NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Harvey Stephen Pasternak, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Pasternak, 2018 ONCPSD 49

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by
the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) f the **Health Professions Procedural Code**
being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. HARVEY STEPHEN PASTERNAK

PANEL MEMBERS:

DR. M. GABEL (CHAIR)
MR. M. KANJI
DR. I. ACKERMAN
MR. J. LANGS
DR. P. POLDRE

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS A. CRANKER
MR. K. MAIJALA

COUNSEL FOR DR. PASTERNAK:

MR. E. LEDERMAN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS J. McALEER

Hearing Date: July 25, 2018
Decision Date: July 25, 2018
Release of Written Reasons: September 21, 2018

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on July 25, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct, and setting out the Committee's penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Harvey Stephen Pasternak committed an act of professional misconduct:

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*("O. Reg. 856/93"), 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; and

2. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Pasternak is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATION

Dr. Pasternak admitted allegation 2 in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew allegation 1 and the allegation of incompetence.

THE FACTS

The following facts were set out in the Agreed Statement of Facts on Liability, which was filed as an exhibit at the hearing and presented to the Committee:

BACKGROUND

1. Dr. Harvey Stephen Pasternak ("Dr. Pasternak") is a 70-year old family physician practising medicine in Toronto, Ontario. Dr. Pasternak received his medical degree at the University of Toronto in 1973 and his certificate of registration authorizing independent practice in Ontario in 1974.

FAILURE TO MAINTAIN THE STANDARD OF PRACTICE - PATIENT A

2. The College investigation began after receipt of information from an Emergency Room physician, practicing in a hospital outside Toronto, that an adult female patient ("Patient A") had been transported to the hospital by ambulance after a family member became concerned about a possible narcotics overdose. The Emergency Room physician expressed concern to the College regarding the amounts of narcotics in the possession of Patient A, which had been prescribed by Dr. Pasternak.

3. The College retained Dr. Elisa Venier to provide an opinion on the care provided by Dr. Pasternak to Patient A. Dr. Venier's report dated August 22, 2016 is attached at TAB A [to the Agreed Statement of Facts on Liability].

4. In her report, Dr. Venier concludes that the care provided by Dr. Pasternak to Patient A did not meet the standard of practice, including in the following ways:

> The patient was provided large doses of opioid and benzodiazepine medication from October 2004 to June 2016 along with dose escalations and changes to

medication in the absence of a physical assessment and in the absence of any documentation in the medical record.

Dr. Pasternak did not re-assess the patient to determine the effectiveness of the dose increases and medication changes in order to support the ongoing prescribing of such large doses of opioids with concurrent benzodiazepine medication.

…

Dr. Pasternak failed to assess the reasons for repeated early prescription refills of opioid medication and by failing to do so did not fully assess for the possibility of drug diversion, overuse and/or misuse.

Dr. Pasternak failed to maintain adequate medical records for the patient.

5. In Dr. Venier's opinion, the clinical care of Patient A potentially exposed the patient to harm or injury, as set out in her report.

FAILURE TO MAINTAIN THE STANDARD OF PRACTICE – 15 PATIENTS

6. Following receipt of Dr. Venier's report, the College conducted a broader investigation of Dr. Pasternak's prescribing practice. Dr. Venier reviewed fifteen patient charts.

7. In Dr. Venier's opinion, dated May 6, 2017 and attached at TAB B [to the Agreed Statement of Facts on Liability], the care provided by Dr. Pasternak did not meet the standard of practice in relation to the fifteen patients. In fourteen of the fifteen patients, Dr. Pasternak's care potentially exposed the patient to harm or injury.

8. In reviewing the fifteen patient charts, Dr. Venier noted amongst other things, the following failures to meet the standard of practice:

(i) Failing to document rationale for prescribing;
(ii) Failing to assess reasons for repeated early prescription refills and failure to fully assess the possibility of diversion, overuse or misuse;
(iii) Failing to assess or re-assess, patients for potential adverse risks associated with big doses of opioids and benzodiazepines including the risk of sedation, cognitive impairments and overdose;
(iv) Providing large doses of opioid in the absence of physical assessments; and
(v) Failure to maintain adequate medical records.

ADMISSION

9. Dr. Pasternak admits the facts specified above, and admits that, based on these facts, he engaged in professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, in that he has failed to maintain the standard of practice of the profession.

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statements of Facts on Liability. Having regard to these facts, the Committee accepted Dr. Pasternak's admission and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession.

AGREED STATEMENT OF FACTS ON PENALTY

The following Agreed Statement of Facts Regarding Penalty was filed as an Exhibit at the hearing:

1. Dr. Harvey Stephen Pasternak ("Dr. Pasternak") has no Discipline history with the College.

2. Since the College investigation began, Dr. Pasternak completed two full-day interactive courses offered by the University of Toronto's Faculty of Medicine as follows:

    - In May 2016, he completed the Medical Record Keeping Workshop.
    - In May 2017, he completed the Challenging Cases in Opioid Use and Misuse Workshop.

    Dr. Pasternak's certificates of completion for these courses are attached at Tab 1 [to the Agreed Statement of Facts on Penalty].

3. On May 25, 2017, Dr. Pasternak voluntarily entered into an Undertaking in lieu of an order under s. 37 (now s. 25.4) of the *Health Professions Procedural Code*, pending the disposition of this matter by the Discipline Committee. Dr. Pasternak undertook to practice under the guidance of a Clinical Supervisor, who reviews the charts for patients to whom Dr. Pasternak prescribes narcotics or controlled substances and makes regular reports to the College. A copy of the undertaking is attached at Tab 2 [to the Agreed Statement of Facts on Penalty].

4. Pursuant to the Undertaking, Dr. Pasternak retained a Clinical Supervisor acceptable to the College. The Clinical Supervisor's reports to the College confirm that Dr. Pasternak's prescribing practices have improved and currently adhere to the Canadian Guideline for Opioids for Chronic Non-Cancer Pain. Specifically, the Clinical Supervisor has noted Dr. Pasternak's use of the following practices which meet the standard of practice for prescribing:

    - Recording patient identifiers;
    - Completing the functional pain scale at visits;
    - Using a pain scale to track patients' complaints of pain;
    - Having patients sign opioid treatment agreements and reviewing the agreements with them;

- Completing opioid risk assessment tools;
- Reviewing non-pharmacological approaches to pain control with patients;
- Documenting discussions of side effects;
- Recording morphine equivalents;
- Prescribing small/limited quantities;
- Documenting discussions about tapering to reduce dosage; and
- Booking follow up visits to assess pain control.

5. Since the commencement of the investigations into Dr. Pasternak's prescribing practices, the College has published a number of articles in *Dialogue* magazine about opioid prescribing with an aim to alerting the profession to the current opioid crisis and working with physicians to ensure appropriate and safe prescribing of opioids to patients who need them. The College has also published several articles regarding investigations into information about high prescribers received from the Narcotics Monitoring System and the remedial approach taken in the majority of cases. A copy of recent *Dialogue* articles is attached at Tab 3 [to the Agreed Statement of Facts on Penalty].

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Pasternak made a joint submission as to an appropriate penalty and costs order. The jointly proposed order included a reprimand, the imposition of terms, conditions and limitations on Dr. Pasternak's certificate of registration, and costs payable to the College by Dr. Pasternak in the amount of $10,180.00.

As stated in *R. v Anthony-Cook*, 2016 SCC 43, when adversarial parties make a joint submission as to penalty, such a penalty should be accepted, unless it would bring the administration of justice into disrepute, or is otherwise not in the public interest.

When determining the appropriateness of the proposed penalty, the Committee had regard to well-accepted penalty principles. Those principles include protection of the public, specific deterrence of the member, general deterrence of the profession, maintaining the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest, and, where appropriate, the rehabilitation of the physician.

The Committee also considered the following aggravating and mitigating factors in this case.

Aggravating Factors

The Committee considered the serious nature of the misconduct in this matter. Dr. Pasternak's failure to reassess Patient A, while prescribing large doses of opioids and benzodiazepines over many years, exposed the patient to the overdose that ultimately harmed the patient. In addition, the College expert's review of additional charts demonstrated that Dr. Pasternak's misconduct with respect to Patient A was not an isolated case. Rather, this case reflects a constellation of failures related to Dr. Pasternak's failing to follow guidelines related to opioid and benzodiazepine prescribing, including failing to maintain adequate records, failing to reassess patients prior to renewing prescriptions, and failing to assess for the possibility of diversion, overuse or misuse, which exposed multiple patients to risk of harm.

Mitigating Factors

The Committee noted that Dr. Pasternak had no prior discipline history with the College. Dr. Pasternak cooperated with the College in its investigation. His admission to the allegation of professional misconduct reduced the time and cost of the hearing and the need for witnesses to testify. Dr. Pasternak's admission and his voluntary undertaking to have a clinical supervisor demonstrated insight into his misconduct and willingness to remedy his professional shortcomings. The Committee noted that he voluntarily

completed courses related to medical record-keeping and opioid use and misuse. Over the course of the clinical supervision related to his undertaking, his clinical supervisor reported that Dr. Pasternak's prescribing practices have improved, and that he currently adheres to the Canadian Guideline for Opioids for Chronic Non-Cancer Pain.

Prior Cases

The Committee was provided with three prior cases to consider when assessing the jointly proposed penalty for Dr. Pasternak. The Committee acknowledges that it is not bound by prior decisions of the Discipline Committee, but may be guided by these cases in determining an appropriate penalty.

In *CPSO v. Haines* (2014), a patient of Dr. Haines died as a result of oxycodone toxicity. The case proceeded by way of an Agreed Statement of Facts and Admission to the allegation of professional misconduct for failing to maintain the standard of practice of the profession. College expert expressed concerns about opioid and benzodiazepine prescribing as well as inadequate clinical assessments. The Committee found that Dr. Haines demonstrated insight into his deficiencies and entered into an undertaking to practice under the guidance of a clinical supervisor. The Committee accepted the jointly proposed penalty in this case, which included a reprimand and terms, conditions and limitations on Dr. Haines certificate of registration that included a practice assessment. Dr. Haines was also ordered to pay hearing costs to the College.

In *CPSO v. Redekopp* (2011), the death of a patient prompted a College investigation. The case proceeded by way of an Agreed Statement of Facts and Admission to the allegation of professional misconduct by failing to maintain the standard of practice of the profession. College expert expressed concerns about Dr. Redekopp's record-keeping and opined that with regard to the prescription of opioids, benzodiazepines and psycho-stimulants, Dr. Redekopp lacked knowledge, skills and judgment. The Committee accepted the joint proposal on penalty and ordered a reprimand and terms, conditions and limitations on Dr. Redekopp's certificate of registration, including prescribing

prohibitions with respect to narcotics and controlled drugs. Dr. Redekopp was also ordered to complete a medical record-keeping course and to pay hearing costs to the College.

In the recent case of *CPSO v. Syed* (2018), a family physician displayed a wide range of concerns, including poor documentation (described as "woefully sparse" by the College expert) as well as concerns about the prescribing of psychoactive drugs, benzodiazepines, narcotics and anti-depressants. Dr. Syed had also prescribed high doses of benzodiazepines to six patients without being aware that they were on methadone. Some of these patients were subsequently admitted to the intensive care unit. College expert also noted concerns about Dr. Syed's failure to conduct a physical examination on a patient with a suspected lesion. This case also proceeded by way of an Agreed Statement of Facts and Admission to the allegation of professional misconduct for failing to maintain the standard of practice of the profession. The Committee noted that two clinical supervisors provided mixed assessments of Dr. Syed's progress. However, Dr. Syed was noted to be motivated to improve his practice. The parties made a joint proposal with respect to penalty, which was accepted by the Committee. The Committee ordered a reprimand, a two-month suspension of Dr. Syed's certificate of registration, and that terms, conditions and limitations be placed on Dr. Syed's certificate of registration, which included a prescribing log, multi-phased clinical supervision of his narcotic practice, clinical supervision of his non-narcotic practice, and a re-assessment of his practice. Dr. Syed was also ordered to pay hearing costs to the College.

The Committee found these three cases helpful when assessing the proposed penalty for Dr. Pasternak. The only case in which a suspension was ordered, the *Syed* case, was clearly distinguishable from Dr. Pasternak's case, because of the broader array of clinical concerns as well as the mixed assessments from two clinical supervisors. The Committee was satisfied that the jointly proposed penalty for Dr. Pasternak was within the range of penalties ordered in recent similar cases.

DECISION

The imposition of terms, conditions and limitations on Dr. Pasternak's certificate of registration, including the requirement that Dr. Pasternak practise under clinical supervision, maintain a prescribing log, and undergo a reassessment of his practice after the completion of the clinical supervision, serves to protect the public. In addition, monitoring provisions allow the College to conduct unannounced inspections and to make appropriate enquiries of the Ontario Health Insurance Plan and the Narcotics Monitoring System.

The terms, conditions and limitations on Dr. Pasternak's certificate of registration play a vital role in Dr. Pasternak's rehabilitation. He will practise under the guidance of a clinical supervisor for 12 months and he must abide by the recommendations of the supervisor. He must also undergo a reassessment of his practice.

The emphasis on rehabilitation of Dr. Pasternak demonstrates the commitment of the College to education as the preferred approach to issues related to opioid prescribing. The Committee noted the following comments of College President Dr. Steven Bodley in *Issue 1, 2018 Dialogue* (which was an attachment to the Agreed Statement of Facts on Penalty):

> Our goal is to keep the physician in practice and to support education and provide guidance, where the physician's capacity for remediation is apparent…
>
> We want to facilitate safe and appropriate prescribing, protect patient access to care and reduce risk to both patients and public. As we have said many times, prescribing opioids under the right circumstances is critical for good patient care and our goal is to ensure that physicians have the resources and the information they need to prescribe appropriately.

The reprimand in this matter allows the Committee to denounce Dr. Pasternak's misconduct directly to him. The reprimand serves as a specific deterrent for Dr. Pasternak and a general deterrent to the profession during a time when opioid prescribing practices are under intense scrutiny and must conform to established guidelines. The penalty as a whole should also serve to maintain confidence in the College's ability to regulate the profession in the public interest.

COSTS

Pursuant to the *Regulated Health Professions Act, 1991*, the Committee has the jurisdiction, in appropriate cases, to award costs. The Committee considered this to be such a case. The current daily tariff rate for a one-day hearing is $10,180.00. The Committee accepted this as a reasonable costs order in this case.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of July 25, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Pasternak attend before the panel to be reprimanded.

3. The Registrar impose the following terms, conditions and limitations on Dr. Pasternak's certificate of registration:

Clinical Supervision

(a) Within twenty (20) days of this Order, Dr. Pasternak shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor") with respect to his prescribing of narcotics and controlled substances, who will sign an undertaking in the form attached as Schedule "A" [to the Order].

(b) Dr. Pasternak shall practise under the guidance of the Clinical Supervisor for a period of twelve (12) months, commencing on the date that the Clinical Supervisor is approved by the College ("Clinical Supervision").

(c) Clinical Supervision of Dr. Pasternak's prescribing of narcotics and controlled substances shall contain the following elements:

(d) Throughout the entire period of Clinical Supervision, Dr. Pasternak shall maintain a log of all prescriptions ("Prescribing Log") for:

(i) **Narcotic Drugs** (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19);

(ii) **Narcotic Preparations** (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act,* S.C., 1996, c. 19);

(iii) **Controlled Drugs** (from Schedule G of the Regulations under the *Food and Drugs Act,* S.C., 1985, c. F-27);

(iv) **Benzodiazepines and Other Targeted Substances** (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act.,* S.C., 1996, c. 19);

(A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached as Schedule "B" [to the Order]; and the current regulatory lists are attached as Schedule "C" [to the Order]);

(v) **All other Monitored Drugs** (as defined under the *Narcotics Safety and Awareness Act, 2010,* S.O. 2010, c. 22 as noted in Schedule "D" [to the Order]).

(e) The Prescribing Log shall be in the form set out at Schedule "E" [to the Order], which will include at least the following information:

(i) the date of the prescription;

(ii) patient identifier;

(iii) the medication, dose, direction, number of tablets to be dispensed and frequency (if applicable);

(iv) the clinical indication for use;

(v) whether it is a new prescription; and

(vi) physician initials.

(f) For an initial period of at least six (6) months, the Clinical Supervisor will engage in a period of moderate-level supervision, during which time the Clinical Supervisor will, at minimum:

I. review materials and have an initial in-person meeting with Dr. Pasternak to discuss issues and practice recommendations;

II. meet with Dr. Pasternak at his Practice Location, or another location approved by the College, once every two (2) months thereafter;

III. review charts and prescriptions for at least twenty (20) of Dr. Pasternak's patients at every meeting, which shall be selected from the Prescribing Log at the sole discretion of the Clinical Supervisor. If the Prescribing Log contains fewer than twenty (20) patients, the Clinical Supervisor shall review all charts and prescriptions contained in the Prescribing Log;

IV. review charts and prescriptions for any new patient(s) to whom Dr. Pasternak prescribed a Narcotic Drug, Narcotic Preparation, Controlled Drug, Benzodiazepine and Other Targeted Substance or other Monitored Drug at the next meeting with the Clinical Supervisor following any such prescribing;

V. keep a log of all charts reviewed with patient identifiers and sign and date the Prescribing Log to confirm the charts that the Clinical Supervisor has reviewed and discussed with Dr. Pasternak;

VI. evaluate whether the assessment, clinical examination, risk assessment for addiction and on-going management and follow up is appropriate in all cases reviewed;

VII. discuss with Dr. Pasternak any concerns the Clinical Supervisor may have arising from the chart review and make recommendations for practice improvements or ongoing professional development;

VIII. perform any other duties, such as reviewing other documents or conducting interviews with staff or colleagues, that the Clinical Supervisor deems necessary to Dr. Pasternak's Clinical Supervision; and

IX. submit written reports to the College at least once every two (2) months, or more frequently if the Clinical Supervisor has concerns about Dr. Pasternak's standard of practice;

(g) After a minimum of six (6) months, and only upon recommendation by the Clinical Supervisor and approval of the College, the level of supervision may be reduced for the balance of the period of Clinical Supervision.

(h) Once permission is received from the College, Clinical Supervision shall continue as described in paragraph (3)(f) above for the balance of the period of Clinical Supervision, subject to the following two modifications: meetings between Dr. Pasternak and his Clinical Supervisor shall occur once every three (3) months, and written reports from the Clinical Supervisor shall be submitted to the College at least once every three (3) months, or more frequently if the Clinical Supervisor has concerns about Dr. Pasternak's standard of practice.

Other Elements of Clinical Supervision

(i) Throughout the period of Clinical Supervision, Dr. Pasternak shall abide by all recommendations of his Clinical Supervisor.

(j) If a person who has given an undertaking in Schedule "A" to this Order is unable or unwilling to continue to fulfill its provisions, Dr. Pasternak shall, within twenty (20) days of receiving notice of same, obtain an executed

undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.

(k) If Dr. Pasternak is unable to obtain a Clinical Supervisor as set out in this Order, he will cease prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and other Monitored Drugs until such time as he has obtained a Clinical Supervisor acceptable to the College.

(l) If Dr. Pasternak is required to cease prescribing as a result of paragraph (3)(k) above, this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the public register until such time as he has obtained a Clinical Supervisor acceptable to the College.

Reassessment of Practice

(m) Approximately six (6) months after completion of the Clinical Supervision, Dr. Pasternak shall undergo a reassessment of his practice by a College-appointed assessor or assessors (the "Assessor"). The Assessor shall report the results of the reassessment to the College.

(n) The reassessment may include (at the College's discretion) a review of a minimum of twenty (20) of Dr. Pasternak's patient charts, direct observation of Dr. Pasternak's practice, an interview with Dr. Pasternak, interviews with colleagues and co-workers, and any other tools deemed necessary by the College. Dr. Pasternak shall abide by all recommendations made by the Assessor.

(o) Dr. Pasternak shall consent to the sharing of information among the Assessor, the Clinical Supervisor and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

Monitoring

(p) Dr. Pasternak shall inform the College of each and every location where he practices, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

(q) Dr. Pasternak shall cooperate with unannounced inspections of his Practice Location(s) and patient charts and to any other activity the College deems necessary in order to monitor his compliance with the provisions of this Order.

(r) Dr. Pasternak shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan, the Narcotics Monitoring System and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.

(s) Dr. Pasternak shall be responsible for any and all costs associated with implementing the terms of this Order.

4. Dr. Pasternak pay to the College its costs of this proceeding in the amount of $10,180 within thirty (30) days from the date of this Order.

At the conclusion of the hearing, Dr. Pasternak waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND
Delivered July 25, 2018
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. HARVEY STEPHEN PASTERNAK

Dr. Pasternak,

We, in the name of the profession and the public are shocked by the facts we heard today concerning your lack of proper and expected prescribing of controlled drugs to your patients.

You ought to have been aware that the prescribing of high doses of opioids and benzodiazepines requires careful and ongoing awareness of effectiveness, complications, and the risks of misuse. As well, there is an implicit expectation that you pay attention to the potential for adverse psychological and physical effects. You did not do so.

You brought patients and the community into the serious possibility of harm, and possibly contributed to the present opioid crisis by your lack of meeting professional standards.

Society cannot tolerate this type of practice as it not only endangers the public, but reflects on the reputation of the profession.

We are encouraged that you have made positive strides in correcting your deficiencies and we expect this process will emphasize your need to continue a high standard of practice.