can use (i.e., dosage and period of use).

While there are no restrictions under the new Marihuana for Medical Purposes Regulations on the daily amount that physicians may recommend, there is a possession cap of the lesser of 150 grams or 30 times the daily amount.

The College expects physicians to adhere to College polices and safe prescribing practices.

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The College expects physicians to adhere to College polices and safe prescribing practices.

Have your say

Our MEDICAL MARIJUANA policy is up for review. We are looking for feedback on the current policy and would like to hear your opinion by February 7, 2014.

More information can be found on the College website at www.cpso.on.ca under Policies and Publications>Consultations

Contact: medicalmarijuana@cpso.on.ca
Mailing address:
CPSO Policy Department, 80 College Street, Toronto, Ontario M5G 2E2
Our Dialogue series on end-of-life care started last year with a recognition of this simple and stark fact. Throughout this series, we have engaged in conversations with physicians, other health-care professionals and the public about topics as diverse as education and professional development in palliative care, advance care planning, interprofessional understanding and collaboration in care, and certifying death at home. Now we come to the last installment of the series: medical futility at end of life.

When the physician, the patient, or the patient’s Substitute Decision Maker (SDM) believe that treatment is futile, negotiating care is a delicate balance. It’s a process built on respect of the patient and professional values. Yet what happens when values or goals clash among those providing and receiving care? How can we balance and yet respect differing values simultaneously? And what conversations must society prepare to engage in?

These and other issues relating to medically futile care are the focus of this fifth and final article in this Dialogue series on end-of-life care.

What is medically futile care and why is it provided?

While there is no universal agreement on the definition, treatment is generally seen as medically futile when:

- it offers no reasonable hope of recovery or improvement; or
- the patient is permanently unable to experience any benefit.

In these cases, treatments may merely prolong the final stages of the dying process. At a recent conference presentation in Ottawa, Dr. Mervyn Dean, a retired palliative care physician, commented that “there comes a point when you are no longer prolonging life, you’re prolonging death.”

Everyone eventually dies.

In 2012, the College hosted a forum of experts in the end-of-life care field. We asked them what needed to change to meaningfully improve the last months, weeks and days of patients’ lives.

The experts describe a current environment where assumptions and misunderstandings – between physician and patient, among specialists and within families – replace informed discussion.

Given that lack of communication appears to be one of the biggest barriers to optimal end-of-life care, we have launched a conversation. What is optimal care and what can be done to achieve it?

This is the last of a five-part series that brings you the views of experts in palliative and end-of-life care, as well as lessons learned from patients’ experiences.

We have also taken the conversation online. Please visit us at www.cpso.on.ca/endoflife and share your thoughts and experiences.
Join the conversation
We want to hear from you about your opinions, your experiences.
• When do you think a treatment is medically futile?
• Have you ever provided medically futile care? If so, why?
• Do you think a societal conversation about the allocation of scarce medical resources is needed?
• What lessons have you learned from those experiences when you and a family were not in agreement that care was futile?
Join the conversation and let us know what you think:
www.cpso.on.ca/endoflife

How prevalent is futile care? While it is hard to know exactly, one study of the perceptions of physicians and nurses in the Journal of Critical Care suggests that a majority of clinicians believe that their ICUs have provided futile care over the last year.

The most commonly stated reasons for providing such care: family requests, prognostic uncertainty, legal pressures, poor provider-family communication, and the perception that death was a treatment failure.

Rasouli case highlights ethical complexities
The complexities associated with providing medically futile care, and the disagreements that can arise in this context, have been highlighted by the case of Hassan Rasouli.

Mr. Rasouli has been kept alive on a ventilator and feeding tube at Toronto’s Sunnybrook Health Sciences Centre since his brain surgery in 2010. His doctors concluded that there was no therapeutic hope of recovery and recommended that he be taken off artificial ventilation and nutrition and be provided with palliative care until death.

At the centre of this case is the question of whether or not consent is required for the withdrawal of life-sustaining treatment. In Ontario, the Health Care Consent Act (HCCA) outlines what constitutes consent and when physicians must obtain consent. In brief, the HCCA requires that consent be obtained for any medical treatment, understood as “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.”

Mr. Rasouli’s wife, acting as substitute decision maker, refused to provide her consent to withdraw life-sustaining treatment being offered to her husband. In doing so, she cited religious beliefs held by her husband, and her contention that his movements indicate minimal consciousness. Mr. Rasouli’s wife applied to the court for an order preventing the physicians from withdrawing life support without her consent.

Mr. Rasouli’s doctors argued that doctors do not have a responsibility to provide treatment that has no medical benefit, and that the withdrawal of treatment is not itself a treatment and so does not require consent.

Ultimately, a majority of the Supreme Court of Canada ruled that the withdrawal of life-sustaining treatment in this case falls within the definition of treatment under the HCCA, and therefore requires consent from the patient or his/her SDM. As such, physicians do not have the unilateral authority to withdraw life-sustaining treatment.

Writing for the majority, Chief Justice Beverly McLachlin made it clear, however, that patients and SDMs do not have unconstrained rights to receive or insist upon any and all treatments.

Most notably, she states that “this case does not stand for the proposition that consent is required under the HCCA for withdrawals of other medical services or in other medical contexts,” thereby limiting the implications of this decision beyond cases such as Mr. Rasouli’s.

Jocelyn Downie, a Professor of Law and Medicine at Dalhousie University in Halifax, reflected on the decision in an Impact Ethics blog, calling the decision “a good first step toward reducing uncertainty, conflict, and distress for those who care for, and about, the critically ill in Canada.”

This does not mean, however, that there are no outstanding issues with
respect to medically futile care. Downie, for example, observes that we still need to have a conversation about the allocation of scarce resources in the end-of-life context. And Chief Justice McLachlin acknowledges that “a practical solution that enables physicians to comply with the law and satisfy their professional and personal ethics” may be needed to address the fact that “no legal principle can avoid every ethical dilemma.”

In other words, doctors and other health-care professionals still need to face, understand and address disagreements with their patients or their patients’ SDMs regarding treatment they believe is futile. Much practical work remains in order to appropriately address these disagreements.

**Respecting values**

Dr. Jonathan Hellmann, a medical advisor in the bioethics department at the Hospital for Sick Children in Toronto, said he hopes that the Rasouli decision “doesn’t change the way we practise.”

In particular, he observes that “we still derive consensus in 99% of the cases” and notes that “legal recourse is the least satisfactory way to resolve these disputes. I don’t want to see more and more hospital committees debate these things.”

His concern is that doctors might start to worry that their opinion no longer counts, and simply defer to the patient’s wishes or the SDM’s wishes — “That’s the line of least tension, but it’s abdicating our duty. We have to exercise our clinical judgment,” said Dr. Hellman who practised as a pediatrician until last July.

At the same time, the patient or SDM, of course, has to be part of the decision-making. When there is medical futility at end of life, Dr. Hellmann hopes for decisions that are based on “an open expression of values.”

That requires empathy and patience. In studying best practices in palliative care, Rose Steele, RN, PhD, has found that the golden rule is trying to understand the other person’s perspective. She acknowledges that every professional brings his or her own moral, cultural and religious beliefs or values to the practice. That’s normal, but “we can’t impose these beliefs on others. People will have differing views. Support has to be there for families,” said Dr. Steele, a Professor in the School of Nursing at York University.

When patients or their SDMs struggle with end-of-life care, some doctors take the attitude of “we’re going to get them there.” That’s not quite the correct objective, Dr. Steele suggests. Instead, here’s the better starting point: What is the goal of care for this individual?

One study reported in the Canadian Medical Association Journal noted that “initiatives to improve end-of-life care are hampered by our nascent understanding of what quality care means to patients and their families.” Having trust and confidence in the doctors looking...
after you emerges as an important element of the physician-patient relationship.

Apart from clinical care, providing quality care at end of life – and negotiating that care – revolves to a huge degree around building relationships and trust.

“You’re going in with an openness, a willingness to learn,” Dr. Steele says. “It’s not about going in and saying ‘this is how it’s to be done’.”

What is the patient or their family feeling? What do they think will happen? What experiences can you share of what to expect? That, says Dr. Steele, “paints a picture for people of things they never imagined.” Maybe then, the goal can then shift from a cure to a pain-free death.

**Aligning the relationship**

With advances in health care, “societal expectations are enormous,” says Dr. Hellmann, who also teaches at the Joint Centre for Bioethics, University of Toronto.

Many people view technology as the solution to any medical challenge. But there are often unintended consequences that patients or their families may not be aware of. “Progress,” says Dr. Hellmann, “comes at a cost.” Not just financial costs but, often, the toll on families when the inevitable is prolonged. Physicians, nurses and other health-care professionals might be aware of this cost even when patients and families are not, and some research has suggested that witnessing the prolonged suffering of patients can be very distressing for health-care professionals.

Dr. Steele agrees. Professionals who believe a patient is suffering because treatment is continuing, or feel they’ve failed if the family is not on the same wavelength, can be greatly distressed, she said.

But sometimes the challenge is simply that the patient or family isn’t there yet. “They’re not in denial; they just haven’t processed everything,” says Dr. Steele.

**With advances in health care, “societal expectations are enormous”**

“Progress,” says Dr. Hellmann, “comes at a cost.” Not just financial costs but, often, the toll on families when the inevitable is prolonged. Physicians, nurses and other health-care professionals might be aware of this cost even when patients and families are not, and some research has suggested that witnessing the prolonged suffering of patients can be very distressing for health-care professionals.

Dr. Steele concurs, recalling one father whose child was going to die. He said it felt as if the health-care world was going at 100 miles per hour, and he was going at only 10 miles per hour. “Sometimes everything slows down for families, and they can only take in so much at a time,” says Dr. Steele.

She says doctors and other health-care professionals need to “pace” the delivery of information to match where the patient or family is at.

**Supporting difficult decisions**

When families do make decisions on discontinuing treatment, be aware that the result can be peace or agony. Dr. Steele has studied parents whose child had died after foregoing artificial hydration or nutrition. She says that even when families had come to terms with their decision, “they were often afraid of being judged, by family,
friends, and sometimes by health-care professionals.”

She describes one family who, with the support of their health-care professionals, decided to take their child home to die. In the meantime, it was important to have nursing care for the child at home. As Dr. Steele recounts, “One nurse came into the home and was aghast. She literally told the parents ‘I can’t believe you’re killing your child.’ Nobody wants their child to die, but in this case, the quality of life was worse.”

Questions of appropriate or inappropriate care are often a matter of perception. At end of life, discussions can centre around likely outcomes. But at any given moment, actions, results and emotions may not be so black and white. Sometimes, “everything can be grey,” says Dr. Steele, “with no right or wrong.”

Societal debate needed

For health-care professionals, what’s a successful outcome at end of life? “When you’ve done as much as possible to help the patient and family feel that everything possible was done,” says Dr. Steele. “And that’s so specific to each individual.”

Another CMAJ article, on decision-making around feeding tubes for cognitively impaired seniors, described how SDMs are eager for more of everything – more information on risks and benefits, more details on alternatives, more discussion on implications, more time to make a decision, and more input from other health-care professionals.

In looking at end-of-life care and futility, improvements will hinge on sound institutional policies, greater education (for health-care professionals, patients and families), better training, open communication, and a heightened appreciation for the patient’s and/or family’s beliefs. When conflicts arise over treatment, physicians need to probe the root reason. Denial? Misinformation? Lack of trust? Differing values? Physicians also need to pay close attention to the mechanics of building consensus and resolving disagreements.

All of these things are true, but end-of-life care also requires something else: an honest societal debate about death, how we allocate health-care resources, responsible treatments, and what it means to live well until life ends. It’s a debate that some say is long overdue. “We are,” states Dr. Steele, “a death-denying society.”

Everyone eventually dies

We all know it, yet, says Dr. Steele, “people think that technology always works, that because we have all these machines, we can keep going forever. People don’t understand the limitations. In the past, all we talked about was cure, cure, cure. Now, we have to have a shift to really raise the issues of death and dying.”

Stuart Foxman is a Toronto freelance writer.

REFERENCES


Ending life with grace and agreement; Amir Attaran (Editor-in-Chief) & Matthew B. Stanbrook (Deputy Editor) (2008) CMAJ 178(9), p. 1115-6.


Physicians suspended for non-completion of membership requirements in 2013

As of November 1 2013, 35 physicians continue to have their certificate of registration suspended for failure to complete the College’s 2013 annual renewal requirements by the deadline.

Many of the physicians listed below may be practising outside Ontario or have retired. It is in physicians’ best interest to officially resign from the College rather than let their memberships lapse. Once a certificate of registration is suspended for non-completion of annual requirements, a permanent record of the suspension must be entered in the register. All institutional requests for a physician’s status with the College will include this information.

To resign from the membership, simply complete and return the resignation form that is provided with the annual fee invoice, or download one from the College’s website.

The following list is provided as a public service announcement. Its main purpose is to alert the medical community, particularly health facilities and other employers, of physicians who are suspended and might be continuing to practise, unaware of their suspension. Past publication of this list has helped the College locate physicians who had lost contact with us and not known of the suspension of their registration.

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Each year, through our annual renewal form, physicians who perform exposure prone procedures (EPPs) must disclose whether they perform EPPs and, if so, whether they have been tested for the human immunodeficiency virus, Hepatitis B and Hepatitis C in the past year.

The general definition of exposure prone procedures that the College uses is:

(i) Digital palpation of a needle tip in a body cavity (a hollow space within the body or one of its organs) or the simultaneous presence of the health-care worker’s fingers and a needle or other sharp instrument or object in a blind or highly confined anatomic site e.g. during major abdominal, cardiothoracic, vaginal and/or orthopedic operations, or

(ii) Repair of major traumatic injuries, or

(iii) Manipulation, cutting or removal of any oral or perioral tissue, including tooth structures, during which blood from a health-care worker has the potential to expose the patient’s open tissue to a blood borne pathogen.

The College has also developed a list of procedures considered to be exposure prone, based on the SHEA Guideline (http://www.shea-online.org/Assets/files/guidelines/BBPathogen_GL.pdf). This list is included as an appendix to the Blood Borne Pathogens (BBP) policy and is also included as a resource to the Annual Renewal Form.

Often, physicians will contact us for assistance in answering the question about EPPs. We explain that the policy and the annual renewal questions also apply to those who might be called upon to perform an exposure prone procedure.

If there is a chance of conversion of any procedure performed to an EPP, the physician should describe themselves as performing EPPs and ensure that they have been tested for the three BBPs.

The policy also applies to physicians who assist in procedures that have the potential of becoming exposure-prone. One example is surgical assistants. There is always some level of risk during surgery that a person working in the capacity of assistant may be called upon to assist in a way that becomes exposure prone. An example would be if there is a sudden hemorrhage in a cavity, the assistant may have to help tamponade the bleeding.
Postgraduates are also expected to comply with the BBP policy.

When the College is notified by a physician that he or she is seropositive, the information is treated with confidentiality. All information the College receives or creates in the course of fulfilling its regulatory functions is treated in accordance with the College’s legal obligations with respect to privacy. This includes information about blood borne pathogens and physician health.

The College ensures that information about physicians’ serological status is only made available to College staff, Committees or experts who are involved in issues related to blood borne pathogens. All those who have access to this information know and understand their obligations regarding confidentiality and privacy.

Physicians who have incorrectly identified themselves as not performing exposure prone procedures should update their information immediately with the College.

If there is a chance of conversion of any procedure performed to an EPP, the physician should describe themselves as performing EPPs and ensure that they have been tested for the three BBPs.

Have your say

The College’s Policy Department is currently seeking your feedback on a number of consultations. The topics are:

- Medical Marijuana
- Providing Physician Services During Job Actions
- Proposed Regulation Amendment to Maintain Jurisdiction of the Premises Inspection Committee over Colonoscopy Clinics and other Community-based Specialty Clinics

More information can be found on the College website at www cpso on ca under Policies and Publications Consultations

Mailing address:
CPSO Policy Department,
80 College Street, Toronto, Ontario M5G 2E2
In March 2013, the Ministry of Health and Long-Term Care (MOHLTC) asked the College and Cancer Care Ontario (CCO) to join forces to plan and design comprehensive quality management programs in colonoscopy, mammography and pathology.

Working closely with physicians, other health-care professionals and organizations, the College and CCO will design quality management programs that leverage existing quality initiatives where possible, remove duplication, address inconsistencies and fill gaps.

The program is put forward as part of the Ministry of Health’s commitment to shaping a patient-centred quality culture, as articulated in the Excellent Care for All Act.

We spoke recently to Wade Hillier, who is providing leadership on behalf of the College. Mr. Hillier is director of the College’s Quality Management Division.

Q: Why is this Quality Management Partnership (QMP) necessary?
A: Across the province there is actually no consistent approach to the delivery of these types of services and the partnership will bring a level of continuity so that anybody going anywhere to receive these three types of services will be able to have the same experience. It creates a level playing field for the receipt of those services. The partnership is a way to bring quality to the health-care system. This is just the beginning of that work.

Q: What are the principles underpinning this initiative?
A: We want to deliver quality service in Ontario and those three services need to be delivered using a lens that looks at the provider, the facility and system. By doing so, we are able to deliver on many dimensions of quality that will essentially improve outcomes for patients and build a system where the experience across the province is consistent.

This is not an exercise in reducing resources to the system. It is an exercise in identifying quality and its dimensions and then articulating what needs to be done to achieve a quality system. There’s no underlying agenda to look at saving money to the system and, in fact, in some cases it might mean adding to the system.

Q: Why do you believe the College was asked to be a partner in this initiative?
A: The College has a significant amount of experience doing both physician and facility-based inspections. The College has worked closely with the MOHLTC, especially through the Independent Health Facilities program. The Ministry realized that the partnership with CCO would be a way to build on all of our good work in ensuring quality, along with the valuable expertise brought by CCO in data collection, quality reporting, clinical engagement and program implementation. So the partnership builds on the great work of two system players to create a circle around quality.

Q: How important is stakeholder engagement?
A: We can’t make this work without it. It is critical to the implementation and success of this project. We have a very broad and deep stakeholder engagement plan.
Q: How will you engage stakeholders?
A: We have been engaging stakeholders in multiple ways. We have a newsletter, webinars. We are responding to requests to go out and do presentations to groups and organizations. We are doing consultations on our draft report. We have put together expert advisory panels for each of these service areas that involve people from across the sector including LHINs, hospitals, community clinics, patients. So we’ve done a huge amount of work around stakeholder engagement. We need their expertise to get it right.

Q: How will performance data be used?
A: There will be different kinds of performance data – data that is individually-based, facility-based, and system-wide. Those data will be used in different ways. Essentially, the individual data of physicians will be provided to them to give them an opportunity to see how they compare to norms and to give them opportunity to improve their practice.

That data will then be used to roll up into facility and system-based trends that may point to areas that need to be improved from a quality standpoint.

Each of the expert panels will be giving advice on how performance data is to be used in each of the three areas and they will help us to determine at what level performance data should be seen and if performance data is concerning, how to deal with that.

Q: Should doctors worry that any work undertaken by the College as part of this initiative can lead to the College taking action against a member?
A: In any quality initiative we’re going to continue to do our assessments of physicians and inspections of facilities and so it won’t change what we do. Out of that process there’s always the opportunity to identify people who might have learning needs in areas where they could improve. Our primary focus in this project is about opportunities for remediation – education and improvement. But definitely the assessment of physicians will continue and the result may be that we identify physicians who need more help.

Q: How will the QMP avoid duplication of existing quality initiatives in each of the three health services?
A: One of the big things we are doing is a current state analysis in each service area and, within that, we are identifying what is happening with quality initiatives across the province. Those initiatives are being brought to the expert panels. The panels will determine which of those current initiatives actually fill a gap that we’ve identified and should continue, and which of those initiatives are redundant or don’t meet the quality requirements as we would determine. In those instances, we need to improve them or decide to discontinue them. The intention is not to duplicate.

The QMP is not going to be the deliverer of quality. Quality is still the responsibility of individuals, organizations and the system as a whole. We are going to bring consistency to what everybody does and at the same time identify areas where there are duplications and try to get those out of the system.
A Matter of Time

In doctor-patient relationships, confidence – in each other – can support better outcomes

Do your patients trust you?
That’s a central question in developing productive and satisfying encounters – and the answer may be more complex than it once was.

Patients have historically had high levels of confidence in the medical profession and individual practitioners. However, in all realms, people are deferring to authority less and less, demonstrating more independence and autonomy. When it comes to their health, people also have more access to their own sources of information than ever, and are often seeking a partnership in care.

In a Reader’s Digest survey last year of the most trusted professions in Canada, firefighters came first, but GPs, nurses and pharmacists were all in the Top 10 list. (Incidentally, the magazine noted that “Regulation is the name of the game when it comes to building trust in industries and their workers. The poll’s top professionals have our lives in their hands, which is why the laws, entry requirements and professional standards to which they must adhere are exhaustive.”)

The high level of trust in the health-care professions is encouraging. Yet another poll a few years back, by Angus Reid for Maclean’s, found some aspects of trust in doctors was slipping a bit. While 92% of Canadians surveyed held doctors in high esteem, 40% feel that doctors care less about their patients than they did a decade ago. More than 50% said doctors don’t readily acknowledge their mistakes.

Managing Pregnant Women with High BMI

The Maternal and Perinatal Death Review Committee reviewed the tragic death of a pregnant woman with a BMI of 44, admitted in her third trimester. During that admission she developed coagulopathy, sustained an intracerebral hemorrhage, delivered a stillbirth and herself succumbed. The Committee’s main recommendations to obstetrical care providers were:

The following recommendations have been compiled from the reports of the expert review committees of the Office of the Chief Coroner and patient safety organizations.
If overall trust in the profession hasn’t eroded, it has evolved. Today, it is perhaps not a “doctor knows best” blind trust. As an article in the *European Journal of Public Health* suggested, “trust is now more conditional and negotiated.”

None of that has diminished the importance of trust. Trusting their doctor can help patients adhere to treatment, improve abilities to manage health issues, and lead to shared decision-making. Without trust, patients may not even access health-care services in the first place. The issue isn’t why to generate trust; it’s how.

**Trust barriers affect shared decisions**

A Manitoba study (reported in the *Journal of Participatory Medicine*) looked at some of the barriers that inhibited shared understanding and decision-making between doctors and patients.

The doctors in this study complained most about their patients’ inability to provide complete and accurate information. They cited many obstacles – rambling patient histories, difficulty getting the patient to understand the diagnosis, patients who simply don’t buy into the treatment plan, and an apparent lack of interest in self-care.

Patients, however, told a different story. They wanted to speak up, ask questions, reveal the use of complementary and alternative treatment, and share other information. When they didn’t, it was often because they simply weren’t comfortable. There was some degree of wariness. Somewhere in the relationship was a degree of mistrust.

Which physician behaviours or attributes are most strongly correlated with trust? The Manitoba study, another study reported in the *Journal of Family Practice*, and other analyses have all come to similar conclusions.

A high level of physician competency is a given. But such skills and knowledge alone isn’t enough to breed trust. Patients can’t always judge technical abilities; they can recognize other traits. Here are 10 key elements cited by studies of doctor-patient trust:

1. Taking a comforting and caring approach.
2. Encouraging and asking questions.
3. Explaining what you’re doing.
4. Respecting the patient’s views.
5. Understanding the patient’s culture.
6. Acting professional and unhurried.
7. Looking for common ground.
8. Trying to stand in the shoes of patients, i.e., empathy for their experience.
9. Talking in the patient’s language (i.e., how the information makes sense to them).
10. Raising the concept of partnerships, with agreed upon expectations.

In short, better communications and interpersonal skills can build more trust – not just strong rapport, but genuine trust.

There’s a difference. Congeniality is important. But in a trusting relationship, patients are likelier to share their story and agenda, reveal their hopes and worries, believe the doctor is offering advice and treatment in their best interests, and get on the same page.

In the Manitoba study, a trusting relationship was
perhaps the biggest determinant for shared decisions. That’s essential at a time when many patients demand and expect more involvement in their care. That desire can vary, but not the overall need for trust.

**Is trusting patients a moral duty?**

Consider not just whether your patients trust you, but whether you trust your patients.

The *Journal of Medical Ethics* once ran an article asking if trusting one’s patients was a doctor’s moral duty. It’s an intriguing and rarely explored question. Most of the literature around trust in doctor-patient relationships centres on the patient’s faith in the doctor. Yet for various reasons, doctors may not totally trust their patients. As the article states, that has ethical and practical implications.

Why would doctors mistrust their patients? Sometimes, the patient’s motives might be under suspicion. For example, are they feigning pain to obtain drugs? With other patients, problems that are presented as urgent turn out to be minor.

In other patients still, the number or nature of symptoms appears unusual, or the symptoms don’t match up with a physical sign. By their nature, pain or fatigue, wrote the *Journal of Medical Ethics*, are less easily trusted than broken bones.

Then there’s the patient’s general competence. Do you trust that they’re able to make informed decisions about diagnosis or treatment?

The potential consequences of mistrust on the part of the doctor are enormous. If you lack faith in a patient’s ability to grasp certain medical information, would you (perhaps unconsciously) withhold it? Do you trust the patient to express and act on their wishes? Would distrust of symptoms influence your judgments? Would you feel that some patients aren’t really interested in working towards a solution or improving their health?

As the *Journal of Medical Ethics* suggested: “Distrust isn’t morally neutral since harm may ensue when doctors don’t trust patients. Patients already lack power in the medical context; being distrusted shifts that balance of power further towards the doctor. While it may not be possible to trust at will, the conscious adoption of a trusting stance is warranted, as the burdens of misplaced trust fall more heavily on patients than doctors.”

Trust is a two-way street. For doctors, trust in patients may be a way of offering both moral and medical support to patients.

**Trust, satisfaction and results are all linked**

As in any relationship, the most beneficial doctor-patient partnerships come down to communications and trust.

The same behaviours that are most often associated with trust – open and honest communications, a feeling of care (in addition to providing care), understanding – are also linked to patient satisfaction.

Moreover, these qualities support health benefits, not least of which is arriving at and following a course of action.

Today in health-care relationships, trust isn’t blind but well-considered and perhaps deeper – a mutual respect, where information and decisions are shared, for the sake of better results. ☞

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### Top 10 Most Trusted Professions*

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<th>Profession</th>
<th>Trust Level</th>
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<tr>
<td>Firefighters</td>
<td>89%</td>
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<tr>
<td>Pharmacists</td>
<td>82%</td>
</tr>
<tr>
<td>Airline Pilots</td>
<td>82%</td>
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<tr>
<td>Nurses</td>
<td>81%</td>
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<tr>
<td>GPs</td>
<td>74%</td>
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<tr>
<td>Teachers</td>
<td>67%</td>
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<tr>
<td>Veterinarians</td>
<td>67%</td>
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<tr>
<td>Armed Forces</td>
<td>64%</td>
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<tr>
<td>Dentists</td>
<td>63%</td>
</tr>
<tr>
<td>Daycare Workers</td>
<td>60%</td>
</tr>
</tbody>
</table>

* Readers Digest survey results
• To have full accurate documentation.

• To review the SOGC Guideline on ‘Obesity in Pregnancy’.

• To ensure that hospitals have access to appropriate equipment to monitor patients (e.g., blood pressure cuffs of varying size for different ages and body habitus).

• To differentiate maternal from fetal heart rates during fetal monitoring.

• To remind providers of the importance of adequate and thorough assessment and documentation of maternal and fetal status at initial triage.

Non-Diabetic Man Accidentally Given Insulin

The Patient Safety Review Committee reviewed the tragic death of a man post-operatively. He was a non-diabetic who mistakenly was given insulin that was prescribed for another patient. He succumbed to hypoglycemic encephalopathy due to parenteral administration of synthetic insulin. The Committee’s recommendations were made to a number of stakeholders. To physicians, the recommendations included:

• When reviewing a sudden change in a patient’s clinical status, consider medication error.

• Routinely check blood glucose levels when a patient experiences a sudden altered level of consciousness.

• Improve staff identification practices by wearing identification tags, visible to patients and family members and always introducing oneself to patients and family members if not known to them.

• Support processes to improve critical incident debriefing and employee assistance for staff involved in incidents.

Managing Trauma Patient who Co-Morbidly has Serious Mental Illness

The Geriatric and Long-Term Care Review Committee reviewed the tragic death of a woman with a long history of schizophrenia, who had stopped her antipsychotic medication. She developed a recurrence of hallucinations and delusional thinking.

One day she was struck by a motor vehicle, and was admitted to hospital with a number of injuries. She was found to be not capable of making health-care decisions, and her substitute decision-maker agreed to a plan of care. Because of her psychiatric symptoms, she was transferred to a psychiatric unit. Shortly thereafter, she arrested, and could not be resuscitated. The Committee’s main recommendations to healthcare professionals:

• Be aware of responsibilities under the Health Care and Consent Act. Specifically, providers have to discuss treatment with the patient, evaluate capacity, and if the provider feels that an individual is not capable, the physician must inform the patient of the finding of incapacity, and if the patient agrees, then have the discussion with the substitute decision-maker. If the patient disagrees with the finding of incapacity, the physician must offer the patient a Form A (Application to the Board to Review a Finding of Incapacity) so that the patient may complete it and submit to the Consent and Capacity Board for a hearing.

• Involve a psychiatrist as part of the team as early as possible in situations where a patient, with polytrauma, has a serious psychiatric illness such as schizophrenia.

• Improve communications amongst the various members of the health-care team, when managing patients with multiple complex problems.
Treating Self and Family Members

Erica, a pediatrician, has written a sick note to excuse her 21-year-old daughter from one week of college in order to join the family for a vacation. Erica’s daughter had been suffering from a depressive episode and her mother hoped that a vacation would improve her mood. The note did not mention that Erica was the patient’s mother.

The daughter and daughter-in-law of Henry, a psychiatrist, live in a remote town where there are few physicians. Henry’s daughter-in-law has run out of her anti-hypertensive medication and has asked Henry for help. He provides repeats for a year.

Sidney’s wife has been struggling with adult acne for several months. Sidney, a cardiologist, provides a prescription for Accutane to his wife, who last took the medication when she was 14. While on the medication, Sidney’s wife becomes pregnant.

Amanda has suffered from a terrible fear of flying ever since her orthopedic surgery fellowship. There is a death in her family overseas. Knowing that no pharmacy will fill a prescription she writes for herself, Amanda writes a prescription for 10 tablets of lorazepam in her son’s name which she plans to take on the plane in the event of a panic attack.

According to CPSO policy, physicians should not treat themselves or family members except in the case of an emergency or a minor condition. At times, these limitations can be frustrating for physicians who, often, only wish to be of assistance to those they care for by providing medical care in times of need. However, when physicians treat themselves and their family members, they may be unknowingly and unintentionally compromising the quality of care that is provided.

The four cases outlined here are an amalgam of several cases recently reviewed by the Inquiries, Complaints and Reports Committee of the CPSO.

It is important to return to basic principles to carefully consider the risks in treating oneself and family members. The practice of medicine relies on the foundation of the physician-patient relationship. Confidentiality, consent and privacy solidify the foundation and are prerequisites to quality care. What happens to these values when physicians bring their own emotions into the story? When they become part of the patient narrative as a loved one? What exactly is at risk of being compromised?

Erica treats her daughter in the form of communicating a diagnosis and providing a recommended treatment.
It is never acceptable for a physician to prescribe a controlled substance to him or herself or to a family member for any reason. The treatment does not appear to be in the context of an emergency, nor is the diagnosis of depression a minor condition. While it may have been Erica’s intent to help her daughter, the act of writing the note can be interpreted as self-serving, allowing her daughter to join her on a family vacation. As well, the failure to mention that she is the mother of the patient may be viewed as deceptive. Consequently, such acts reflect poorly on the profession in addition to being in contravention of the policy.

It would have been reasonable for Henry to prescribe a few weeks’ worth of medication to his daughter-in-law on an urgent basis; allowing her the opportunity to find a physician in the area without risking her health. Several concerns arise from providing an extended prescription to his relative, including the absence of follow-up care for the patient, as well as Henry repeatedly prescribing a medication whose indication may lie outside his scope of practice. The lengthy supply of medication may also serve as a disincentive for the patient to seek out and access regular care.

Sidney was treating his wife for an ongoing, chronic condition, which is a violation of the policy. Also, the medication in question carries with it significant risk of birth defects. Because she is Sidney’s wife, there is no documentation of risks and benefits being discussed. There is likely no chart at all in which to document informed consent.

At first glance, it seems that Amanda was faced with an emergency situation. Arguably, situational anxiety may be considered to be a minor condition. However, it is never acceptable for a physician to prescribe a controlled substance to him or herself or to a family member. As well, it is potentially harmful for her son to have a prescription on file which erroneously ascribes a condition to him. In addition, there may be issues of insurance fraud.

Thus far, the focus has been on the risk to the patient. However, treating self and family members can also create a situation of risk for the prescribing physician. As much as one assumes relationships will remain healthy and sustainable, circumstances can change. Prescribing to one’s children may be raised when custody issues are at hand. The regular prescribing of medication to one’s partner may be reframed as the sexual abuse of a patient either in the present tense, or upon reflection during court proceedings for other matters.

While certain risks may be acceptable in the case of an emergency or a minor condition, in other cases the lack of informed consent, the potential for bias and undue influence, as well as the lack of medical documentation makes treating one’s self and family members a potentially hazardous endeavour.

In a recent decision, the Ontario legislature passed a private member’s bill which allows each health professional regulatory body in the province to decide whether or not to allow their members to treat spouses. The College of Physicians and Surgeons of Ontario will not be pursuing this avenue of exemption. While there is often a temptation to make exceptions to such policies, doing so can present risk to patients and physicians that result in ethical, moral and practical consequences.
Assessor Close-Up: 
Dr. Debbie Schachter

Name: Debbie Schachter

Practice Location: Child, Youth and Family Program, Centre for Addiction and Mental Health, (CAMH), Toronto

Specialty: Psychiatry with a focus on child and adolescent psychiatry

How long have you been an assessor?
I have been a peer assessor since 2009 and have been conducting practice registration assessments since 2010.

What attracted you to your specialty?
I worked as a GP for two years following my internship and found that I was interested in helping patients deal with their mental health difficulties. Once I started my psychiatry residency, I realized that I preferred working with children, adolescents and families. I value the opportunity to intervene earlier in the course of psychiatric disorders.

What is the one word that your patients would be most likely to use to describe you?
I hope they would use words like thorough, caring or compassionate.

What is the most effective way for you to participate in continuous professional development?
Learning is most effective for me if it is related to a clinical encounter or question. For the last few years, the psychiatrists in the Child, Youth and Family Program at CAMH have met on a monthly basis to discuss our difficult clinical cases and this is a valuable opportunity to learn from colleagues. During the course of my clinical work when I have a question, I try to read around the issue, discuss the question with colleagues, or other professionals. The hospital has a very strong pharmacy department and I value being able to contact them with questions. Since I work at a teaching hospital, I work closely with residents in psychiatry; the supervision process and questions raised are another impetus to ongoing continuous professional development.

What has been a great moment for you as a peer assessor?
I try to make the peer assessment process collegial and hope it will be an educational process for the physician, recognizing that many physicians are quite nervous about the process. I feel that the peer assessment process has gone well when a physician I have assessed approaches me at a conference to chat or contacts me following the assessment to ask a question or discuss an issue.
Multisource feedback allows for assessment of professionalism

The College operates in the public interest by ensuring that practice certificates are issued to applicants who display the necessary medical knowledge, skill, and judgment to practise medicine in Ontario.

There are multiple “routes” to registration and these can be described as either a “traditional pathway” (the applicant completed postgraduate training in Canada and passed necessary Canadian exams) or an “alternative pathway” (physician applicants who meet the criteria of a registration policy).

In 2012, the College embarked on an initiative to better understand whether differences exist in the performance of physicians who are registered through alternative pathways compared to those registered through traditional pathways. This initiative, called the “Evaluation of Registration Pathways and Policies,” will inform future registration policy directions as well as help the College to better understand the educational needs of physicians entering practice in Ontario. An understanding of the differences, if any, would enable the development of appropriate quality improvement and practice support activities.

To assess physician performance, the pathways evaluation project is using two data collection tools: the CPSO peer assessment program and multisource feedback (MSF).

Multisource feedback – often called a 360-degree assessment – is a questionnaire-based method of assessing an individual’s professional performance through confidential feedback from multiple individuals.

The College’s expectation is that the competencies of a doctor should extend beyond medical knowledge and clinical expertise to encompass competencies such as the ability to communicate well, to collaborate with other health-care professionals and to demonstrate professionalism. These qualities have not, historically, been assessed in the peer assessment program.

“The use of MSF allows for the assessment of broader dimensions of physician performance above and beyond the medical expert role,” said Dr. Rocco Gerace, College Registrar.

Recently, the College conducted a pilot project on MSF, using 31 volunteers from our pool of physician assessors as the assessed physicians.

A research group contracted by the College provided the questionnaires to the physician’s medical colleagues, non-physician co-workers, patients and the physician himself/herself.

After the information was collated and analyzed, the results were fed back to the doctor to help promote personal development and continuing performance improvement.

Generally, the physicians participating in the pilot responded positively to the project and described the results as being informative and useful.

“We all have our psychological blind spots,” said Dr. Gerace. “We believe that multisource feedback may be able to provide physicians with insight into the areas of their performance that can be improved.”

As we move through the duration of the pathways evaluation, it will be critical to have all physicians who are assessed – both through the peer assessment program and MSF – describe their experiences. Physicians will be asked to describe the usefulness of the two tools to provide a comprehensive picture of practice. They will also be asked whether the feedback they receive from both tools will inform the way they practise medicine.

We will continue to provide updates of the pathways evaluation in Dialogue and on our website.
Advisory group a resource for assessment initiatives

The College is currently engaged in a number of endeavours aimed at providing valuable insight into physician practice and assessment. These initiatives include the evaluation of registration pathways and policies (see facing page) and the continuous improvement of tools and processes within the peer assessment program.

Given the complex nature of our work, the College convened a group of experts from organizations and institutions across Canada to provide insight into our research and evaluation initiatives.

This group, known as the Research Advisory Group, is an external, academically-oriented set of individuals, with diverse qualifications and experiences both within and outside of the regulatory world.

To date, the group has met four times with each successive meeting building on the one before it. Meetings are designed to provide an update on our projects, and to receive critique and advice on project design, methods and analysis. Their contributions have already helped shape and guide several strategic projects established by Council. For example, as part of the evaluation of registration pathways and policies, a pilot of multisource feedback was conducted in collaboration with members of our Research Advisory Group.

“We convened this group to provide the College with regular and objective critical appraisal, support and suggestions in a number of domains, and help us continuously use evidence in our program decisions,” said Rhoda Reardon, Manager of the College’s Research and Evaluation Department.

“This group is a wonderful resource for the College,” said Ms. Reardon. “They help us shape the questions that we need to ask and I believe they will prove critical in helping us develop our own research agenda.”

The members of the group include:

- Geoff Anderson
  Professor, Institute of Health Policy, Management and Evaluation, University of Toronto

- Joan Sargeant
  Director, Research and Evaluation, Continuing Medical Education, Associate Professor and Director, Program in Health and Medical Education Research, Dalhousie University

- Elizabeth Wenghofer
  Associate Professor, School of Rural & Northern Health, Laurentian University

- André De Champlain
  Consulting Chief Research Psychometrician, Medical Council of Canada

- Kathryn Parker
  Director, Academic Affairs, Holland Bloorview Children’s Rehabilitation Hospital
We want your input!

We value your feedback on policies, regulations, by-laws and other initiatives and invite you to participate. Materials for each consultation, including instructions on submitting feedback, can be found on our website at www.cps.on.ca under Consultations. Please provide your feedback by February 7, 2014.

Providing Physician Services During Job Actions
This revised draft policy sets out the College’s expectations regarding the provision of physician services during job actions. The key components of the College’s current policy have been retained; however, revisions have been made to emphasize the protection of the public interest and clarify expectations for physician conduct.

Medical Marijuana
A preliminary consultation on our existing Medical Marijuana policy is underway in order to obtain feedback on how it can be revised to be more effective. As part of this review, the College will consider new federal regulations that will significantly alter the process for accessing dried marijuana for medical purposes.

Proposed Amendment to Ontario Regulation 114/94
The College is proposing an amendment to a section of Ontario Regulation 114/94 in regard to the College’s Out-of-Hospital Premises Inspection Program. The amendment involves removing a provision of the regulation that exempts Independent Health Facilities from the College’s OHP Inspection Program. This amendment was prompted by the provincial government’s decision to move some procedures out of the hospital environment, and into community specialty clinics and to classify the clinics as Independent Health Facilities.

Proposed Fee Increase of $20
After approving the proposed budget for 2014, Council has proposed a 1.3% increase in membership fees. This increase would bring the fee that a physician pays to renew most classes of certificates of registration from $1,550 to $1,570.

Consultation on Reinstatement Decisions: Transparency Project Amendment
The College is seeking feedback on a proposed by-law that would add information to the public register regarding applications for reinstatement that are made to the Executive Committee or Council.

We welcome your comments, and will review all feedback carefully as we proceed. In keeping with College practices, all feedback received will be posted on our website in accordance with our posting guidelines. Thank you for your time and attention. Your contribution is greatly appreciated.
### Discipline Summaries

The following pages contain summaries of the decisions of the Discipline Committee. To read the entire decision of a particular case, please go to www.cpso.on.ca, select Doctor Search and enter the doctor’s name. A PDF of the decision is posted under Additional Details.

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DR. LUCY AWAD
Practice Location: Toronto
Practice Area: Family Medicine

Hearing Information: Agreed Statement of Facts, Admission, and Joint Submission on Penalty

On October 5, 2012, the Discipline Committee found that Dr. Lucy Awad committed an act of professional misconduct, in that she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Awad admitted to the allegation.

Dr. Awad is a family physician. She was born in Egypt and received her medical degree in Egypt in December 1992. Dr. Awad came to Canada in April 1996. With two exceptions, between April 1996 and October 2003, Dr. Awad did not practise medicine.

The exceptions were that she:

(a) worked on a part time basis between December 1996 and May 1997 at the American Hospital in Tanta, Egypt; and

(b) completed two months of training in the Psychiatric Department of the Ain Shams University Hospital between December 2002 and February 2003.

Dr. Awad applied for registration/membership to the following licensing/professional bodies:

• Newfoundland Medical Board in July 2003.
• College of Family Physicians of Canada in October 2003.
• College of Physicians and Surgeons of Ontario in December 2004.
• College of Physicians and Surgeons of Manitoba in January 2006.

Dr. Awad provided inaccurate information to these licensing/professional bodies regarding her practice history. On the basis of the above four applications, which included inaccurate information, Dr. Awad obtained her respective certificates of registration/memberships.

Finding
The Committee found that Dr. Awad committed an act of professional misconduct, in that she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

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

The relevant penalty principles that guided the Committee were the principles of public protection, deterrence, rehabilitation, maintaining the integrity of the profession and maintaining public confidence in self-regulation. The Committee wanted to ensure that the penalty would send a message to future applicants for registration that it is crucial to be clear and truthful in their application submissions to the College.

The Committee also considered aggravating and mitigating factors. Mitigating factors included quick acknowledgement of wrongdoing by the member and her cooperation with the College. These factors, in addition to making a joint submission with agreed facts, spared the College the cost and time of pursuing a potentially lengthy hearing. Further, the Committee considered the fact that Dr. Awad had not had any other previous findings of professional misconduct with the College.

Aggravating factors included the fact that not only did Dr. Awad mislead the College by failing to disclose her practice gaps, but that she also provided three other similar, misleading applications over two and a half years to other regulatory bodies. The Committee also took into account that these were not errors, but intentional attempts to mislead on applications that she signed.

The Committee further determined that this was an appropriate case for ordering that Dr. Awad pay costs to the College at the tariff rate for a one-day hearing.

The Committee accepted the penalty and costs order jointly proposed as being in the public interest and appropriate in the circumstances of this case.

Order
The Discipline Committee ordered and directed that:

1. The Registrar place the following term, condition and limitation on Dr. Awad’s certificate of registration:

   (i) At her own expense, Dr. Awad shall successfully complete College-facilitated instruction in ethics no later than one year from the date of this Order.
2. Dr. Awad appear before the panel to be reprimanded.
3. Dr. Awad pay costs to the College in the amount of $3,650 within 30 days from the date of this Order.

At the conclusion of the hearing, Dr. Awad waived her right to an appeal and the Committee administered the public reprimand.

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**DR. JOYCE BERYL REJEANNE WONG BUCKLEY**

Practice Location: Ottawa
Practice Area: Obstetrics/Gynecology

**Hearing Information: Agreed Statement of Facts, Admission and Joint Submission on Penalty**

On August 30, 2012, the Discipline Committee found that Dr. Joyce Beryl Rejeanne Wong Buckley committed an act of professional misconduct, in that the governing body of a health profession in a jurisdiction other than Ontario has found that the member committed an act of professional misconduct that would, in the opinion of the panel, be an act of misconduct as defined in the regulations.

Dr. Buckley admitted to the allegation.

Dr. Buckley practised in New York State pursuant to a licence which authorized her to practise obstetrics and gynecology only in the medically under-serviced area of Watertown. On September 12, 2008, the New York State Board for Professional Medical Conduct found that, between approximately 2005 through 2007, Dr. Buckley reviewed information submitted online and authorized the dispensing of prescriptions for non-controlled prescription drugs to persons located throughout the United States. Approximately 75,000 prescribing determinations were made in her name, at $2 per determination. The online patient information was grossly insufficient to make an informed decision about whether the drug should ultimately be dispensed.

It was found that Dr. Buckley’s conduct was well below acceptable standards of care and constituted negligence on more than one occasion, gross negligence, practising the profession beyond its authorized scope, failure to maintain patient records and failure to make requested records available to the Board. Based on its findings, the New York State Board revoked Dr. Buckley’s medical licence and ordered her to pay a fine of $40,000.

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**What does this mean?**

We provide definitions for the legal terminology used in the discipline process

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<th>Term</th>
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<td><strong>Admission</strong></td>
<td>The physician admits that the facts alleged amount to professional misconduct and/or incompetence.</td>
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<td><strong>Plea of No Contest</strong></td>
<td>The physician does not contest the facts. The College files a statement of facts as an exhibit at the hearing. The Discipline Committee can accept the facts as correct and make a finding of professional misconduct and/or incompetence. The physician does not admit to the facts or findings for the purpose of any other proceeding.</td>
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<tr>
<td><strong>Agreed Statement of Facts</strong></td>
<td>A statement of facts that are negotiated and agreed to by the College and the physician. It is filed as an exhibit at the hearing.</td>
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<td><strong>Joint Submission on Penalty</strong></td>
<td>A penalty that is proposed to the Committee as an appropriate penalty by both the College and the physician. In law, the Discipline Committee must accept a joint submission on penalty unless it would be contrary to the public interest and bring the administration of justice into disrepute.</td>
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<tr>
<td><strong>Contested Hearing</strong></td>
<td>The physician denies the allegations. The College must prove the allegations on a balance of probabilities (the civil standard of proof) by calling evidence such as witnesses. If one or more of the allegations is proved, a penalty hearing is scheduled. The College and the physician may agree and jointly propose a penalty to the Committee or they may disagree and a contested penalty hearing takes place.</td>
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Full decisions are available online at [www cpso on ca](http://www.cps.org.on.ca). Select Doctor Search and enter the doctor’s name.
Finding

The New York State Board found that Dr. Buckley committed acts of misconduct that would, in the opinion of the Committee, be an act of professional misconduct as defined in the regulations. Having regard to this, the Committee accepted Dr. Buckley’s admission and found that she has committed an act of professional misconduct in Ontario.

Reasons for Penalty

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

Aggravating factors included the fact that the misconduct for which Dr. Buckley was convicted in New York was serious. The New York State Board sustained 59 specifications of misconduct against Dr. Buckley. It found that Dr. Buckley’s conduct constituted negligence on more than one occasion, gross negligence, practising medicine beyond the scope of her licence, as well as failure to maintain patient records and to make requested records available to the regulator. It concluded that Dr. Buckley made prescribing decisions about whether a medication should be dispensed based only on reviews of information submitted online. It found that the information on which Dr. Buckley relied to have been “grossly insufficient” for her to have made an informed decision about whether or not the medication should be dispensed. It concluded, among other things, that she “displayed utter disregard for the potential and unknown consequences of her online prescribing practices.”

A mitigating factor is that Dr. Buckley admitted to professional misconduct in this proceeding, thereby negating the need for a full hearing. As well, Dr. Buckley has had no prior disciplinary findings against her with this College.

The Committee agreed that the principles that should govern a penalty order will be upheld by the proposed penalty order. The reprimand will serve to express the profession’s disapproval of Dr. Buckley’s conduct. This will help to maintain public confidence in the profession and in its ability to regulate itself. The reprimand will also act as a general deterrent to the profession and a specific deterrent to Dr. Buckley. The ethics course is a one-to-one course that will be tailored specifically to Dr. Buckley’s misconduct and, therefore, will have a remedial function. Last, it is appropriate to order that Dr. Buckley pay part of the College’s costs of conducting the hearing.

The Committee therefore concluded that the proposed penalty set out in the joint submission was appropriate.

Order

The Discipline Committee ordered and directed that:

1. Dr. Buckley attend before this panel to be reprimanded.
2. The Registrar impose the following term, condition and limitation on the certificate of registration of Dr. Buckley:
   (i) Dr. Buckley must successfully complete, at her own expense, College-facilitated instruction in ethics.
3. Dr. Buckley pay costs to the College in the amount of $3,650 within 60 days of the date of this Order.

At the conclusion of the hearing, Dr. Buckley waived her right to an appeal and the Committee administered the public reprimand.

DR. KENNETH BUTTOO

Practice Location: Ajax
Practice Area: Internal Medicine and Clinical Immunology

Hearing Information: Agreed Statement of Facts, Admission and Joint Submission on Penalty

On February 1, 2013, the Discipline Committee found that Dr. Kenneth Buttoo committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession.

Dr. Buttoo admitted to the allegation.

As a result of concerns regarding his practice, Dr. Buttoo executed an undertaking to the College on March 10, 2009, by which he agreed that he would engage in an assessment of his practice within one year.

As a result of concerns that arose out of the subsequent practice assessment, the College proceeded with a section 75 investigation into Dr. Buttoo’s practice and retained a medical inspector to review 20 patient charts, visit the site, interview Dr. Buttoo and observe five patient visits in February 2010.

As set out in the inspector’s report, Dr. Buttoo fell below the standard of practice of the profession in the
areas of allergy management and respiratory management.

In particular, in the care of multiple patients in 2009-2010, Dr. Buttoo:

•  inappropriately ordered and/or recommended testing that was unnecessary and/or not indicated;
•  inappropriately failed to mention airways resistance findings in his interpretation of pulmonary function test results;
•  in circumstances in which Dr. Buttoo made a provisional diagnosis of asthma and then conducted testing which did not support the diagnosis, he inappropriately failed to address the provisional asthma diagnosis in his follow-up consultation letters to referring physicians and did not state that asthma had been ruled out;
•  inappropriately presented “hyper responsive airways” to referring physicians in terms that suggested it represented a final diagnosis of a patient’s condition, when in fact no diagnosis had been reached on the basis of the testing conducted and the patient’s symptoms remained undiagnosed;
•  inappropriately prescribed medications that were unnecessary and not indicated; and
•  utilized inappropriate sterilization techniques.

Finding

The Committee found that Dr. Buttoo committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession.

Reasons for Penalty

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

The Committee noted the principles which underlie an appropriate penalty when there has been a finding of professional misconduct. Paramount among these is the need for public protection. Others include the need to demonstrate the profession’s willingness and ability to govern itself, specific deterrence through denunciation or sanction of the member’s behaviour and, by example, general deterrence to the profession as a whole. Where appropriate, rehabilitation of the member should also be considered.

Aggravating factors included the fact that the concerns regarding Dr. Buttoo’s practice were longstanding and the deficiencies in his practice were serious. Unnecessary tests and inappropriate sterilization techniques carry the risk of adverse consequences for patients. Mitigating factors included his admission and acceptance of responsibility for his misconduct, his agreement to the terms imposed having as their objective improvements in his practice, and the fact that he had no prior disciplinary record with the College.

The Committee was confident that the terms, conditions and limitations imposed on Dr. Buttoo’s practice and the requirement for supervision will ensure protection of the public. Public denunciation through the reprimand should deter Dr. Buttoo from a repetition of the failings which brought him to the attention of the College. The ongoing mentorship of the supervisor will assist in rehabilitation. The awarding of costs for a single day of hearing is appropriate in the circumstances.

Order

The Discipline Committee ordered and directed that:

1. Dr. Buttoo attend before the panel to be reprimanded.
2. the Registrar impose the following terms, conditions and limitations on Dr. Buttoo’s certificate of registration:
   a) For an indefinite period of time, Dr. Buttoo shall not prescribe inhaled corticosteroids and/or anticholinergic medication for a patient unless he or she has a diagnosis of asthma, and in any case Dr. Buttoo shall not prescribe such medication in cases in which the patient has had a negative methacholine challenge.
   b) While Dr. Buttoo is subject to the term, condition and limitation set out at paragraph 2(a), Dr. Buttoo shall maintain a detailed log listing all patients to whom he has prescribed inhaled corticosteroids and/or anticholinergic medication, their OHIP number, the date on which he saw the patient, whether the patient has a diagnosis of asthma, and in any case Dr. Buttoo shall not prescribe such medication in cases in which the patient has had a negative methacholine challenge.

Full decisions are available online at www.cps.on.ca. Select Doctor Search and enter the doctor’s name.
log at any time upon request of the College.

c) Dr. Buttoo shall, within 30 days from the date of this Order, retain a College-approved clinical supervisor, who will sign an undertaking. For a period of at least 12 months commencing on the day the Clinical Supervisor is retained, Dr. Buttoo may practise only under the supervision of the Clinical Supervisor, who will meet with Dr. Buttoo on a monthly basis for the duration of the supervision, except that after three months of supervision, the frequency of meetings may be decreased to every two months if the Clinical Supervisor is of the view that this is appropriate and it has been pre-approved by the College.

d) For the duration of the clinical supervision required by paragraph 2(c), Dr. Buttoo shall, within 20 days of receiving notice that his Clinical Supervisor is unwilling or unable to continue to fulfill the terms of his or her undertaking, obtain an executed undertaking 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. Buttoo is unable to obtain a Clinical Supervisor on the terms set out under paragraphs 2(c) and 2(d) to this Order, he shall cease to practise until such time as he has obtained a Clinical Supervisor acceptable to the College, and the fact that he has ceased to practise shall be a term, condition and limitation on his certificate of registration until that time.

e) Dr. Buttoo shall abide by all recommendations of his Clinical Supervisor with respect to practice improvements and education.

f) Dr. Buttoo 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 to monitor Dr. Buttoo’s compliance with the Order. This shall include, without limitation, providing the Clinical Supervisor with the reports of any assessments of Dr. Buttoo’s practice in the College’s possession.

g) Approximately 12 months after the completion of the period of supervision required by paragraph 2(c), Dr. Buttoo shall undergo a re-assessment of his clinical practice by a College-appointed assessor. This re-assessment will include determining whether Dr. Buttoo meets the standard of practice of the profession and whether Dr. Buttoo is in compliance with this Order. The Assessor(s) shall make recommendations regarding Dr. Buttoo’s practice and shall report the results of the re-assessment to the College.

h) Dr. Buttoo 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 among the Clinical Supervisor, the Assessor(s) and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

i) For an indefinite period of time, Dr. Buttoo shall inform the College of each and every location where he practises including, but not limited to hospitals, clinics, and offices, in any jurisdiction (collectively, his “Practice Location(s)”), within 15 days of this Order, and shall inform the College of any and all new Practice Locations within 15 days of commencing practice at that location.

j) For an indefinite period of time, Dr. Buttoo shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution who may have relevant information, in order for the College to monitor his compliance with this Order.

k) For an indefinite period of time, Dr. Buttoo shall submit to, and not interfere with, unannounced inspections of his Practice Location(s) and patient records by a College representative for the purposes of monitoring his compliance with this Order.

l) Dr. Buttoo shall be responsible for any and all costs associated with implementing the terms of this Order.

3. Dr. Buttoo pay to the College costs in the amount of $3,650 within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. Buttoo waived his right to an appeal and the Committee administered the public reprimand.
DR. BRYAN WILLIAM CARROLL

Practice Location: Leamington
Practice Area: Gynecology

Hearing Information: Agreed Statement of Facts, Admission and Joint Submission on Penalty

On October 15, 2012, the Discipline Committee found that Dr. Bryan William Carroll committed acts of professional misconduct, in that:

• he contravened a term, condition or limitation on his certificate of registration, and
• he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Carroll admitted to the allegations.

In 2008, Dr. Carroll was the subject of a discipline proceeding, in which the Discipline Committee ordered, among other things, that he undergo a Comprehensive Practice Assessment (CPA) and that he abide by any and all recommendations made. The CPA assessor recommended that Dr. Carroll comply with the currently accepted guidelines with respect to ordering colposcopy and uroflow studies. On January 8, 2010, Dr. Carroll entered into an undertaking to abide by the currently accepted consensus threshold for ordering colposcopy and uroflow studies.

In 2010, Dr. Carroll’s supervisor reported that Dr. Carroll continued to perform colposcopy without indication. An investigation, including a review by an independent assessor, Dr. Z, found that Dr. Carroll had performed repeated colposcopy and/or uroflow studies where they were not indicated or were unnecessary in relation to 7 of 15 patient charts reviewed.

Findings

The Committee found that Dr. Carroll committed acts of professional misconduct, in that he contravened a term, condition or limitation on his certificate of registration, and in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Additional Facts Considered for Penalty

The Committee considered the following additional facts for the purposes of penalty:

• Dr. Carroll had been under supervision pursuant to the 2008 Discipline Committee Order. Throughout 2010, the supervisor reported that with the exception of colposcopy, he did not see any evidence of patient care or prescribing that did not meet the standard of care for an obstetrician/gynecologist practising in Ontario.
• On three occasions in 2011, Dr. Carroll’s supervisor provided positive reports indicating that in the charts he reviewed, Dr. Carroll performed few colposcopies, all of which were indicated. He continued to report that he saw no evidence of patient care or prescribing that did not meet the appropriate standard of care for an obstetrician/gynecologist practising in Ontario.
• In the course of the investigation which gave rise to the proceedings, Dr. Carroll accepted the opinion of the College assessor, Dr. Z, and conceded that he failed to adhere to the guidelines regarding the performance of colposcopy and uroflow studies.
• Prior to the referral of this matter to the Discipline Committee, on April 12, 2012, Dr. Carroll entered into an undertaking agreeing that, effective immediately, he will cease to engage in colposcopy and uroflow studies altogether, and to arrange referral to other physicians in the future for these studies.
• Following the referral to discipline, Dr. Carroll agreed to proceed by way of agreement, obviating the need for disclosure and proceeding directly to a hearing in the matter.
• Dr. Carroll is subject to a further reassessment of his practice pursuant to the December 2008 Discipline Committee Order.

Reasons for Penalty

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

In general, a penalty must first and foremost protect the public. Other penalty principles include maintenance of public confidence in self-regulation of the profession,
specific and general deterrence and rehabilitation of the physician.

The proposed penalty of a two-month suspension and reprimand should send a clear message to both the public and the profession that it is a serious matter when a physician does not abide by an undertaking with this College. A failure to comply with an undertaking raises concerns regarding a member’s governability and challenges the self-regulation process. It is always very concerning to the Committee when a physician disregards his or her regulatory body. In order for the public to have confidence in self-regulation, a physician must scrupulously abide by his or her undertaking with the College. Dr. Carroll’s breach of his undertaking was tantamount to breaching an order of the Discipline Committee, and such conduct cannot be tolerated.

The Committee did consider the mitigating factors in this case, including the timely cooperation and admission made by Dr. Carroll, which led to a speedy resolution, obviating the need for a contested hearing. Also, Dr. Carroll accepted the expert opinion of Dr. Z, and agreed to cease performing colposcopies and uroflow studies altogether and to arrange referral to other physicians in the future for these studies. This will ensure the public will be protected. Dr. Carroll’s practice will continue under supervision and he is to undergo another practice assessment in accordance with the previous order. This will provide further protection for the public.

For these reasons, the Committee finds the jointly proposed penalty to be fair and reasonable in the circumstances, and adequately addresses the guiding principles of penalty.

Order
The Discipline Committee ordered and directed that:

1. Dr. Carroll appear before the panel to be reprimanded.
2. the Registrar suspend Dr. Carroll’s certificate of registration for a period of two months.
3. Dr. Carroll pay costs to the College in the amount of $3,650 within 30 days from the date of this Order.

At the conclusion of the hearing, Dr. Carroll waived his right to an appeal and the Committee administered the public reprimand.

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**DISCIPLINE SUMMARIES**

**DR. SAMI JOHN GEORGE KARKANIS**
Practice Area: Obstetrics and Gynecology
Practice Locations: Ajax, Pickering

**Hearing Information: Contested Hearing, 4 days**
On November 16, 2012, the Discipline Committee found that Dr. Sami John George Karkanis committed acts of professional misconduct, in that:

- he has engaged in the sexual abuse of a patient; and
- he has engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Karkanis contested the allegations.

**Findings**
The Committee found that Dr. Karkanis made repeated inappropriate comments to his patient, Ms. X, concerning the attractiveness of her abdominal skin while touching her abdomen in 2002 and 2003, and that this conduct constitutes disgraceful, dishonourable or unprofessional conduct.

The Committee also found that Dr. Karkanis sexually abused Ms. X during a pelvic examination in 2006, through inappropriately touching Ms. X’s clitoris and repeatedly inserting his fingers in and out of Ms. X’s vagina, and through making remarks of a sexual nature towards the patient.

The Committee further determined that Dr. Karkanis’ conduct during this appointment constitutes conduct that is disgraceful, dishonourable or unprofessional.

In conclusion, the Committee finds that Dr. Karkanis has engaged in the sexual abuse of a patient and has engaged in conduct that constitutes disgraceful, dishonourable or unprofessional conduct.

**Reasons for Penalty**
Dr. Karkanis’ behaviour in this case, as found by this Committee, was an intentional, unprofessional, medically unnecessary sexualized touching of the complainant’s genitals, which involved moving his fingers repeatedly in and out of the complainant’s vagina and the touching or rubbing of her clitoris and asking her “how does that feel?” In the Committee’s view, this amounts to masturbation of the patient by the member within the meaning of the Code. Dr. Karkanis was seeking to sexually stimulate the complainant’s genitals and that
constitutes masturbation as far as the Committee is concerned. It does not matter that this was a relatively brief encounter, nor does it matter whether or not the patient enjoyed or derived pleasure from the activity. The Committee considers that it was precisely this type of conduct that was intended to be covered by subsection 51(5) of the Code. The Committee is of the view that this conduct is included within the type of conduct that the legislature was attempting to “eradicate” when it enacted the sexual abuse provisions of the Code, including the requirement for revocation of a member’s certificate of registration for masturbation of a patient by a member.

The Committee’s determination is consistent with the overarching purpose of the legislation which is to serve and protect the public interest, and it is also consistent with the ultimate purpose of the sexual abuse provisions which is to eradicate the sexual abuse of patients by members. The penalty is consistent with accepted penalty principles, including the need to maintain the reputation of the profession and its ability to self-regulate, specific deterrence to Dr. Karkanis and general deterrence to all members.

The public reprimand is an appropriate way to express the profession’s abhorrence of Dr. Karkanis’ professional misconduct, as well as inform the public of our concerns and aid Dr. Karkanis in his understanding of his transgressions.

The Committee also considers that this is an appropriate case in which to require the member to post an irrevocable letter of credit as security for the funding that the College may be called upon to pay for the therapy or counselling of the complainant. College counsel indicated that the maximum amount as of January 1, 2013 was $18,520.

The Committee considers that this is an appropriate case for it to exercise its discretion to award costs as per the tariff for four hearing days, at the daily tariff of $3,650, totaling $14,600.

**Order**

The Discipline Committee orders and directs that:

1. the Registrar shall revoke Dr. Karkanis’ certificate of registration, to take effect on the date this Order becomes final;

2. Dr. Karkanis shall appear before the panel to be reprimanded on a date to be fixed by the Hearings Office, which shall be no later than six months from the date this Order becomes final;

3. Dr. Karkanis shall reimburse the College for any funding provided to the patient under the program required under section 85.7 of the Code, and shall post an irrevocable letter of credit or other security acceptable to the College to guarantee payment of such amounts, in the amount of $18,520 by May 13, 2013; and

4. Dr. Karkanis shall pay to the College by May 13, 2013, costs of the hearing in the amount of $14,600.

On May 9, 2013, Dr. Karkanis appealed the finding and penalty decisions of the Discipline Committee to the Superior Court of Justice (Divisional Court). In the circumstances, the decision of the Discipline Committee remains in effect despite the appeal.

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**DR. HEATHER ALLISON LARTON**

**Practice Location:** Waterloo  
**Practice Area:** Family Medicine  
**Hearing Information:** Agreed Statement of Facts, Admission and Joint Submission on Penalty

On November 12, 2012, the Discipline Committee found that Dr. Heather Allison Larton committed acts of professional misconduct, in that:

- she failed without reasonable cause to provide a report or certificate relating to an examination or treatment performed by her to her patient or her authorized representative within a reasonable time after the patient or her authorized representative requested such a report or certificate;
- she failed to respond appropriately or within a reasonable time to a written inquiry from the College; and
- she 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.

Dr. Larton admitted to the allegations.
Between 1998 and 2008, Patient A was Dr. Larton’s patient at her practice in Sudbury, Ontario. Commencing on April 15, 2004, Patient A, through her legal counsel, requested copies of Dr. Larton’s clinical notes and records. Patient A’s counsel required the clinical notes and records in furtherance of litigation related to two car accidents in which Patient A was involved. In total, Patient A’s counsel sent Dr. Larton 14 requests of increasing urgency over the course of four years.

In 2008, Dr. Larton closed her practice in Sudbury. As Patient A had yet to obtain a copy of her clinical notes and records, she complained to the College. Patient A’s new family physician could not complete her application for CPP Disability Benefits without Dr. Larton’s clinical notes and records. In addition, litigation relating to the two car accidents was unable to proceed.

Upon receipt of the complaint letter on August 20, 2008, College staff made attempts to contact Dr. Larton to secure the delivery of Patient A’s records. Dr. Larton failed to respond to Patient A’s records request or to her complaint letter, despite repeated requests by the College that she do so.

On the eve of the discipline hearing scheduled to commence on March 7, 2012, Dr. Larton retained counsel and requested an adjournment. She subsequently located and delivered the patient’s chart to her.

**Findings**

The Committee found that Dr. Larton committed acts of professional misconduct, in that she failed without reasonable cause to provide a report or certificate relating to an examination or treatment performed by her to her patient or her authorized representative within a reasonable time after the patient or her authorized representative requested such a report or certificate; she failed to respond appropriately or within a reasonable time to a written inquiry from the College; and she has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

**Reasons for Penalty**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. In making a penalty determination, the Committee is guided by the need to provide protection to the public, proportionality with its finding, and to maintain public confidence in the profession and its ability to regulate itself. The Committee’s penalty order should reflect its denunciation of the misconduct, and should address specific and general deterrence and, where appropriate, rehabilitation of the member.

In considering the proposed penalty, the Committee was mindful of the seriousness of the finding and the aggravating factors in this matter.

Despite repeated requests from Patient A’s counsel commencing on April 15, 2004 and, in addition, repeated requests from the College, Dr. Larton did not send Patient A the requested clinical notes until July 6, 2012. Dr. Larton sent them, through her counsel, only after discipline proceedings had been commenced against her and several months after requesting and having been granted an adjournment of the original hearing date. The Committee considers this to be unacceptable behaviour.

In this case, failure to respond in a timely fashion to requests from Patient A’s counsel for clinical notes and records potentially jeopardized Patient A’s claim for CPP benefits and, in addition, her civil remedies arising from two motor vehicle accidents. It is essential for the maintenance of public confidence and trust in the profession that physicians fulfil their obligation to respond to a patient’s requests for a copy of their clinical notes and records in a timely fashion. Producing requested clinical records in a timely fashion is an important component of effective office management. In addition, physicians must respond to requests by the College in a timely fashion. Failure to do so is disrespectful to the College and its process of self-regulation, and to the profession as a whole. When, as in this case, a member does not respond to repeated requests from her governing body to secure delivery of a patient’s clinical notes and records, it can also call into question the governability of that member.

The Committee also considered mitigating factors. Dr. Larton admitted to the facts and in doing so saved the time and expense of a contested hearing. This is Dr. Larton’s first appearance before this Committee. The Committee also noted that in a letter to the College dated January 7, 2009, Patient A’s counsel noted that, “Even though it has been an extremely difficult task to
obtain any medical documentation from Dr. Larton, she has been a wonderful physician to [Patient A]."

After considering the facts in this case as well as the aggravating and mitigating factors, the Committee was satisfied that the proposed penalty of a public reprimand, and terms, conditions and limitations to be placed on Dr. Larton’s certificate of registration, addresses the principles of specific and general deterrence and rehabilitation of the member. It upholds the honour and reputation of the profession, and at the same time will maintain public confidence in the profession’s ability to govern and regulate itself while protecting the public. In particular, the Committee felt that rehabilitation would be addressed through the proposed terms, conditions and limitations to be imposed on Dr. Larton’s certificate of registration.

The Committee also concluded that this was an appropriate case in which to order the member to pay a portion of the College’s costs and expenses incurred in conducting the hearing.

**Order**

The Committee ordered and directed that:

1. Dr. Larton attend before this panel to be reprimanded.

2. The Registrar impose the following terms, conditions and limitations on Dr. Larton’s certificate of registration:
   
i) Dr. Larton shall obtain a clinical supervisor, being a Director, office manager or other person in a comparable role, at each location at which she practises (“Clinical Supervisor(s)”), who is acceptable to the College and who has signed an undertaking. The Clinical Supervisor(s) shall report to the College on a quarterly basis in respect of Dr. Larton’s office management, administrative, organizational and communications skills;

   ii) Dr. Larton shall abide at her own expense with the Clinical Supervisor(s)’s recommendations with respect to her practice, including with respect to any practice improvements and/or ongoing professional development and/or education;

   iii) If a Clinical Supervisor who has given an undertaking is unwilling or unable to continue to fulfill its terms, Dr. Larton shall, within 30 days, obtain an undertaking in the same form from a person who is acceptable to the College;

   iv) If Dr. Larton is unable to obtain a Clinical Supervisor at a location at which she practises as set out in (i) or (iii) above, Dr. Larton shall cease to practise at that location immediately until such time as she has obtained a Clinical Supervisor at that location acceptable to the College; and

   v) If, at any time after two years have passed since the Order, every one of Dr. L Barton’s Clinical Supervisor(s) is or are of the opinion that Dr. Larton’s office management, administrative, organizational and communications skills are such that there is no further purpose to be served by clinical supervision, such clinical supervision shall be discontinued only upon:

      a. An assessment of Dr. Larton’s practice at her primary practice location, undertaken by a College-appointed assessor at Dr. Larton’s expense, the results of which are satisfactory to the College; and

      b. The approval of the College.

   vi) Dr. Larton shall be solely responsible for all fees, costs and expenses associated with her compliance with the terms of this Order.

3. Dr. Larton pay costs to the College in the amount of $3,650 within 60 days of the date of this Order.

At the conclusion of the hearing, Dr. Larton waived her right to an appeal and the Committee administered the public reprimand.

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**DR. CALVIN TAI-LEN LIAN**

**Practice Area:** Family Medicine, Emergency Medicine

**Practice Location:** Toronto

**Hearing Information:** Agreed Statement of Facts, Admission and Joint Submission on Penalty

On November 26, 2012, the Discipline Committee found that Dr. Calvin Tai-len Lian committed an act of professional misconduct, in that he has been found guilty of an offence that is relevant to his suitability to practise.

Dr. Lian admitted to the allegation.

On December 22, 2009, Dr. Lian pleaded to and was found guilty of one count of assault under section 266 of the Criminal Code in relation to an assault on his wife. He received a conditional discharge, contingent...
upon 18 months’ probation.

Prior to the 2009 assault which is the subject of this proceeding, Dr. Lian pleaded guilty to assault in relation to an assault on his wife in 2002, for which he received an absolute discharge. Dr. Lian entered into individual and marital counselling in October 2009.

**Finding**

The Committee found that Dr. Lian committed an act of professional misconduct, in that he has been found guilty of an offence that is relevant to his suitability to practise.

**Reasons for Penalty**

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

The Committee considered the principles relevant to determining a penalty. First and foremost, the penalty must protect the public. Other penalty principles include maintenance of public confidence in self-regulation of the profession, specific and general deterrence and rehabilitation of the physician.

The Committee found the proposed penalty to be appropriate. The Committee noted that there are aggravating factors in this case. Although this is Dr. Lian’s first time before the Discipline Committee, it is not the first time Dr. Lian has been found guilty of assault. He was found guilty of assaulting his wife in 2002 and received an absolute discharge at that time. It is very disturbing to the Committee to find he has been found guilty of a repeated offence.

Mitigating factors included Dr. Lian’s cooperation in this matter. In fact, he reported the conduct himself to the College. This led not only to a cost savings as a contested hearing was avoided, but also spared his wife the necessity of testifying. As mentioned above, this is the first time Dr. Lian has appeared before the Discipline Committee. The Committee is aware that Dr. Lian has received for his behaviour from the criminal court a conditional discharge with probation of 18 months. Dr. Lian is still in counselling with his wife and counsel for Dr. Lian informed the panel that he is embarrassed by and remorseful for his behaviour.

The offence for which Dr. Lian was found guilty is relevant to his suitability to practise. As an emergency room physician, Dr. Lian may very well be called upon to diagnose and treat victims of violence and of domestic abuse. It is important that a treating physician who is presented with patients with injuries be attuned to the possibility of domestic violence, be sensitive to such issues, and be approachable and open to disclosure from victims of abuse.

The proposed penalty of a reprimand will serve to express the Committee’s abhorrence of Dr. Lian’s behaviour and denounce his conduct. Physicians are held to a high ethical standard and must be beyond reproach in their personal conduct. Patients must be able to trust physicians, who are in a position of a power, to behave in a manner that respects that trust and does not abuse that power. Violence cannot be tolerated. A physician’s misconduct reflects on the profession as a whole and can undermine the trust that is necessary for a proper physician-patient relationship. A public reprimand will serve to uphold the public trust in our self-regulation process.

The imposition of a condition on Dr. Lian’s certificate of registration that he participate in and successfully complete an ethics course relating to the ethical issues raised by his misconduct, will specifically address the issues of Dr. Lian’s that led him to behave in a violent manner. This will serve to rehabilitate the member and, consequently, will protect the public.

The Committee orders Dr. Lian to pay $3,650 toward the College’s costs for this one day hearing.

**Order**

The Committee ordered and directed that:

1. Dr. Lian appear before it to be reprimanded;
2. the Registrar impose the following terms, conditions and limitations on Dr. Lian’s certificate of registration until the terms referred to in paragraph 2(a) below has been completed:
   a) Dr. Lian shall participate in and successfully complete an educational program in ethics facilitated by the College, relating to the ethical issues raised by his misconduct, such program to be completed at the earliest opportunity and in any case not later than within six months of the date of this Order, with Dr. Lian to provide proof of successful completion of the program to the College...
within that time;

b) Dr. Lian shall be responsible for any and all costs associated with implementing this term of this Order.

3. Dr. Lian pay costs to the College in the amount of $3,650 within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. Lian waived his right to an appeal and the Committee administered the public reprimand.

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**DR. JOHN ANTHONY PAOLONE**

**Practice Location:** St. Catharines  
**Practice Area:** Family Medicine

**Hearing Information: Agreed Statement of Facts, Admission and Joint Submission on Penalty**

On September 14, 2012, the Discipline Committee found that Dr. John Anthony Paolone committed an act of professional misconduct, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Dr. Paolone admitted to the allegation.

In October 2008, the College requested records from Dr. Paolone in relation to a complaint. Dr. Paolone re-wrote and revised the patient's record and provided it to the College without providing the original record. He did not advise the College that what he was providing was not the original patient record and did not advise the College that he had made changes, additions, deletions and corrections.

In May of 2010, Dr. Paolone's counsel informed the College that the patient record Dr. Paolone had submitted had been re-written and revised, and provided, for the first time, the original patient record.

**Finding**

The committee found that Dr. Paolone committed an act of professional misconduct, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

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**Reasons for Penalty**

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

The fact that Dr. Paolone had previously been cautioned by the College’s Inquiries Complaints and Reports Committee for similar behaviour was an aggravating factor on penalty.

As a mitigating factor, Dr. Paolone did admit the allegation and agreed to the facts in the Agreed Statement of Facts, thereby saving the College the time and costs associated with a contested hearing. The Committee noted, however, that Dr. Paolone only admitted late in the complaints process that the patient record he had submitted during the investigation of the complaint had been rewritten.

Additional mitigating factors include the fact that Dr. Paolone did not destroy the original record, and there is no evidence that he intended to deceive the Committee.

A public reprimand is consistent with the penalty principles of both general deterrence to the medical profession and specific deterrence to Dr. Paolone.

The one-month suspension sends a strong message to the profession that altering patient records will not be tolerated.

Dr. Paolone will be required to successfully complete, at his own expense, the College facilitated instruction in record-keeping within 12 months and then cooperate with a re-assessment within six to 12 months of the completion of the record-keeping course. The record-keeping course should assist Dr. Paolone to maintain the standard of practice of the profession in the future and is consistent with the penalty principle of rehabilitation. The reassessment of his practice is designed to ensure that the misconduct is not repeated. The Committee was satisfied that the penalty proposed by the parties will serve to protect the public and maintain confidence in the profession's ability to self-regulate.

Furthermore, the costs associated with the record-keeping course and the reassessment will be borne by.
Dr. Paolone personally, rather than the profession at large, which should be further specific deterrence for Dr. Paolone.

The Committee, therefore, decided that the penalty proposed is both fair and reasonable.

Order
The Discipline Committee ordered and directed that:
1. Dr. Paolone attend before this panel to be reprimanded;
2. the Registrar suspend Dr. Paolone’s certificate of registration for a period of one month;
3. the Registrar impose the following terms, conditions and limitations on Dr. Paolone’s certificate of registration:
   i) Dr. Paolone shall, at his own expense, successfully complete College-facilitated instruction in Ethics within 12 months of this Order; and
   ii) Dr. Paolone shall, at his own expense, successfully complete College-facilitated instruction in record-keeping within 12 months of this Order, and shall cooperate with a re-assessment of his medical records by representatives of the College within six to 12 months of his completion of the record-keeping course.
4. Dr. Paolone pay costs to the College in the amount of $3,650 within 60 days of the date of this Order.

At the conclusion of the hearing, Dr. Paolone waived his right to an appeal and the Committee administered the public reprimand.

DR. JOHN KENRICK PARIAG
Practice Location: Mississauga
Practice Area: General Surgery
Hearing Information: Agreed Statement of Facts, Admission and Joint Submission on Penalty (rejected)

On March 22, 2012, the Discipline Committee found that Dr. John Kenrick Pariag committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession.

The Committee also found that Dr. Pariag is incompetent. Dr. Pariag admitted to the allegations of professional misconduct and incompetence, as follows:

Regarding a review of 35 patient charts from his surgical practice:
- improper placement of chest tubes in a cystic fibrosis patient;
- performing a cholecystectomy in the presence of evidence that the common bile duct was not clear;
- failure to protect an anastomosis with a stoma where appropriate;
- improperly discharging three post-surgical patients with elevated white blood cell counts and fevers;
- unnecessary transfusion of one patient;
- questionable decision to perform a targeted bowel resection in a patient with rectal blood loss when the point of bleeding was unknown, and failure to investigate a possible foreign body as indicated by X-rays of the patient;
- incorrectly repairing a hernia, leading to recurrence;
- unnecessary removal of three healthy appendices;
- failure to obtain a right breast ultrasound despite a radiologist’s suggestion in a cancer patient;
- failed to give deep vein thrombosis prophylaxis perioperatively to a patient with known breast cancer;
- failure to properly control intraoperative bleeding;
- improperly performing surgery without first addressing the patient’s elevated INR;
- perforating a patient’s bowel while removing two 0.25 cm polyps;
- improperly ordering a blood transfusion of a 12-year-old with a hemoglobin count of 108, which order was subsequently cancelled by another physician, and failure to investigate percutaneous pelvic abscess drainage before proceeding to perform a laparotomy on that patient;
- improperly performing an elective thyroidectomy without supervision when Dr. Pariag had never performed such a procedure at the hospital and had not reviewed thyroid surgery during his residency; and
- dissecting a patient’s portal triad during surgery to correct a bowel obstruction, which error resulted in the patient’s death due to hemorrhagic shock.
Regarding Patient A, who had surgeries for an intra-abdominal mass, later identified as a sarcoma:

- failed to adequately document a differential diagnosis, treatment plan, or informed consent discussions with Patient A; and,
- after the recurrence of the sarcoma, failed to solicit an opinion from the Regional Cancer Centre where the patient had been seen in the past, and improperly attempted to treat the sarcoma outside a multidisciplinary care centre.

Dr. Pariag admitted to the facts set out above.

**Findings**

The Committee found that Dr. Pariag committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession, and found him incompetent.

**Reasons for Penalty**

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

The Committee has discretion to accept or reject a joint submission on penalty, but the legal standard provides that a joint submission should only be rejected if it is contrary to the public interest and would bring the administration of justice into disrepute. The Committee was not prepared to accept the proposed order without the additional stipulation that any patient be informed of the terms, conditions and limitations on Dr. Pariag’s certificate of registration.

The proposed order does not address the fact that a significant component of Dr. Pariag’s office-based practice will consist of performing surgical consultations. What particularly concerns the Committee is the fact that Dr. Pariag would be allowed to perform surgical consultations without any notice to patients that he has been prohibited from performing all but certain minor surgical procedures. Patients being referred or triaged to Dr. Pariag would have no knowledge of his clinical deficiencies or the restrictions on his practice. In fact, he was to be represented to patients as a fully qualified general surgeon. In the Committee’s view, this would be a serious misrepresentation which would be contrary to the public interest and bring the administration of justice into disrepute.

Although the Committee notes that many of the consequences of Dr. Pariag’s incompetence occurred in the perioperative period, the deficiencies described in the Agreed Statement of Facts and Admission demonstrates repeated examples of misdiagnoses, lack of clinical judgment, misinterpretation of laboratory tests and investigations, failure to obtain informed consent, ignoring serious clinical signs and symptoms, ignoring abnormal laboratory results, failure to conduct appropriate investigations and failure to disclose clinical errors. These concerns are separate and apart from his lack of technical surgical skills and incompetence in the operating theatre.

The Committee has concluded here that the proposed order, without the addition of notice to patients of terms, conditions and limitations on Dr. Pariag’s certificate of registration, is very clearly not in the public interest, and given the potential risk to patients, would bring the administration of justice into disrepute. In the opinion of the Committee, patients must be fully informed as to the restrictions under which Dr. Pariag practises. This could affect their reliance upon his advice in surgical matters.

Counsel for Dr. Pariag argued against the addition of the notice provision contemplated by the Committee. He submitted that it would result in the loss of Dr. Pariag’s job in the clinic in which he works. The Committee considered the needs of patients to be paramount, and concluded that it was necessary.

The Committee is therefore ordering that all patients being seen by Dr. Pariag are made aware that his clinical activities are subject to restrictions. To do otherwise would be manifestly unfair to patients seeking a surgical opinion and mislead such patients as to Dr. Pariag’s competencies.

Additionally, the Committee directs that the individual who is conducting the Clinical Practice Assessment be provided with a copy of this decision and reasons prior to the assessment to ensure he or she understands the Committee’s concerns regarding Dr. Pariag’s clinical practice.

Full decisions are available online at www.cpso.on.ca. Select Doctor Search and enter the doctor’s name.
Order
The Discipline Committee orders and directs that:

1. The Registrar impose the following terms, conditions and limitations on Dr. Pariag’s certificate of registration for an indefinite period of time:
   a. Dr. Pariag is prohibited from engaging in any hospital-based surgical practice save and except as a surgical assistant when a College-approved certified surgeon is performing the surgery and is in attendance. At no time shall Dr. Pariag be the most responsible physician with respect to any patient in a hospital setting;
   b. Dr. Pariag is prohibited from performing surgery in an office-based setting save and except for minor surgical procedures under local anesthetic involving the skin and subcutaneous tissues;
   c. At his own expense, Dr. Pariag shall undergo a comprehensive practice assessment by an assessor selected by the College (the “CPA”). Dr. Pariag shall cooperate fully with the CPA, including permitting the College’s assessor to observe him in the performance of any permitted procedures the assessor deems necessary, provided it is possible to schedule the procedure in question. The CPA shall be completed within eight months of the date of this Order. Dr. Pariag shall abide by any and all recommendations made as result of the CPA; and
   d. Dr. Pariag shall promptly notify the College should he cease practising medicine before completion of the CPA. If he does cease practising medicine prior to completion of the CPA, Dr. Pariag shall provide the College with at least 45 days advance notice of his intention to resume the practise of medicine. If this occurs, the CPA shall be completed within eight months of Dr. Pariag’s resuming practice, in addition to any other requirements that may apply at that time to physicians resuming the practise of medicine following a leave of absence. Nothing in this Order shall alter or detract from Dr. Pariag’s obligations pursuant to the College’s policy on Re-entering Practice, or such equivalent policies as may apply to Dr. Pariag in the future.

2. The terms, conditions and limitations on Dr. Pariag’s certificate of registration under 1(a) and 1(b) of the Order be included on a written form and the written form is to be presented to any patient before Dr. Pariag sees the patient, and a copy signed by the patient is to be included in the patient’s chart;
3. Dr. Pariag attend before the panel to be reprimanded, with the fact of the reprimand to be recorded on the register; and
4. Dr. Pariag shall within 30 days of this Order pay the College its costs of this proceeding in the amount of $3,650.

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DR. ALEX SAVELIJ SEMEON RIVLIN
Practice Location: Toronto
Practice Area: General Practice

Hearing Information: Agreed Statement of Facts, Admission and Joint Submission on Penalty

On December 11, 2012, the Discipline Committee found that Dr. Alex Savelij Semeon Rivlin committed acts of professional misconduct, in that he has been found guilty of an offence that is relevant to his suitability to practise, and he has engaged in disgraceful, dishonourable or unprofessional conduct.

Dr. Rivlin admitted to the allegations.

On or about December 21, 2010, Dr. Rivlin pleaded guilty in the Ontario Court of Justice to one count of fraud over $5,000 and one count of possession of a prohibited weapon with ammunition. Convictions were entered on the basis of Dr. Rivlin’s admissions to fraudulently billing OHIP in the amount of $168,794.21 between September of 2000 and February of 2008, while he was out of the country. He also admitted to illegally possessing a prohibited firearm and ammunition in a locked safe at his residence, which he had, at a patient’s request, agreed to store in his safe after the patient inadvertently left it in his office, until the patient’s return to Canada from the United States. It was seized by police during the execution of the search warrant in March of 2008. In the criminal proceedings, Dr. Rivlin was given a nine-month conditional sentence with three months house arrest, followed by a two-year term of probation. He was also prohibited from billing OHIP for the duration of his conditional sentence and probation. At the time of his guilty plea and sentencing, Dr. Rivlin made restitution to OHIP.
Findings
The Committee found that Dr. Rivlin committed an act of professional misconduct, in that he has been found guilty of an offence that is relevant to his suitability to practise; and in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

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

In accepting the joint submission, the Committee was mindful of the principles underlying the crafting of a penalty, which include an expression of abhorrence of the profession for the behaviour found to have occurred, the need for public protection, specific and general deterrence, the need to uphold the reputation and honour of the profession and, where appropriate, rehabilitation of the member. The Committee also considered the nature of the misconduct, the circumstances under which it occurred, aggravating and mitigating factors and the guidance of similar decisions of this Committee.

The Committee noted that the fraud to which Dr. Rivlin admitted was substantial, although not at the top end of such cases, and took place over a prolonged period of time (approximately eight years). Fraud is not a victimless crime. It deprives the health-care system of much-needed resources to the detriment of patient care. In the opinion of the Committee, this conviction was directly relevant to Dr. Rivlin’s suitability to practise medicine. His conduct fully justifies the substantial suspension proposed.

While the weapons offense resulted in a criminal conviction, the Committee agreed with Justice Caldwell that the circumstances were “very unusual” and gave little weight to this particular incident in assessing Dr. Rivlin’s suitability to practise medicine, or the proposed penalty.

In mitigation, the Committee considered several factors. Dr. Rivlin admitted his misconduct and cooperated fully with both the criminal and the College processes. He made restitution in the amount of $200,000, a sum which included an amount for unverified billings.

He ceased billing OHIP in 2008, even prior to his criminal conviction. Dr. Rivlin has no prior criminal or discipline history.

Order
The Discipline Committee ordered and directed that:
1. the Registrar suspend Dr. Rivlin’s certificate of registration for a period of 12 months, commencing immediately;
2. Dr. Rivlin appear before the panel to be reprimanded; and
3. Dr. Rivlin pay costs to the College in the amount of $3,650 within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. Rivlin waived his right to an appeal and the Committee administered the public reprimand.

DR. JACOB VEENSTRA
Practice Location: Brampton
Practice Area: General Practice
Hearing Information: Agreed Statement of Facts, Admission and Joint Submission on Penalty, and Cost Order Disputed

On November 5, 2012, the Discipline Committee found that Dr. Jacob Veenstra committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession.

Dr. Veenstra admitted to the allegation.

With respect to Patient A
The care provided in the diagnosis and treatment of the patient’s pearly penile papules, as well as Dr. Veenstra’s record-keeping practices, were found to be deficient and did not meet the expected standard of practice.

With respect to a review of 24 patient charts during a College investigation
The College’s expert, Dr. X, identified major concerns in Dr. Veenstra’s practice in her July and October 2010 reports, including the following:
DISCIPLINE SUMMARIES

- record-keeping deficiencies, including illegible or incomplete records;
- concerns regarding prescribing, including improper combinations of prescription medications; prescription of medications in cases in which the prescriptions were contra-indicated; and multiple and simultaneous changing of medications;
- inadequate histories, physical examinations and investigations;
- use of potent biological agent without adequate screening or monitoring in one case;
- failure to follow-up test results; and
- failure to consult with or follow the advice of specialists.

In November 2011, Dr. Veenstra’s clinical supervisor, Dr. Y, reported to the College that he found no evidence of any documented activity that raised concerns or undue risk to Dr. Veenstra’s patients’ safety or wellbeing.

Dr. Veenstra retained Dr. Z to review the charts of Patient A, as well as Charts 1 to 24. In his October 2012 report, Dr. Z opined that although Dr. Veenstra’s practices with respect to record-keeping, prescribing, and referrals to specialists demonstrate significant deficiencies and require improvement, he is not lacking in the necessary skills to practise successfully or to meet the standard of care expected of a general practitioner, and that the deficiencies should be remediable.

Finding

The Committee found that Dr. Veenstra committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession.

The report of Dr. X (November 2009) clearly indicates that Dr. Veenstra’s diagnosis, treatment and record-keeping fall below the standard of practice in the matter of Patient A. The report of Dr. Y highlights the breadth and serious nature of Dr. Veenstra’s deficiencies found in the care of other patients. Even the report of Dr. Veenstra’s expert, Dr. Z, supports significant deficiencies which require improvement. This evidence, included with the agreed statement, fully supports the finding made of professional misconduct.

Reasons for Penalty

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty. However, the matter of costs to be ordered was disputed.

The proposed penalty components included a suspension, an educational requirement, and terms and conditions designed to ensure safe practice and proper monitoring. The Committee understands that Dr. Veenstra retired from active practice in the early winter of 2012. The jointly proposed order states that following the suspension, should Dr. Veenstra return to practice, he will be subject to terms, conditions and limitations on his certificate of registration.

The proposed six-month suspension speaks to the serious nature of the deficiencies exhibited and the neglect of standards of clinical care and medical record-keeping. Adequate investigation and proper follow up are expected professional responsibilities. Knowledge and judgment were lacking in many of Dr. Veenstra’s prescribing practices. His errors were both of commission and omission. The significant suspension proposed in this matter is justified. It addressed both specific and general deterrence, and speaks to denunciation by the profession of the professional misconduct in failing to maintain the standard of practice of the profession.

The proposed penalty order requires Dr. Veenstra to complete both a record-keeping course and a prescribing skills course. This is intended to rehabilitate the member, whose deficiencies, at least in part, directly relate to these areas.

The parties have agreed on an intensive and graded supervision program, as detailed in the proposed Order. Progression to less onerous supervision will occur only upon demonstrated success, and the combined period of supervision shall not be less than 12 months. This represents significant and direct oversight and is supported by the need to protect the public.

Following successful completion of the low supervision phase, the proposed joint order requires that Dr. Veenstra will undergo a comprehensive practice assessment which will determine whether he is ready to engage in
unsupervised practice. Dr. Veenstra must abide by the recommendations of his supervisors and assessors and fully cooperate with all monitoring and assessments. These conditions, in addition to unannounced inspections, impose a pattern of practice which protects the integrity of the profession and instills public confidence that Dr. Veenstra will not be permitted to practise unless and until it is safe to do so.

In this matter, the proposed penalty elements are, in the view of the Committee, justified and represent appropriate sanction for the misconduct.

Order
The Discipline Committee ordered and directed that:

1. the Registrar suspend Dr. Veenstra’s certificate of registration for a period of six months, commencing immediately.

2. the Registrar place the following terms, conditions and limitations on Dr. Veenstra’s certificate of registration:
   a) Dr. Veenstra shall complete the Ontario CPD Consortium’s Record-Keeping Course and Prescribing Skills Course;
   b) Upon Dr. Veenstra’s return to practice, he shall obtain a clinical supervisor or supervisors, acceptable to the College;
   c) For a period of at least three months, Dr. Veenstra will only see patients in the presence of the clinical supervisor, who will be present during Dr. Veenstra’s clinical visits, and who will conduct a contemporaneous review of those patient charts. During the period of high supervision, the Clinical Supervisor shall provide bi-weekly reports to the College. The period of high supervision will continue until the clinical supervisor in his sole discretion agrees that the level of supervision may be reduced to moderate supervision. The clinical supervisor shall reconsider the need for high supervision after the first three months of Dr. Veenstra’s return to practice, and at the beginning of every month thereafter for so long as the period of high supervision continues. If the supervisor believes that Dr. Veenstra is ready to practise under moderate supervision, he/she shall provide the College with a report addressing the practice concerns raised by Drs. x, Y and Z, and explain why Dr. Veenstra’s progress under high supervision justifies a transition to medium supervision;
   d) Following the period of high supervision described in paragraph (c) above, provided that the clinical supervisor and the College agree that the level of supervision can be reduced, for a further three months, at a minimum, the clinical supervisor will engage in a period of moderate supervision, during which time he will meet with Dr. Veenstra on a bi-weekly basis to review a minimum of 15 of his patient records and discuss any issues or concerns arising therefrom. If, during this period, Dr. Veenstra has fewer than 15 patient encounters in a specific two-week period, the clinical supervisor shall review the records of all patient encounters during that period. The clinical supervisor shall provide monthly reports to the College;
   e) Following the period of moderate supervision described in paragraph (d) above, provided that the clinical supervisor and the College agree that the level of supervision can be reduced, for a further six months, at a minimum, the clinical supervisor will engage in a period of low supervision, during which time he will meet with Dr. Veenstra on a monthly basis to review a minimum of 15 of his patient records and discuss any issues or concerns arising therefrom. If, during this period, Dr. Veenstra has fewer than 15 patient encounters in a specific month, the clinical supervisor shall review the records of all patient encounters during that period. The clinical supervisor shall provide monthly reports to the College;
f) The combined period of supervision set out in paragraphs (c), (d) and (e) above shall not be less than 12 months;

g) Dr. Veenstra shall fully cooperate with and abide by any recommendations of, his clinical supervisor, including any recommendations that Dr. Veenstra participate in further educational opportunities;

h) Dr. Veenstra shall consent to the disclosure by his clinical supervisor to the College, and by the College to his clinical supervisor, of all information necessary to fulfill the Clinical Supervisor’s undertaking and to monitor Dr. Veenstra’s compliance with the Order. This shall include, without limitation, providing the supervisor with the reports of any assessments of Dr. Veenstra’s practice in the College’s possession;

i) All costs associated with the clinical supervisor shall be at Dr. Veenstra’s expense;

j) Following the period of low supervision described in paragraph (e) above, Dr. Veenstra shall submit to a comprehensive practice assessment of his clinical practice, at Dr. Veenstra’s expense, by an assessor or assessors selected by the College. The assessor shall report the results of the assessment to the College, who shall determine on the basis of the supervisor and assessment report, whether Dr. Veenstra can engage in unsupervised practice;

k) Dr. Veenstra shall co-operate fully with the assessment of his practice, conducted under this term of this Order, and shall abide by the recommendations of the assessor(s);

l) Dr. Veenstra 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 such information between the clinical supervisor, the assessor and the College, as any of the parties deem necessary or desirable in order to fulfill their respective obligations; and

m) Dr. Veenstra shall submit to, and not interfere with, unannounced inspections of his office(s), practice(s) and patient charts by a College representative for the purposes of monitoring his compliance with the terms of this Order.

3. Dr. Veenstra shall pay costs to the College of $3,650 within 90 days of this Order.

4. The results of this proceeding be included in the register.
COURT APPEALS

APPEAL SUMMARY

DR. BEHNAZ YAZDANFAR

Toronto

The decision of the Discipline Committee was published in Dialogue, Issue 3, 2012.

On January 20, 2012, Dr. Yazdanfar appealed from the May 4, 2011 decision of the Discipline Committee on the merits of Dr. Yazdanfar’s disciplinary hearing (which included a decision on her constitutional challenge to the College’s advertising regulation), as well as the December 21, 2011 penalty order of the Committee. The Committee found that Dr. Yazdanfar had failed to maintain the standard of practice of the profession; had engaged in disgraceful, dishonourable or unprofessional conduct; had contravened the advertising regulation; and was incompetent in relation to her care of certain liposuction and breast augmentation patients. The Discipline Committee’s order included a two-year suspension of Dr. Yazdanfar’s certificate of registration; a public reprimand; a restriction on her practice such that she shall not practise other than as a surgical assistant in a hospital-based setting, provided that a member of the College, who is approved by the College, is in attendance and performing the surgery, and costs to the College in the amount of $219,000.

On April 24, 2012, the Divisional Court dismissed Dr. Yazdanfar’s motion to stay the penalty decision of the Discipline Committee pending the outcome of the appeal. Therefore the penalty decision remained in effect. The appeal was heard on May 9 and 10, 2013. Dr. Yazdanfar argued that the Discipline Committee erred in concluding that she knowingly breached the acceptable standard of practice with respect to the performance of liposuction; it erred in various evidentiary rulings regarding the admission and rejection of certain evidence; it erred in finding that her website postings contravened the advertising regulation; and it erred in essentially revoking her certificate of registration by limiting her practice to that of a surgical assistant in a hospital-based setting.

On October 16, 2013, the Divisional Court dismissed Dr. Yazdanfar’s appeal in its entirety and awarded costs to the College in the amount of $12,500.

On October 31, 2013, the College received Dr. Yazdanfar’s Notice of Motion for Leave to Appeal to the Court of Appeal for Ontario.

We welcome your feedback on any issue raised in Dialogue.

Please send your comments by email to Dialogue’s Managing Editor at editor@cpsso.on.ca, or send your letters to:

Managing Editor, Dialogue
College of Physicians and Surgeons of Ontario
80 College Street, Toronto, ON M5G 2E2
Fax: (416) 961-8035

We reserve the right to edit letters for length and clarity.
COUNCIL MEMBERS

ABOUT COUNCIL

Council is the governing body of the College. The Regulated Health Professions Act stipulates that it consist of at least 32 and no more than 34 members including:

- 16 physicians elected by their peers on a geographical basis every three years;
- physicians appointed from among the six faculties of medicine (at the Western University, McMaster University, University of Toronto, Queen’s University, University of Ottawa, and the Northern Ontario School of Medicine);
- no fewer than 13 and no more than 15 non-physician or ‘public’ members appointed by the provincial government for terms decided by the government.

Both medical faculty members and public members may be re-appointed at the end of their terms. Elected members may not serve more than three terms (nine consecutive years). The College President is elected from and by Council and serves a one-year term.

Council members sit on one or more committees of the College. Each committee has specific functions, most of which are governed by provincial legislation.

General Council meetings are held four times a year to review the activities of the College and debate and vote upon matters of general policy. Council meetings are open to the public and are held in the 3rd floor Council Chamber at 80 College Street, Toronto.

For more information about the actions, processes and structures by which the mandate of the College is fulfilled, please refer to the Governance Process Manual available at www,cpso.on.ca under About Us>Council and Committees.

DISTRICT REPRESENTATIVES

1. Dr. Peter Tadros  
   Tecumseh, Ontario  
2. Dr. Ronald Wexler  
   London, Ontario  
3. Dr. Jerry Rosenblum  
   Waterloo, Ontario  
4. Dr. Eric Stanton  
   Hamilton, Ontario  
4. Dr. Brenda Cops  
   Hamilton, Ontario  
5. Dr. Carol Leet  
   Brampton, Ontario  
5. Dr. David Rouselle  
   Newmarket, Ontario  
6. Dr. Wayne Spotswood  
   Kingston, Ontario  
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   Ottawa, Ontario  
7. Dr. Andrew Falconer  
   Ottawa, Ontario  
8. Dr. Steven Bodley  
   North Bay, Ontario  
9. Dr. William McCready  
   Thunder Bay, Ontario  
10. Dr. Marc Gabel  
    Toronto, Ontario  
10. Dr. Joel Kirsh  
    Toronto, Ontario  
10. Dr. Richard Mackenzie  
    Toronto, Ontario  
10. Dr. Peeter Poldre  
    Toronto, Ontario

PUBLIC COUNCIL MEMBERS APPOINTED BY LIEUTENANT-GOVERNOR

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Ms. Diane Doherty  
Burlington, Ontario  
Mr. Pierre Giroux  
Toronto, Ontario  
Mr. Ron Pratt, MBA  
Toronto, Ontario

Mr. Sudershen K. Beri  
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Mr. Harry Erlichman, LLB  
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Ms. Lynne Cram  
London, Ontario  
Mr. Martin Forget  
Toronto, Ontario  
Mr. Robert Plain, LLB  
Kingston, Ontario  
Ms. Veena Pohani, LLB  
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Ms. Susan Davis, LLB  
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Ms. Debbie Giampietri  
Toronto, Ontario  
Ms. Veena Pohani, LLB  
Toronto, Ontario

Mr. Harry Erlichman  
Toronto, Ontario  
Ms. Veena Pohani, LLB  
Toronto, Ontario

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Hamilton, Ontario  
Dr. Robin Richards  
University of Toronto  
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Ottawa, Ontario  
Dr. Barbara Lent  
Western University  
London, Ontario  
Dr. Michael Franklyn  
Northern Ontario School of Medicine  
Sudbury, Ontario
Change of Address Notification

This form is provided for members to notify the College of any change in address.

Each member is required under College by-law to provide his or her primary practice address, preferred mailing address, and email address.

The primary practice address is public and is entered in the College’s public register in the website. The email address is not public. The mailing address is also not public, unless the member chooses to use the primary practice address for the mailing address.

If not in practice, the member may check the ‘not in practice’ box, but current mailing address and email address must always be provided.

Every change of address – practice, mailing or email – must be reported to the College in writing within 30 days of the change.

Please mail, email or fax this form to:
Membership Services
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON
M5G 2E2
Email: membership@cpso.on.ca
Fax: (416) 967-2643

Updated Address Information (please print legibly)

<table>
<thead>
<tr>
<th>CPSO Registration Number</th>
<th>___ ___ ___ ___ ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>____________________</td>
</tr>
<tr>
<td>Given Names</td>
<td>____________________</td>
</tr>
</tbody>
</table>

**Primary Practice Address:**
- Not in practice
  - ____________________
  - ____________________
  - ____________________

- Postal code
  - ____________________
- Phone number
  - ____________________
- Fax number
  - ____________________

**Mailing Address:**
- Same as primary practice address
  - ____________________
  - ____________________
  - ____________________

- Postal code
  - ____________________
- Phone number
  - ____________________
- Fax number
  - ____________________

**Email Address:**
- ____________________

**Important for Security – Please provide the following information:**

- Date of birth
  - ____________________

- Name of base hospital during your Internship (PGY1)
  - ____________________

- Effective date
  - ____________________

- Signature
  - ____________________
Whom to Call at the College

To Dial Known Extensions ............................................................... (416) 967-2600
Toll Free ............................................................................................. (800) 268-7096
Recorded Information ................................................................. (416) 967-2620
General Inquiries ............................................................................... (416) 967-2603
To Make a Complaint ....................................................................... (416) 967-2603
Media Inquiries ................................................................................... (416) 967-2611
Licensing Information ......................................................................... (416) 967-2617

Have a Question? Contact the Physician Advisory Service

The Physician Advisory Service was established to provide guidance and information to members. Physicians often contact the College with questions pertaining to practice issues, or seek guidance in managing challenging situations. In addition, PAS staff manage all calls regarding annual renewal.

Please contact us if you have any questions. We are here to help.

Physician Advisory Service
416-967-2606 or Toll Free: 1-800-268-7096, ext. 606

Council Meeting Schedule

Council meetings are open to the membership and the public.
If you plan to attend, please contact the Communications Department at (416) 967-2611 or 1 (800) 268-7096 ext. 611.

2014 Council Meeting Dates:
March 6 & 7; May 29 & 30; September 4 & 5; December 4 & 5.