2021

IN THE MATTER OF: The *Paramedics Act*, S.N.S. 2015, c. 33

and

IN THE MATTER OF: A Settlement Proposal

BETWEEN:

The College of Paramedics of Nova Scotia

(the "College")

Michelle d'Eon

(the "Respondent" or "Ms. d'Eon")

HEARING PANEL DECISION

Date heard:	June 7, 2021
Mode:	Teams meeting
Hearing Panel:	Douglas Lloy, Q.C., Chair David Feargrieve Tyler MacCuspic
Counsel:	Marjorie Hickey, Q.C. for the College of Paramedics of Nova Scotia Neither Ms. d'Eon, nor her counsel, were in attendance

1. On June 7, 2021, a panel of the Hearing Committee considered a settlement proposal which was submitted both by the College and an Advanced Care paramedic, Ms. Michelle d'Eon, registration number 31545. The proposal had been recommended by an Investigation Committee of the College for acceptance as an order of the Hearing Committee.

2. The issue before the Hearing Panel, as set out in s. 71 – 72 of the *Paramedics Act*, S.N.S. 2015, c. 33 is whether to approve, suggest modifications, or reject the settlement proposal as written.

3. The chief factors guiding the Hearing Panel in this type of deliberation is whether the settlement proposal protects the public and whether the settlement proposal is in the best interests of the public and the profession. These issues will be canvassed at the end of this decision.

4. Before this issue can be addressed, the history of this case will be summarized below to provide context.

5. The College of Paramedics received a letter from the Nova Scotia Health Authority (NSHA) dated October 25, 2017. The NSHA was the employer of Ms. d'Eon. Due to what the NSHA found to be egregious professional misconduct on behalf of their employee, the NSHA had terminated Ms. d'Eon's employment a little over a week before the College received this letter. The letter disclosed two professional complaint allegations against Ms. d'Eon arising out of two separate incidents:

    i. <u>February 4, 2016</u>: The NSHA alleged that Ms. d'Eon falsified a health care document relating to a procedural sedation and analgesia (PSA) of a patient located at the Halifax Infirmary Emergency Department. The patient was being sedated by a student under the supervision of another paramedic. Ms. d'Eon at the time had to perform 50 successful PSA's before she could be permitted to do so independently.

Ms. d'Eon signed off on a health form which on its face suggested that Ms. d'Eon performed the procedure itself on this date and time. A subsequent NSHA investigation showed that video evidence did not place Ms. d'Eon in the pod where the patient was located so as to perform a PSA. Subsequent NSHA investigation could not confirm that Ms. d'Eon was present on another 30 sedations which Ms. d'Eon reported that she was present and administering sedation.

ii. <u>September 13, 2017</u>: The NSHA privacy office received a complaint from AB that Ms. D'Eon had changed his next-of-kin designation to herself without his consent. The NSHA investigation revealed that Ms. d'Eon had also accessed the private healthcare information of AB, his spouse and his mother as well as six other patients for non-healthcare purposes. The NSHA confirmed that Ms. d'Eon was working at a location where she could have accessed the records at the time.

6. Ms. d'Eon's employment with the NSHA was terminated on October 17, 2017. The NSHA stated in their letter of termination to Ms. d'Eon that she had accessed patient information for no apparent clinical reason. Such conduct, the NSHA wrote, was a significant breach of patient confidentiality and an irreparable breach of trust in Ms. d'Eon's relationship with the NSHA. It was upon such reasons that Ms. d'Eon was terminated from her employment with the NSHA.

<u>Respondent Background</u>

7. As background, the Respondent, Ms. d'Eon, competed her Primary Care Paramedicine Program at Holland College on June 2003. She completed her Advanced Care Paramedic Program at the Maritime School of Paramedicine in June 2008. She was employed by the NSHA since February 24, 2014 until her termination on October 17, 2017.

8. Ms. d'Eon has not practiced as a paramedic since her termination from the NSHA. Her licence to practice as a paramedic has expired since that time. She has not applied for licence renewal.

The College's Investigation

9. The College employed an initial investigator to collect information to substantiate or disprove the complaint. Interviews were conducted by the investigator and an Investigation Report was submitted to the College on May 1, 2018 outlining the investigator's findings.

10. In this report, the investigator recorded that Ms. d'Eon believed that the complaint regarding her falsification of a health care report was inspired by personal animosity from one of her practice managers. The complaint of privacy breaches, Ms. d'Eon claimed, was baseless. She claimed to have received text authorization from AB to make her his next-of-kin, and showed this to the data clerk to implement the change. She denied accessing private healthcare information of AB or his relatives.

11. The investigator spoke to personnel at the NSHA, Halifax Infirmary location. Ms. d'Eon was found to have a troubled employment history with the NSHA. The NSHA stood firm in their assertions that health care documents were falsified and privacy breaches occurred.

12. On June 18, 2018, given the seriousness of the allegations, the College employed a second investigator to interview further witnesses. A subpoena was even issued to secure the attendance of one reluctant witness, an unusual feature for regulatory investigations.

13. Video evidence was obtained from the Halifax Infirmary that showed that Ms. d'Eon was not in the pod where the PSA occurred. Other healthcare documentation signed at the same time the PSA was occurring showed that Ms. d'Eon was providing care to other patients at the time when the PSA was being performed.

14. Nevertheless, Ms. d'Eon (and the paramedic who did perform the PSA) maintained that she did speak to this paramedic who performed the PSA, albeit from out of camera shot of the NSHA cameras.

15. The investigator also found that the times when AB's private health care information was accessed, and times when the private healthcare information of his relatives were accessed, were not at all synchronous with the actual hospital attendances of AB and his relatives. The data clerk who also changed AB's next-of-kin further confirmed that she did so at the request of Ms. d'Eon. No text message was observed by the clerk from AB authorizing this change of next-of-kin. AB was not present in the hospital when this status was changed to personally authorize this change, as was subsequently alleged by Ms. d'Eon.

16. AB relayed to the investigator his frustrating experience of being surprised that his next-of-kin was changed to Ms. d'Eon, requesting that it be changed back to his wife, then discovering on subsequent hospital visits that his next-of-kin was still Ms. d'Eon. It was this aggravating experience that prompted AB to make the inquiry of the privacy office of the NSHA to have his next-of-kin permanently designated as his wife. This prompted the NSHA to commence the investigation which led to Ms. d'Eon's eventual employment termination.

17. Ms. d'Eon initially denied knowing AB, but then relented to the second investigator and said that she did know him. She maintained that she did not change AB's next-of-kin or accessed his or his relatives' private healthcare information. She said to one of her practice managers that a physician colleague had used her NSHA account to access these records.

18. Ms. d'Eon continued to deny any unauthorized changes to AB's next-of-kin status as well as accessing private healthcare records.

19. The case was referred to the College's Investigation Committee. The Investigation Committee conducted a thorough review of the evidence collected to date, confirming the evidence already elicited above.

20. Following an extensive investigation, the Committee rendered a fulsome report dated September 12, 2019.

21. The Investigation Committee decided that, pursuant to s. 67(4)(g) of the *Paramedic Regulations*, there was sufficient information that if proven, would constitute professional misconduct. The matter was serious enough to warrant a licensing sanction.

22. The Investigation Committee found that paramedics are trusted professionals who are held in a high standard in their personal and professional conduct. Honesty is expected in their interactions with their patients, employer and professional regulator. This candour was not present in Ms. d'Eon's interactions with her employer and regulator.

23. The Investigation Committee determined that she abused a position of trust to obtain information to which she was not otherwise entitled to view. She either viewed this information herself or, if her explanation that someone else used her account to view the information was true, she failed to protect patients' healthcare information. Either way, she failed to secure the private healthcare information of patients of the NSHA.

24. The Investigation Committee also rejected Ms. d'Eon's dual explanation of how AB's next-of-kin designation was changed, namely either she was acting as his agent via AB's text message authorizing the change or AB was present when the next-of-kin designation was changed into her name. No text message was ever produced by Ms. d'Eon to show that she was authorized as AB's agent to change the designation. AB was not receiving health care on January 8, 2017 when the information change was made, so he was not in a position to personally authorize the change.

25. Ms. d'Eon did not convincingly explain why her presence was not shown on the video where the PSA was conducted. She failed to explain why her submitted healthcare documentation on other patients showed she was attending to other patients at the same time the PSA was occurring.

26. The Investigation Committee's conclusion was that Ms. d'Eon did not display the trustworthiness required of a paramedic. Neither an acceptance of responsibility nor remorse was shown by Ms. d'Eon. Her behaviour was motivated by personal factors – a desire to complete the 50 PSA's and her personal relationship with AB – at the expense of her professional obligations.

27. The case was referred to a hearing per s. 67(6)(b). The Registrar was also directed on behalf of the College to attempt to negotiate a settlement proposal with Ms. d'Eon in accordance with s. 70 of the *Regulations*.

28. Negotiations between the Registrar and Ms. d'Eon led to Ms. d'Eon agreeing to a consent revocation under s. 74(1) of the *Regulations*. This agreement January 5, 2021 can be found at **Tab One** attached to this decision.

29. It is with this background that the case comes before the present panel of the Hearing Committee for adjudication of the appropriateness of the consent revocation.

Statutory Authority of the Hearing Panel

30. The Hearing Panel is a creature of statute. It derives its entire authority from the *Paramedics Act* and *Regulations*.

31. Under s. 74 of the *Regulations*, there are two requirements of a legitimate consent revocation agreement that a Hearing Panel may consider:

    i. A respondent who either admits or does not contest the allegations found in either a complaint or a decision of the Investigation Committee (s. 74(1)); and

    ii. The allegations, if proven, must result in the revocation of the respondent's registration and license (s. 74(2)).

32. As to the first requirement, the facts accepted by the Investigation Committee are more than sufficient to support the agreed-upon disposition of a permanent licence revocation. Ms. d'Eon has chosen not to contest them.

33. Ms. d'Eon, per her signed consent on the consent revocation at para. 31, does not contest the professional misconduct allegations found in the agreement.

34. She specifically does not contest that she falsified documentation when she signed off on a PSA that she was not present for.

35. She also does not contest that she breached privacy and confidentiality when she assessed patient health records without a valid medical reason and made changes to a patient's next-of-kin information without having authorization to do so.

36. If the consent revocation agreement is accepted by the Hearing Panel, the College and Ms. d'Eon have agreed that there would be no costs payable by Ms. d'Eon to the College (para. 36).

37. The Hearing Panel finds that the requirements under s. 74 have been met for the consent revocation agreement to be properly before the Hearing Panel for consideration as to its acceptance.

38. The question then turns to whether the consent revocation agreement should be accepted by the Hearing Panel. To this effect, the Hearing Panel has two stark options under s. 74- to either accept or reject the consent revocation agreement. How the Hearing Panel determines this issue will be discussed next.

Analysis and Decision

39. The *Paramedics Regulations* in s. 74 sets out the powers of the Hearing Panel when a consent revocation agreement has been referred to it by an Investigation Committee. This section is reproduced below in full:

Consent Revocation

74 (1) A respondent who admits or does not contest the allegations set out in either of the following may, with the consent of the Registrar, submit a proposed consent revocation agreement to the Hearing Committee for approval:

(a) a complaint; or

(b) a decision of an investigation committee under clause 67(6)(a).

(2) A proposed consent revocation agreement must include allegations that, if proven, would result in a revocation of the respondent's registration and licence.

(3) The Hearing Committee may accept or refuse to accept a proposed consent revocation agreement and must provide a written decision with reasons.

(4) A decision to accept a consent revocation agreement must in all respects be treated in the same manner as a revocation ordered by the Hearing Committee following a hearing, including disclosure and publication in accordance with Section 86.

40. The *Paramedics Act* and *Paramedics Regulations* do not set out any statutory criteria that the Hearing Panel must employ when considering the two options available to it under s. 74. Resort is required to the objects of the College as well as the common law.

41. The objects of the College are set out in s. 4(1) of the *Act*. These objects are:

4 (1) The objects of the College are to

(a) serve and protect the public interest in the practice of paramedicine;

(b) preserve the integrity of the paramedic profession; and

(c) maintain public and member confidence in the ability of the profession to regulate the practice of paramedicine.

42. The Hearing Panel notes that an Investigation Committee is directed in s. 71(a) and (d) of the *Regulations* to only recommend a settlement proposal made under s. 70 to the Hearing Committee only if the public is protected and the settlement is in the best interest of the public and the profession.

43. These factors are not spelled out in the statutory framework for a Hearing Panel's decision in the context of a consent revocation agreement, but are logically imported via the objects of the College in s. 4(1).

44. The common law also plays a role in the Hearing Panel's decision-making process. As cited by counsel for the College, the unreported 2019 case of *The College of Physicians and Surgeons of Nova Scotia* v. *Dr. Sarah Jones* (**Tab Two**) has promulgated the principle that Hearing Committees should defer to the recommendation of an Investigation Committee for approval of a settlement agreement reached between the Registrar and a practitioner.

45. *CPSNS v. Dr. Jones* dealt with a settlement agreement defined in the *Medical Practitioners' Regulations* which is roughly analogous to a settlement proposal in s. 70 of the *Paramedics Regulations*. The Panel finds that the principles in this case equally apply to consent revocation agreements under s. 74 despite the slight procedural variations between the different professions' regulations and ss. 70 and 74.

46. The principles stated in the *CPSNS v. Dr. Jones* which augur for deference to the Investigation Committee's recommendations are:

    - The Investigation Committee has a much more detailed knowledge of the facts than a Hearing Panel because of its involvement in investigating a complaint over an extended period of time;

    - The legislative framework ensures a rigorous and exacting approach to whether a complaint should be settled; and

    - Settlement proposals should be encouraged as they permit the Registrar and the Investigation Committee to negotiate the resolution of complaints without delay and the expenses of a formal hearing. They also allow dispositions to be reached by negotiation which may not be possible in a formal hearing.

47. *CPSNS v. Dr. Jones* also outlines the limits of deference. The decision aptly states that a Hearing Panel does not just rubber-stamp a settlement proposal recommended by the Investigation Committee. Any settlement proposal must be consistent with the purposes of the regulatory body, first and foremost of which is the protection of the public. The public must be assured that genuine complaints are not concealed by a regulator. The professional regulator must be effective in protecting the public and in maintaining high standards among healthcare practitioners.

48. Further, such principles also require the fair treatment of regulated professionals who are subject to complaints. The numbers of practice-ready personnel must be maintained with good morale to be able to serve the public effectively.

49. In this case, the Hearing Panel finds that the consent revocation agreement is consistent with the objects of the College. As such, deference to the Investigation Committee's decision is just.

50. The consent revocation agreement imposes the ultimate discipline upon a regulated professional- permanent license revocation. Ms. d'Eon is supportive of this disposition. The Hearing Panel concurs that this is a just penalty given the severity of her departure from the professional standard as cited in the settlement proposal.

51. This decision to permanently revoke the licence to practice paramedicine by Ms. d'Eon protects the public from the behaviour exhibited by Ms. d'Eon. It also preserves the integrity of the profession and maintains public confidence in the profession to regulate itself. It is therefore in accord with the objects of the College set out in s. 4(1).

52. The decision also serves the purpose of general deterrence to other members of the profession. It sends a message to other paramedics to take heed of their professional duty to not set aside professional obligations to pursue a personal agenda.

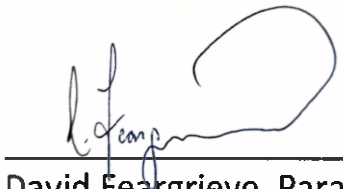
53. Although not a requirement in s. 74, the consent revocation agreement, in the Hearing Panel's view, also appropriately dealt with the issue of costs. The Panel was informed that the costs incurred by the College are in the very low five figures. A fully contested hearing would cause these costs to soar. Recovery from Ms. d'Eon would be uncertain at best.

54. While the College bears the costs incurred to date "on the chin", the decision to not impose costs may have been a deciding factor for Ms. d'Eon in preventing a truly costly hearing, which would not be in the College's best interests.

55. The Hearing Panel therefore fully approves the consent revocation agreement under s. 74(3) of the *Regulations*, making it an order of the Hearing Committee under s. 74(4). Publication of this decision will be pursuant to s. 86 of the *Regulations*.

Decision issued this 8th day of July, 2021.

Douglas J. Lloy, Q.C. Chair



David Feargrieve, Paramedic

Tyler MacCuspic, Paramedic

TAB ONE

APPLICATION FOR CONSENT REVOCATION
MICHELLE D'EON

Section 74(1)(b) of the Paramedics Regulations

Michelle d'Eon, ACP, Registration No. 31545 hereby applies to the Hearing Committee of the College of Paramedics of Nova Scotia, pursuant to Section 74(1)(b) of the Paramedics Regulations, for the permanent revocation of her registration as a Paramedic.

A. Background

1. Michelle d'Eon completed the Primary Paramedicine Program at Holland College in June 2003. She completed the Advanced Care Paramedic Program at the Maritime School of Paramedicine in June 2008. Ms. d'Eon was hired as an Advanced Care Paramedic ("ACP") by the Nova Scotia Health Authority ("NSHA") at the Halifax Infirmary Emergency Department site on February 24, 2014. Her position as an ACP was terminated by the NSHA on October 17, 2017.

2. Ms. d'Eon does not have a prior disciplinary history with the College.

B. Complaint

3. A complaint was filed with the College of Paramedics of Nova Scotia (the "College") on October 25, 2017. The complaint was initiated by the Health Services Manager of the Emergency Department, at the NSHA. The complaint alleged Ms. d'Eon had falsified healthcare documentation and had breached patient privacy.

4. The complaint alleged that on February 4, 2016 Ms. d'Eon had falsified a health care document relating to a procedural sedation and analgesia ("PSA"). The PSA was performed on a patient by a student, with supervision from another employee. The complaint alleged that Ms. d'Eon had completed the heath care documentation for the procedure, despite being absent during the procedure.

5. In the course of an internal investigation of the matter, the NSHA discovered that time-stamped documentation placed Ms. d'Eon in another location, at the time the PSA was completed. Ms. d'Eon was required to complete 50 supervised PSAs prior to working independently.

6. During the College's investigation, the College obtained videotape footage of the February 4, 2016 PSA procedure. Ms. d'Eon did not appear in the video.

7. The complaint also alleged that on September 13, 2017, the NSHA privacy office received a complaint from a patient, whose next of kin information ("NOK") had been changed without the patient's authorization to do so and that Ms. d'Eon may have been involved. A privacy audit was completed by NSHA and the results indicated there was a "strong possibility" that Ms. d'Eon breached the patient's personal health information, as well as the health information of two other patients. An internal investigation by the NSHA determined that Ms. d'Eon had accessed the personal health information of the patient who filed the NSHA privacy complaint, as well as his spouse and mother.

8. Ms. d'Eon has not practised as a paramedic since her termination from NSHA. Ms. d'Eon's licence expired and she has not applied for the renewal of her licence.

9. On September 12, 2019, the Investigation Committee suspended Ms. d'Eon's ability to obtain a licence, and referred the matter to the Hearing Committee.

C. Allegation of Falsification of Healthcare Documents

10. In her employment as an ACP at the Halifax Infirmary, Ms. d'Eon was required to perform 50 supervised PSA procedures before she could perform PSA procedures independently.

11. On February 4, 2016, a paramedic carried out a PSA on a patient in Pod 2, the trauma room, at the Halifax Infirmary Emergency Department.

12. After the paramedic completed the PSA and his patient was sedated, Ms. d'Eon came to Pod 2 and had a discussion with the paramedic about the procedure. Ms. d'Eon proceeded to sign the patient's health form, which on its face suggested that Ms. d'Eon performed the procedure herself, with the other paramedic as co-signer.

13. Ms. d'Eon recorded the February 4, 2016 procedure as one of the 50 required PSAs she had to perform under supervision as a prerequisite to performing the procedures independently.

14. During its internal investigation the NSHA determined that Ms. d'Eon signed off on approximately 30 PSAs, which NSHA was unable to verify.

15. During its internal investigation, NSHA obtained time-stamped documentation placing Ms. d'Eon in Pod 5 at the same time that she was supposedly completing a PSA in Pod 2. Video footage demonstrated that Ms. d'Eon was not present in the trauma room at anytime during the PSA procedure, performed on February 4, 2016. As a result, NSHA suspended Ms. d'Eon for four-shifts, and placed further restrictions on her.

16. In her response to the complaint, Ms. d'Eon states she was present for the PSA procedure, but out of camera range.

17. In her response to the College's preliminary investigation report, Ms. d'Eon denied signing off on a PSA that she did not perform.

D. Investigation of Privacy Breach

18. An individual identified as AB and Ms. d'Eon initially met around October of 2015. Over time, AB and Ms. d'Eon became friendly and developed an intimate personal relationship.

19. In late 2016, AB received a text message from Ms. d'Eon requesting his health care card number. AB sent this information to Ms. d'Eon and shortly after received another text message from her, indicating that she had changed his next-of-kin ("NOK") information to her own name.

20. Ms. d'Eon states she received a text message from AB confirming his request to change his NOK. The text message was not produced in evidence during the investigation of this matter by the College.

21. AB states he had not requested this change, and replied immediately asking Ms. d'Eon to change his NOK information back to that of his wife. Ms. d'Eon responded that she could not do so, as someone else at her request had changed the information as a favour and that if the information were changed too many times within a given period, it would trigger an alert.

22. AB attended the Emergency Department several times after his NOK information was changed. Upon each visit, during triage, the staff asked AB to verify that Ms. d'Eon was his NOK. Each time, AB indicated to the NSHA staff that this was incorrect. He asked the staff to change his NOK back to his wife, but the change did not seem to take effect. Finally, AB contacted the NSHA privacy office to have the NOK permanently changed, and this took place in July, 2017.

23. The relationship between AB and Ms. d'Eon ended sometime in July, 2017.

24. Information provided by a data clerk supports that Ms. d'Eon had requested her to change AB's NOK information to herself. The data clerk has no recollection of receiving a text from AB.

25. Ms. d'Eon never triaged AB or provided health care to him during any of his hospital visits, with the exception of drawing blood on one occasion in early spring of 2017.

26. There was no clinical reason for Ms. d'Eon to access AB's medical records.

27. In September, 2017 it came to the attention of officials at NSHA that Ms. d'Eon appeared to have accessed nine electronic health care records for individuals to whom she had not provided care. These individuals included AB, his wife and mother.

28. In September, 2017, representatives from NSHA met with Ms. d'Eon to discuss the suspected breach. In each case, Ms. d'Eon denied knowing the patient or accessing the patient records. Ms. d'Eon eventually admitted that she knew AB and had a relationship with him. NSHA representatives confirmed that Ms. d'Eon was working in the department on the dates the various records were accessed.

29. Ms. d'Eon's employment was terminated in October, 2017. The termination letter advised her that the NSHA had concluded that Ms. d'Eon had accessed health information for which there was no legitimate clinical reason; and that such conduct was a significant breach of patient confidentiality and an irreparable breach of trust in her relationship with the employer.

E. Agreement for Consent Revocation

30. The Complaints Committee reviewed the following two allegations against Ms. d'Eon:

1. Ms. d'Eon engaged in professional misconduct and/or conduct unbecoming in the period between 2016 and 2017 in that she:

   (a) Falsified health documentation when she signed off on a PSA that she was not present for; and

   (b) Breached patient privacy and confidentiality when she accessed patient health records without a valid medical reason and made changes to a patient's next of kin information without authorization to do so.

31. Ms. d'Eon does not contest the allegations set out in paragraph 30, and applies to have her registration as a paramedic permanently revoked.

32. Ms. d'Eon confirms her understanding that if the Hearing Committee agrees to grant this application for consent revocation, she will be treated as a person whose registration as a paramedic has been revoked by a Hearing Committee.

F. Notification and Publication

33. Ms. d'Eon understands that notification of the revocation of her registration shall be given as provided for in section 83 of the *Paramedics Act* and section 86 of the Paramedics Regulations.

34. She acknowledges that a copy of this application for consent revocation and the decision and reasons of the College Hearing Committee will be provided to her former employer, the complainant in this matter, and to the Nova Scotia Real Estate Commission, where she has held a licence.

35. Ms. d'Eon further understands that the full decision of the Hearing Committee, this application, and any investigative material gathered by the College, may be made available in any subsequent processes of the College relating to her conduct, and may be made available to any other regulatory body in the event she applies for registration or a licence to such other regulatory body.

G. Costs

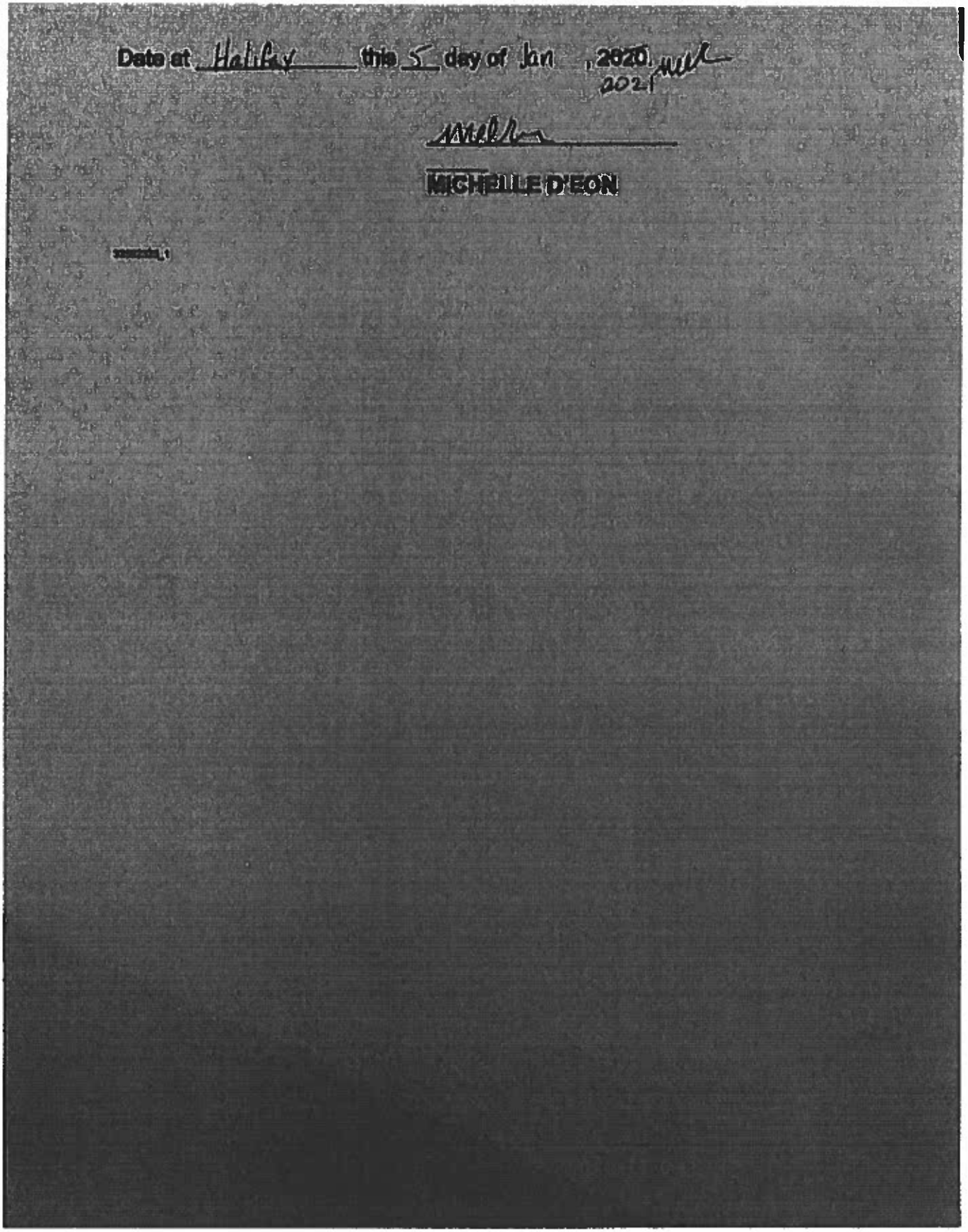
36. Ms. D'Eon understands that if this Application for Consent Revocation is accepted by the Hearing Committee, there will be no costs payable by her to the College.

H. Legal Representation

37. Ms. d'Eon confirms she has received legal advice prior to signing this document. She confirms she is voluntarily applying for this consensual revocation of her registration and licence to practice as a paramedic.

Date at _____ this ___ day of , 2020.

_____
MICHELLE D'EON


Date at Halifax this 5 day of Jan , 2020. 2021

MICHELLE D'EON

TAB TWO

IN THE MATTER OF: The *Medical Act*, S.N.S. 2011, c. 38

and

IN THE MATTER OF: A Settlement Agreement

BETWEEN:

The College of Physicians and Surgeons of Nova Scotia

("the College")

-and-

Dr. Sarah Jones

("Dr. Jones")

HEARING COMMITTEE DECISION

Date Heard:	June 26, 2019
Location:	Halifax, Nova Scotia
Hearing Committee:	Mr. Raymond F. Larkin, Q.C. Dr. Michael Teehan Dr. Erin Awalt Dr. Zachary Fraser Ms. Mary Hamblin
Counsel:	Ms. Marjorie Hickey, Q.C., Counsel for the College of Physicians and Surgeons of Nova Scotia Mr. Colin Clarke, Q.C., Counsel for Dr. Sarah Jones

1. On June 26, 2019, the Hearing Committee considered a proposed Settlement Agreement between the College and Dr. Sarah Jones which had been recommended by the Investigation Committee.

2. Dr. Jones, over a period of years, prescribed a shockingly excessive amount of Oxycodone or similar drugs to one particular patient, lied to the Prescription Monitoring Program and community pharmacists to justify these prescriptions, and failed to provide the College with any satisfactory explanation for why she prescribed excessive amounts of this drug, or explain what happened to the large quantities of the drug that the patient himself could not have ingested.

3. The Settlement Agreement includes a three year time-served suspension of her licence to practice medicine, strict conditions to be met before her return to practice and extensive conditions and restrictions on her practice when she does return.

4. At the hearing, the Hearing Committee indicated that it accepted this Settlement Agreement as recommended by the Investigation Committee, with an amendment agreed to by the Registrar and Dr. Jones, with reasons to follow.

5. These are the reasons for the Hearing Committee's decision to accept the Settlement Agreement.

Partial Publication ban

6. Since the hearing, counsel for the College and Dr. Jones have requested the Hearing Committee to order a partial publication ban on aspects of the Settlement Agreement that included Dr. Jones' personal medical information and to order a number of redactions to the Settlement Agreement that are made necessary by the partial publication ban.

7. The Hearing Committee is authorized by Section 53(5) of the Medical Act and Section 109(4) of the Medical Practitioners' Regulations to order a publication ban for proper reasons as the Committee deems necessary. In our opinion, it is unnecessary to publish the personal medical information of Dr. Jones to meet the objective of a clear and transparent account of her conduct in this case. We agree that the proposed redactions are necessary and appropriate to protect her personal privacy.

8. Accordingly, we order that the paragraphs in the Settlement Agreement which disclose certain personal medical information of Dr. Jones be redacted in any publication of the Settlement Agreement in the manner set out in the Redacted Settlement Agreement which is attached to these reasons for decision as Appendix 1.

9. The full Settlement Agreement without redactions is attached to the original approval by the Hearing Committee signed on June 26, 2019 and is incorporated into these reasons and is attached as Appendix 3. Any publication of the Settlement Agreement shall be in the form of the Redacted Settlement Agreement.

Facts

10. The facts which have been agreed to by the College and Dr. Jones are set out extensively in the Redacted Settlement Agreement. It is unnecessary to review all of those facts, but certain key facts must be kept in mind.

11. Dr. Jones began practice in 2009. In the previous decade there was widespread recognition of problems with the use of prescription opioids, both by patients themselves and by others who obtained prescribed drugs from them.

12. In Nova Scotia, the *Prescription Monitoring Act* was enacted in 2004 to establish a prescription monitoring program to promote the appropriate use of monitored drugs such as OxyContin and the reduction of abuse or misuse of monitored drugs. Regulations under the *Act* dealt with the prescription and dispensing of monitored drugs, and authorized the Administrator of the program to obtain detailed information about the prescriber, the recipient, and the dispensers of the monitored drugs.

13. The system under the *Prescription Monitoring Act* was well in place by the time that Dr. Jones obtained her certification in the College of Family Physicians and began medical practice as a family physician in 2009. Shortly after, the 2010 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-cancer Pain established guidelines for opioid prescribing practices aimed at limiting inappropriate or excessive use of opioids.

14. In January 2010 Dr. Jones took on Patient X as a patient. He was a gentleman in his 60s who had chronic pain in his right hip, knee and foot stemming from multiple sources. Based on her initial assessment, Dr. Jones concluded that Patient X's pain was not well controlled, and she prescribed increasing amounts of opioids between then and August 2015, when Patient X was hospitalized and Dr. Jones' prescribing practices to Patient X came under scrutiny.

15. During this four year period, Dr. Jones made frequent strength switches and dosage adjustments in the prescribed drugs which resulted in the dispensing of significant excess amounts of drugs, mainly Oxycodone, beyond what Patient X could ever consume himself. The quantities of drugs prescribed were astonishing in comparison to the 2010 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-cancer Pain. For example, Dr. Jones prescribed Patient X 33,282 tablets of Oxycodone from August 7, 2014 to August 12, 2015, totalling 584,220 mg. of Oxycodone. In the month before Patient X's admission to hospital in August 2015, Dr. Jones prescribed him a total of 47,770

mg. of Oxycodone. These amounts of Oxycodone could not have been safely ingested by one patient.

16. In July 2010, Dr. Jones began picking up Patient X's prescriptions at the pharmacy and making house calls bringing them to Patient X at his home. Within a few months, the Prescription Monitoring Program called her and, as a result, Dr. Jones stopped picking up Patient X's prescriptions as of October 23, 2010. However, in January 2012 she started picking up his prescriptions again, doing so without advising the Prescription Monitoring Program.

17. Over the period of time that Dr. Jones treated Patient X, and as early as 2011, there was evidence that his use of opioids was harmful to him. Dr. Jones continued to prescribe high doses of opioids after there was demonstrable harm such as choking, falling, and confusion with dosing.

18. The amount of opioids prescribed to Patient X while under Dr. Jones' care was excessive, dangerous and inappropriate. Given the quantities of opioids prescribed to Patient X, it is likely there were pills left over, missing, not accounted for, diverted or consumed in excess or inappropriately by Patient X or others, which presented a real danger to Patient X and the public.

19. Dr. Jones let Patient X take over the direction of his care. For example the Seniors' Community Health Team recommended a visit from their Pharmacist to discuss his medication. Patient X refused to undergo the medication review but Dr. Jones did not insist. He refused to follow her advice including her referrals to specialists.

20. Dr. Jones did not properly document Patient X's medication use. Nor did she monitor his actual consumption of opioids or monitor safe storage of the pills.

21. The extent of Patient X's use of opioids drew the attention of others in the health care system but Dr. Jones misled them with false explanations. She gave false and misleading responses to inquiries from the Prescription Monitoring Program and the pharmacists who dispensed the prescriptions and continued to prescribe excessive amounts of opioids to Patient X. She later gave false or misleading information to the Registrar of the College and to her practice colleagues respecting her health.

22. The Investigation Committee ordered two audits of Dr. Jones' practice. Neither audit identified concerns with her clinical care of the patients whose charts were identified. The second assessor concluded that she provided very good clinical care and had excellent medical records. Except for her dealings with Patient X, no issues have arisen about her clinical care of patients.

23. Dr. Jones' treatment of Patient X and her misleading others about it cries out for an explanation. In the Settlement Agreement she admits her many failures to meet the standards of practice. Her explanation for why she engaged in this behavior is that she was a young, naïve physician who got in over her head with a single patient whose pain she was not able to control. There is some suggestion that her deception of the Registrar of the College and her colleagues in October 2015 was the result of severe stress and reactions to sleeping medications. Dr. Jones provided an expert report which concluded that she was a relatively inexperienced physician who found herself clinically over her head but tried her best but ultimately failed in her care of Patient X.

24. These rationales for Dr. Jones' conduct do not come close to explaining the amount of oxycodone ordered for Patient X and her home visits to deliver the medications over a long period of time. There is no real explanation for what happened to the excess drugs prescribed for Patient X. There is no explanation for her repeated misleading explanations of her treatment of Patient X to others in the health system and the

authorities who questioned her conduct. There is no explanation, in particular, for her extensive false statements to the Prescription Monitoring Program.

25. There is no evidence that Dr. Jones used the opioids herself or provided them to anyone but Patient X. There is no evidence that Patient X provided excess medication to others.

26. Dr. Jones was charged criminally for aspects of her dealings with Patient X but was acquitted of all charges.

Allegations of Professional Misconduct, Incompetence and Incapacity

27. The Investigation Committee has referred the following matters to the Hearing Committee:

> 1. With respect to the care provided to the Patient from January 2010 to August 2015, Dr. Jones failed to meet the accepted standards of practice of medicine respecting the prescription of opioids, by engaging in practices including the following:
>
> a. prescribing amounts of opioid medication to the Patient that were excessive, unsafe or otherwise inappropriate;
>
> b. failing to properly monitor Patient's use of opioids;
>
> c. failing to monitor the system for safe storage of opioids in the Patient's home;
>
> d. continuing to prescribe high doses of opioids after there was demonstrable harm to the patient, such as choking, falling and confusion with dosing;
>
> e. failing to properly and safely dispose of opioid medication;
>
> f. failing to properly document the Patient's opioids during an alleged weaning period in July and August, 2015; and/or

g. continuing to prescribe large quantities of opioids during an alleged weaning period in July and August, 2015; and/or

h. failing to obtain and/or retain a written prescribing agreement with the Patient.

2. With respect to the care provided to the Patient from January 2010 to August 2015, Dr. Jones failed to maintain the appropriate physician/patient boundaries by engaging in practices including the following:

a. frequently picking up and delivering the Patient's opioid medication and removing the Patient's unused opioid medication from his residence;

b. ignoring and/or failing to act on indications that the Patient was not using the opioid medication properly or safely;

c. ignoring and/or failing to act on indications that the patient was not storing opioid medication properly or safely and/or

d. permitting the Patient to direct his own care.

3. In Dr. Jones' June 14, 2012 and February 25, 2014 letters to the Prescription Monitoring Program, she violated the accepted standards of practice and *Code of Ethics* by doing one or more of the following:

a. Providing false, misleading and/or incomplete information respecting:

i. the Patient's medical history and quality of life;

ii. the Patient's level of compliance;

iii. the existence of a signed narcotics contract;

iv. the filling of prescriptions;

v. the disposition of excess medication;

vi. her level of consultation with pharmacists and her colleagues about the Patient; and/or

vii. the weaning of the Patient;

b. Failing to advise that she had resumed the pick-up and delivery of medication to the Patient.

4. During Dr. Jones' October 27, 2015 meeting with Dr. D.A. Gus Grant, Registrar of the College, she violated the standards of the profession, the Canadian Medical Association's *Code of Ethics* and the duty to cooperate under the *Medical Act* by providing false, misleading and/or incomplete information (redacted in part by the partial publication ban).

5. Dr. Jones violated accepted standards of practice and the Canadian Medical Association's Code of Ethics by providing false, misleading and/or incomplete information to pharmacists, including information that she was working with a pain specialist regarding prescriptions for the Patient when that was not the case.

6. Between August and October 2015, Dr. Jones violated accepted standards of practice and the Canadian Medical Association's *Code of Ethics* by providing false, misleading and/or incomplete information, [redacted], to her physician colleagues (redacted in part by the partial publication ban).

7. Dr. Jones failed to meet accepted documentation standards by engaging in practices including the following:

a.Failing to retain an alleged written prescribing agreement with the Patient;

b. Failing to properly document the Patient's prescriptions and treatment; and/or

c.Making a number of excessively late entries into the Patient's record.

8. Dr. Jones practiced medicine while suspended by editing a large number of patient encounters on the Patient's electronic record while her license to practice medicine was suspended by the College.

28. In the Settlement Agreement Dr. Jones admits the particulars of above allegations and acknowledges that collectively they constitute professional misconduct,

incompetence and incapacity. The Hearing Committee agrees with the Investigation Committee that the facts support these admissions.

Disposition

29. In the Settlement Agreement Dr. Jones and the College have agreed to the following disposition of the complaint against Dr. Jones:

126. Dr. Jones agrees to the following:

a. Dr. Jones' license to practice medicine is suspended for a period of 36 months. She will receive credit for her time suspended on an interim basis and, accordingly, her suspension is considered fully served.

b. Dr. Jones will provide no medical care to Patient X at any time in the future if she holds a medical license.

c. As Dr. Jones has been out of practice for a period greater than 3 years, she is required to meet the provisions of section 16 of the regulations under the *Medical Act* prior to return to practice. This regulation requires physicians who have been out of practice for 3 years or more to complete a competence assessment prior to returning to practice. For purposes of the competence assessment Dr. Jones will be issued a Clinical Assessment licence, whereby Dr. Jones will not be considered the most responsible physician, and will not bill for her services. With successful completion of the competence assessment (as determined by the Registration Committee), she can then apply for a Restricted License to practice medicine as the most responsible physician, as set out in subparagraph 126(g). The terms of the competence assessment for Dr. Jones are set out in the document attached as Schedule "B" to this Settlement Agreement. The costs of this competence assessment shall be paid by Dr. Jones as set out in Schedule "B".

d. While engaged in the competence assessment outline in Schedule "B", Dr. Jones must commence counselling with a therapist who will be provided by the College with a copy of this Settlement Agreement in order to understand the context in which the counselling is required. Counselling sessions must occur on a monthly basis or such other more frequent basis as recommended by the therapist. Prior to Dr. Jones applying for a Restricted License upon completion of the competence assessment outlined in Schedule "B", the therapist is required to provide a report to the College's Professional Conduct

Compliance Office either confirming Dr. Jones' fitness to return to practice or identifying any concerns for follow up with the Hearing Committee.

e. While engaged in the competence assessment outlined in Schedule "B", Dr. Jones must maintain contact with her family physician who will be provided by the College with a copy of this Settlement Agreement. Dr. Jones agrees to see her family physician on at least a monthly basis or more frequent basis as recommended by her physician while participating in the competence assessment. Prior to Dr. Jones apply for a Restricted License upon completion of the competence assessment outlined in Schedule "B", the physician is required to provide a report to the College's Professional Conduct Compliance Office either confirming Dr. Jones' fitness to return to practice or identifying any concerns for follow up with the Hearing Committee.

f. Prior to commencing the competence assessment outlined in Schedule "B", Dr. Jones must supply a hair sample to a testing agency selected by the College, in such manner as determined by the College and must test negative for any of the Prohibited Substances set out in subparagraph 126 (g)(vii). The cost of this test shall be initially paid for by the College and then reimbursed by Dr. Jones in the same manner as ongoing tests described in subparagraph 126(g) viii).

g. When the Professional Conduct Compliance Office determines that Dr. Jones has met the criteria set out in subparagraphs (a) to (f) above, she may apply to the College's Registration Committee for a Restricted License. If she is issued a Restricted Licence, she may return to practice under a Restricted Licence, with the following conditions and restrictions, and such other conditions as the Registration Committee may determine are necessary based on the recommendations coming out of the competence assessment set out in Schedule "B" and based on the requirements set out in the *Medical Act* for a restricted licence:

i. Dr. Jones must complete the following remedial education, at her cost, at the first available opportunity following her return to practice in accordance with Schedule "B":

A. The *Understanding Boundaries and Managing Risks Inherent in the Doctor Patient Relationship* course provided by Western University;

B. Ethics education as determined by the Physician Performance Department.

ii. Dr. Jones will have a permanent restriction on her medical licence preventing her from prescribing Narcotics (under the *Controlled Drugs and Substances Act* Schedule I) and cannabis (under the *Controlled Drugs and Substances Act* Schedule II). Dr. Jones will prominently place a College approved sign to that effect in her clinic waiting room and examination room.

iii. Dr. Jones will have a restriction on her licence preventing her from prescribing benzodiazepines, and zoplicone, zaleplon or additional members of this class of drugs that may emerge (collectively the "Z-drugs") for a minimum period of 2 years following her return to practice. Dr. Jones will prominently place a College approved sign to that effect in her clinic waiting room and examination room. Upon completion of the 2-year period she may apply to the Hearing Committee of the day for a variation of this restriction and the Hearing Committee will consider whether it is in the public interest at that time to vary or remove this restriction.

iv. Dr. Jones will be required to notify Health Canada that she has relinquished her privileges for the drugs identified in subparagraph (ii). The Registrar will provide Dr. Jones with a letter template she agrees to sign and return to the College for forwarding to Health Canada with an explanatory letter from the College.

v. Dr. Jones' practice will be subject to the supervision requirements set out in Schedule "C" to this Settlement Agreement for a period of two years following return to practice. The costs of the supervision shall be paid by Dr. Jones as set out in Schedule "C" at the time supervision is provided.

vi. Dr. Jones will not practice as a sole practitioner (in an office with no other practising physicians) for a minimum period of two years following her return to practice. The Physician Performance Department must approve of the location of Dr. Jones' practice for the first two-year period. If, following the two year period, Dr. Jones wishes to practice by herself, she will be required to apply to the Hearing Committee for approval.

vii. Dr. Jones shall abstain from taking any opioids, benzodiazepines, cannabis and Z-Drugs unless expressly prescribed by a physician (the "Prohibited Substances"). Dr. Jones must notify the College of any prescriptions for the Prohibited Substances within 24 hours of such prescription.

viii. For a period of five years, Dr. Jones shall participate in a program of monitoring (the "Monitoring Program") to be conducted by such testing agency as may be approved by the College. The Monitoring Program shall test for the presence of any Prohibited Substances at such times and in such manner as will be specified in a protocol provided by the College, which will, to the extent possible utilize hair testing as the means to test for Prohibited Substances. Testing shall not occur more than four times per year for the first two years, and no more than six times in total for the remaining three years. Reasonable accommodation shall be given to Dr. Jones' work and travel schedules. The College shall pay the invoice received from the testing agency and shall then remit each invoice for reimbursement from Dr. Jones, who shall remit such reimbursement within 30 days of receipt of the invoice from the College.

ix. Dr. Jones shall continue in monthly counselling with a therapist for a minimum period of two years, or such greater frequency as recommended by her therapist, at her cost. At the end of the two year period, if the therapist determines additional therapy is needed, Dr. Jones agrees to abide by the recommendations of her therapist. Dr. Jones consents to her therapist immediately reporting to the College at any time any breach of this settlement agreement or any concerns respecting Dr. Jones' fitness to practice. For clarity, the therapist will not be required to provide the College with any portion of Dr. Jones' patient chart or any notes made during the counselling sessions. Dr. Jones agrees to notify the Professional Conduct Compliance Office of the name and contact information of her therapist during the period of time when she is required to see a therapist, and agrees the College may provide a copy of this Settlement Agreement to her current therapist.

x. Dr. Jones shall continue with regular visits to her family physician at such frequency as recommended by her physician for the first two years following return to practice. Dr. Jones agrees the frequency of her visits will be no less than quarterly, and hereby consents to her family physician providing quarterly reports to the College respecting her fitness to practice during this two year period.

xi. Dr. Jones further consents to attending visits with her family physician at such intervals as recommended by her family physician for a period of 10 years following return to practice, and hereby provides her consent for her family physician to report to the College any breach of this settlement agreement or any concerns respecting Dr. Jones' fitness to practice during this ten year period. She agrees to notify the Professional Conduct

Compliance Office during this ten year period of the name and contact information of her family physician and agrees the College may provide a copy of this Settlement Agreement to the family physician of the day for this ten year period.

Settlement Agreements Generally

30. In its previous decisions, the Hearing Committee has accepted the principle of deference to a recommendation of the Investigation Committee for approval of a settlement agreement reached between the Registrar and a practitioner. There are good reasons for this.

31. In most cases, the Investigation Committee will have a much more detailed knowledge of the facts than a hearing committee because of their involvement in investigating a complaint over an extended period of time. Furthermore, the Investigation Committee makes a recommendation of a settlement agreement within a legislative framework in Section 102 of the Medical Practitioners' Regulations which ensures a rigorous and exacting approach to whether a complaint should be settled.

32. In our view, settlement agreements should be encouraged because they permit the Registrar and the Investigation Committee to negotiate the resolution of complaints without the delay and expenses of a formal hearing. As in this case, there may be significant issues of proof that make the outcome of a formal adjudicated hearing uncertain. Likewise for the practitioner subject to a complaint, the prospect of success in a hearing may be uncertain, and the possibility of a significant costs award provide an incentive to make appropriate admissions and consent to a disposition they can accept. Some agreed dispositions are possible in a settlement agreement that may not be possible in a formal hearing.

33. It is true that the settlement agreement process is not as transparent to the public as a formal hearing but to be acceptable settlement agreements have to include detailed statements of the facts. The decision of a hearing committee to accept a settlement agreement requires the reasons for accepting it. These are made public.

The Limits of Deference

34. This particular case has tested the limits of the Hearing Committee's willingness to defer to the judgment of the Investigation Committee. In the absence of any satisfactory explanation from Dr. Jones for prescribing excessive quantities of opioids for her patient and any adequate explanation for what happened to the Oxycodone that her patient did not use, we have to consider whether the Settlement Agreement assures us that the public is protected by permitting Dr. Jones to return to practice on the one hand and, on the other hand, whether a 3-year time served suspension is an appropriate disposition.

35. The absence of any acceptable explanation for Dr. Jones' conduct creates doubt that she can safely be returned to practice. Her answer that she got in over her head as a young naïve physician, leaves so many questions unanswered that it is really no explanation at all. The fact that she has now admitted her many departures from the accepted standards of practice does not inspire confidence in the face of her persistent dishonesty over several years.

36. The Hearing Committee does not just rubber-stamp a settlement agreement recommended by the Investigation Committee. We not only assess the criteria for the recommendation of a Settlement Agreement by the Investigative Committee set out in Section 102 of the Medical Practitioners Regulations, but we examine the settlement agreement closely for its consistency with the purposes of the College, as set out in Section 5 of the *Medical Act* which provides as follows:

Purpose and duties of College

5 In order to

(a) serve and protect the public interest in the practice of medicine; And

(b) subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine, the College shall

(c) regulate the practice of medicine and govern its members Through

(i) the registration, licensing, professional conduct and other processes set out in this Act and the regulations,

(ii) the approval and promotion of a code of ethics,

(iii) the establishment and promotion of standards for the practice of medicine, and

(iv) the establishment and promotion of a continuing professional
development program; and

(d) do such other lawful acts and things as are incidental to the attainment of the purpose and objects of the College. 2011, c. 38, s. 5.

37. In our opinion, the public interest in the practice of medicine is first and foremost the protection of the public. Members of the public as patients depend fundamentally on the assessment, diagnosis and treatment of illness or injury by medical practitioners for life, health and happiness. The public depends on medical practitioners working in accordance with the accepted standards of the practise of medicine, including high standards of integrity and ethics. The College strives to ensure the protection of the

public by regulating the practice of medicine and governing the conduct of its members to the high standards that the public expects.

38. Serving and protecting the public interest in the regulation of professional conduct under the *Medical Act* also requires fair treatment of medical practitioners who are subject to complaints. There is a strong public interest in ensuring that the process for the investigation and adjudication of complaints, and the substance of decisions made in that process, are fair to the medical practitioners.

39. There is an important public interest in finding appropriate dispositions that keep medical practitioners in practice so they can serve the public in accordance with the standards of the medical profession. There continues to be a shortage of physicians in Nova Scotia. If possible, medical practitioners who engage in professional misconduct should be returned to practice with appropriate conditions and restrictions.

40. There is also a public interest in maintaining the credibility of the College as a regulator of the practice of medicine. It is important that the public is assured that genuine complaints are not swept under the rug, and that the College is effective in protecting the public and in maintaining high standards among medical practitioners.

41. In our view, in considering whether to accept this Settlement Agreement, the Hearing Committee has to balance all of these aspects of the public interest so that the approval of this Settlement Agreement serves to protect the public, treats Dr. Jones fairly, and maintains the confidence of the public and profession in the College.

42. We recognize that there can often be more than one reasonable conclusion about how to balance these aspects of the public interest in assessing a particular settlement

agreement. If the Investigation Committee recommends a disposition that falls within a reasonable range of alternative conclusions we will defer to their judgement.

43. In assessing whether the dispositions in a settlement agreement fall within a reasonable range of alternatives the Hearing Committee keeps in mind its statutory mandate where it has found professional misconduct, conduct unbecoming, and competence or incapacity after a formal hearing.

Remedial not punitive dispositions

44. Neither the *Medical Act* or the Medical Practitioners Regulations aim primarily at penalizing or punishing medical practitioners who engage in professional misconduct. Section 54 of the Act authorizes a hearing committee to "dispose of the matter in accordance with the Regulations." Section 115 of the Medical Practitioners Regulations sets out the possible dispositions when a hearing committee finds professional misconduct, conduct unbecoming, incompetence or incapacity as follows:

> 115 A hearing committee that finds professional misconduct, conduct unbecoming, incompetence or incapacity on the part of a respondent may dispose of the matter in any manner it considers appropriate, including doing 1 or more of the following, and must include orders for the action in the committee's disposition of the matter:
>
> a. revoke the respondent's registration or licence;
>
> b. for a respondent who held a temporary licence at the time of the incident giving rise to the complaint, revoke the respondent's ability to obtain registration or require the respondent to comply with any conditions or restrictions imposed by the committee if registration is granted;
>
> c. authorize the respondent to resign their registration;

d. suspend the respondent's licence for a specified period of time;

e. suspend the respondent's ability to obtain a licence for a specified period of time;

f. suspend the respondent's licence pending the satisfaction and completion of any conditions a hearing committee orders;

g. impose any restrictions or conditions, or both, on the respondent's licence for a specified period of time;

h. reprimand the respondent and direct that the reprimand be recorded in the records of the College;

i. direct the respondent to pass a particular course of study or satisfy a hearing committee or any other committee established under the Act of the respondent's general competence to practise or competence in a particular field of practice;

j. refer the respondent to for a competence assessment as determined by the Registrar, and require the respondent to pay for any costs associated with the assessment;

k. direct the respondent to pay a fine in an amount determined by the hearing committee for findings that involve

i. practising while not holding a valid licence to practise, or

ii. professional misconduct or conduct unbecoming the profession;

l. direct the respondent to pay any costs arising from compliance with an order under clause (g), (i) or (j);

m. publish or disclose its findings in accordance with the Act and these regulations.

45. In our view, these provisions in the Medical *Act* and the Medical Practitioners Regulations require orders that are remedial in nature, not punitive. In our opinion, the

Medical Act and the Medical Practitioners' Regulations require a hearing committee to dispose of a matter by adopting orders that promote the public interest in the circumstances of the matter. Most often this will be best accomplished by conditions or restrictions that provide an assurance of public protection and demonstrate to the public and the medical profession that there are effective means of maintaining the standards of the profession.

46. There is a role for including sanctions in a set of dispositions that together reflect the public interest. The purpose of a suspending a medical practitioner's license should be correction of the medical practitioner who has engaged in professional misconduct and to send a message to the profession that certain conduct will not be tolerated. In our opinion revocation of a licence should only be ordered as a last resort.

47. We would not be inclined to defer to a recommendation from the Investigation Committee which included a proposed disposition that put excessive emphasis on punishment of the medical practitioner for professional misconduct or conduct unbecoming.

Is the Agreed Disposition in the Public Interest?

48. The Settlement Agreement permits Dr. Jones to return to practice. As a Hearing Committee we could only approve her return to practice if we were satisfied that the conditions and restrictions in the Settlement Agreement protect the public both by assuring that her patients will receive an acceptable standard of care and by assuring both the public and the profession that the College can effectively maintain high standards of competence and professional integrity among medical practitioners.

49. The Settlement Agreement requires Dr. Jones not to provide care to Patient X. It imposes a permanent restriction on her prescribing narcotics and a temporary restriction on prescribing benzodiazepines and Z-type drugs.

50. In a narrow sense, those restrictions will prevent a repetition of the conduct involved in the care of Patient X by Dr. Jones. However, the Settlement Agreement goes much further. Before Dr. Jones can return to practice she must meet the requirements of a Competency Assessment. She must engage in counselling with a therapist who will report whether she is fit to return to practice. She must maintain contact with her family physician who also must confirm her fitness to return to practice. She has to pass a specified drug test.

51. We are satisfied that Dr. Jones will not repeat the conduct that occurred with Patient X if she is permitted to return to practice after her completion of the Competency Assessment and certification of her fitness to return to practice by her therapist and her family physician.

52. For a two year period following her return to work, Dr. Jones may only practice under an onerous supervision requirement and she may not practice as a sole practitioner. She must continue counselling with a therapist and regular visits to her family doctor. For five years, Dr. Jones will be subject to a mandatory Drug Test Monitoring Program. For ten years she will continue with visits to her family practitioner who will be authorized to report any breach of the Settlement Agreement to the College.

53. The depth of this combination of conditions and restrictions provide an assurance not only that Dr. Jones will not repeat the conduct involved in her excessive prescribing of opioids to Patient X but provide a level of supervision and support which should generate any red flags for the College and permit the College to intervene if there are problems.

54. These conditions and restrictions satisfy concerns arising from Dr. Jones' failure to provide any acceptable explanation for prescribing excess amounts of opioids to Patient X and her inability to explain what happened to opioids that he did not ingest. However, they do not address her misconduct in providing false and misleading information in response to legitimate concerns from regulators, her colleagues and others in the healthcare system. The answer for that in the Settlement Agreement is the suspension of 36 months from practice on a time served basis.

36-month Time Served Suspension

55. Counsel for the College has provided the Hearing Committee with a comprehensive review of cases decided in Nova Scotia and in other provinces that involve inappropriate opioid prescribing practices and cases dealing with dishonesty by physicians in their dealings with the College or more generally in the course of their professional activities. A copy of Ms. Hickey's review dated June 24, 2019 is attached as Appendix "2" to this decision.

56. The cases provided to us dealing with misconduct in opioid prescribing tend to be different than this case. Dr. Jones engaged in professional misconduct in opioid prescribing for a single patient. Many of the cases involved multiple patients. Not all of the cases involved conduct similar to the false and misleading explanations that Dr. Jones provided when faced with inquiries about her prescribing practices. However, the cases are helpful in showing that in similar cases a lengthy suspension rather than license revocation is often the appropriate sanction.

57. The following cases illustrate the range of suspensions that have been found appropriate:

- *Ontario (College of Physicians and Surgeons of Ontario) v. Arnold*, 1999 ONCPSD 2 – 12 month suspension for excessive prescription of narcotics.

- *College of Physicians and Surgeons of Ontario v. Pontarini*, 2000 ONCPSD 21 – Nine month suspension for prescribing oxycodone without proper therapeutic purpose.

- *Ontario College of Physicians and Surgeons v. Adams,* 2000 ONCPSD 23 – Suspension until successful completion of Competence Assessment and long-term supervision.

- *College of Physicians and Surgeons of Ontario v. Gale*, 2002 ONCPSD 3 – Revocation for administering excessively high doses of opioids to multiple patients. This decision was overturned by the Ontario Divisional Court in *Gale v. College of Physicians and Surgeons of Ontario,* 2003, CanLII 30486 when some of the charges against Dr. Gale were overturned stating in part "...even if Dr. Gale had been guilty of all of the offences of which he was convicted, the penalty of revocation, the capital punishment of a profession, was excessive to the point of being unduly harsh."

- *Hlynka (Re),* 2010 CanLII 21054 (MB CPSDC) – Prescribing narcotic drugs to multiple patients in a reckless manner, one of the purposes of which was to obtain a supply of narcotic drugs for his own use, providing false and misleading information to the College – Revocation with readmission six months later subject to restrictions.

- *College of Physicians and Surgeons of Ontario v. Redekopp,* 2011 ONCPSD 43 – Over prescribing of narcotics – Reprimand.

- *Coyle, Re* 2013 CarswellMan 810 – Inappropriate prescribing of narcotics and benzodiazepines, creating false records to permit him to divert narcotics and benzodiazepines for his own use. Inappropriately prescribing of narcotics and benzodiazepines to multiple patients, boundary violation and misrepresentations to the College – 18 months with multiple conditions.

- *Datar (Re)*, 2016 CanLII 74173 (AB CSPDC) – Prescribing opioids inappropriately to a single patient – three month suspension.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Proulx*, 2018 ONCPSD 16 – Prescribing large amounts of opioids to a neighbour, diverting narcotics to himself, untruthful responses to the College – Revocation.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Cameron*, 2018 ONCPSD 25 – Prescribing narcotics inappropriately to multiple patients – Agreement to surrender licence.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Aly*, 2018 ONCPSD 33 – Inappropriate prescribing of narcotics to multiple patients – Four month suspension.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Garcia*, 2018 ONCPSD 35 – Inappropriate and excessive prescribing of controlled substances to multiple patients recklessly – Eight month suspension

- *Ontario (College of Physicians and Surgeons of Ontario) v. Pasternak* 2018 ONCPSD 49 - Over prescribing of opioid and benzodiazepine to a single patient – Reprimand, clinical supervision and conditions and restrictions.

- *Ontario (College of Physicians and Surgeons of Ontario) v. LeDuc*, 2018 ONCPSD 59 – Unsafe prescribing of narcotics and benzodiazepines to a single patient with boundary violations – Six month suspension.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Roy*, 2018 ONCPSD 66 – Over prescribing of narcotics and breach of undertaking to the College – Three month suspension.

58. The decisions in all of these cases emphasize that the appropriate disposition, apart from conditions and restrictions to protect the public, should be one that meets the objectives of denunciation of the conduct of the medical practitioner, specific deterrence of the physician personally and general deterrence to send a message that certain conduct will not be accepted. Applying those principles, generally, the cases have limited revocation of license to circumstances where there has been an agreement to do so between the physician and the College. They generally accept that suspensions of varying lengths, depending on the seriousness of the conduct involved, combined with conditions and restrictions, are the disposition of choice.

59. It should be noted that the cases in Ontario and in Manitoba have legislative frameworks that emphasize the use of a penalty where there is professional misconduct. The statutory framework adopts a structure of "charges". A practitioner is "found guilty". Based on that framework, the decisions in those jurisdictions tend to import the principles of sentencing under the *Criminal Code* i.e. denunciation, specific deterrence, general deterrence and rehabilitation. Applying sentencing principles in applying the *Medical Act* and the Medical Practitioners Regulations remedial approach requires some caution.

60. Considering both the cases cited above and the remedial framework in the *Medical Act* and Medical Practitioners' Regulations, we agree that a period of suspension from practice and the conditions and restrictions discussed above is an appropriate disposition. Dr. Jones' misconduct in providing false and misleading information in response to legitimate concerns from regulators, her colleagues and others in the healthcare system and the absence of a satisfactory explanation for overprescribing opioids for Patient X, is serious misconduct which justify a period of suspension from practice.

61. However with a remedial approach, it would be difficult to recognize a 36 month suspension as an appropriate disposition. Generally speaking, it is hard to see how a 36 month suspension on a go forward basis would ever be an appropriate disposition. It would never likely be fair to a medical practitioner. A three year suspension would not be more effective as a denunciation of a medical practitioner's conduct or as a deterrent as, for example, a one year suspension. A one year suspension would demonstrate clearly to the member and the public that the misconduct involved will not be tolerated.

62. It is noteworthy that in the cases from other jurisdictions which are listed above the range of suspensions are generally between three months and 18 months.

63. Nevertheless, the Settlement Agreement provides for a 36 month suspension to be considered fully served. The reason for considering the suspension fully served is that Dr. Jones has been suspended on an interim basis since October 29, 2015. Ordinarily, once an interim suspension is imposed, the Investigation Committee carries on its investigation in as timely a manner as possible. The length of Dr. Jones' interim suspension is very unusual. It resulted from a delay in the investigation as a result of the criminal charges against Dr. Jones. When she was acquitted on October 13, 2017 the investigation proceeded and this matter was referred to hearing on October 30, 2018. The combination of the ordinary delay in completing a proper investigation, the complexity of scheduling a hearing involving several days of evidence and the delay resulting from the criminal charges have combined to extend the interim suspension to three years and nine months.

64. While a 36 month suspension going forward would not be appropriate, the recognition of 36 months of Dr. Jones' suspension as time fully served is fair to her and consistent with the objective of a strong statement of disapproval for her conduct.

65. The ultimate question here is whether the combination of the 36 month time served suspension, strict conditions for permitting Dr. Jones to return to practice and extensive conditions and restrictions on her practice once she does return falls within the range of reasonable alternatives to protect and promote the public interest in this case. We think they do.

66. As set out earlier in these reasons, we are satisfied that the conditions and restrictions in this Settlement Agreement will ensure that Dr. Jones does not repeat the excessive prescribing of opioids. She will not be caring for Patient X. The College's audit indicates that she can meet the standards of the medical profession. She has suffered an interim suspension of three years and nine months and the conditions on her return to practice will extend that time further.

67. Finally, we recognize that Dr. Jones is a young medical practitioner who has a lot to contribute. As a Committee, we think she should have a chance to do that.

68. Accordingly, for all the reasons that are set out above, the Hearing Committee has approved the recommendation of the Investigation Committee and accepts the Settlement Agreement reached between the Registrar and Dr. Jones.

Decision issued this 19th day of August, 2019

Raymond F. Larkin, Q.C., Chair

Dr. Michael Teehan

Dr. Erin Awalt

Dr. Zachary Fraser

Ms. Mary Hamblin