

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Alexander Michael Alexander, 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. Alexander,  
2018 ONCPSD 60**

**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) of 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. ALEXANDER MICHAEL ALEXANDER**

**PANEL MEMBERS:**  
**MR. J. LANGS (CHAIR)**  
**DR. E. STANTON**  
**DR. P. POLDRE**  
**MR. M. KANJI**  
**DR. J. WATTERS**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:**

**MR. K. MAIJALA**

**COUNSEL FOR DR. ALEXANDER:**

**MS G. BURT**  
**MS C. WALDMAN**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MR. R. COSMAN**

**PUBLICATION BAN**

**Hearing Date:** September 25, 2018  
**Decision Date:** September 25, 2018  
**Release of Written Decision Date:** November 22, 2018

## **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 September 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. Alexander Michael Alexander committed an act of professional misconduct:

1. 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; and
2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Alexander 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 ALLEGATIONS**

Dr. Alexander admitted allegations 1 and 2 in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession, and that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the allegation of incompetence.

## **THE FACTS**

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

1. Dr. Alexander Michael Alexander is a 57-year-old general practitioner who received his certificate of registration authorizing independent practice in June 1988.
2. Throughout the relevant time, Dr. Alexander practised in Toronto, Ontario.

## **Background**

3. In 2013, Dr. Alexander underwent an assessment of his practice by a College-appointed assessor, Dr. Kimberly Wintemute. Dr. Wintemute's final report, dated September 30, 2013, is attached at Tab 1 [to the Agreed Statement of Facts and Admission]. It identified concerns with Dr. Alexander's practice, including his approach to chronic disease management, his conduct of physical examinations, his infection control techniques, his prescribing, his record-keeping, and his communication with consultants.
4. As a result of the assessment above, Dr. Alexander entered into an undertaking with the College on January 10, 2014, a copy of which is attached at Tab 2 [to the Agreed Statement of Facts and Admission]. By the terms of the Undertaking, Dr. Alexander agreed, among other things, to engage a supervisor acceptable to the College, to participate in and successfully complete an educational plan and any additional professional education recommended by his supervisor, and to undergo a practice reassessment within six months after the completion of the clinical supervision.
5. Dr. Alexander completed the clinical supervision as required by his undertaking.

**Dr. Alexander's Failure to Maintain the Standard of the Profession**

6. The College retained Dr. Susan Phillips to perform the reassessment of Dr. Alexander's practice required by his 2014 undertaking. Her review focused on care provided from April 2015 onwards, and involved review of fifteen patient charts and observation of professional encounters with six other patients.
7. As indicated in Dr. Phillips's report, received on January 19, 2017, Dr. Alexander failed to maintain the standard of practice of the profession. In reviewing Dr. Alexander's standard of practice, Dr. Phillips observed that Dr. Alexander:
  - Took limited patient histories;
  - Performed physical examinations that were not tailored to the patient's presenting problems and/or were performed incorrectly;
  - Did not consistently document physical examinations;
  - Performed assessments that were lacking;
  - Developed treatment plans that were lacking or absent;
  - Failed to take appropriate steps to manage infection control; and
  - Provided only monthly prescriptions to patients on chronic medication, requiring them to return frequently and unnecessarily to the office.
8. Dr. Phillips's report is attached at Tab 3 [to the Agreed Statement of Facts and Admission], together with a letter from a College Compliance Manager to Dr. Alexander's counsel dated January 25, 2017 providing a missing line on the last page of the report. Dr. Phillips's report forms part of this Agreed Statement of Facts and Admission, except that:
  - Dr. Alexander did not fail to maintain the standard of practice of the profession regarding patient X by failing to acknowledge a fracture shown by an x-ray, as the patient was being followed by an orthopedist and Dr. Alexander did not order the x-ray. Nor did he fail to maintain the standard of practice by referring the patient to a dermatologist for a diagnosis of vitiligo. However, Dr. Alexander otherwise failed to

maintain the standard of practice of the profession regarding patient X as described in Dr. Phillips's report.

- It should be clarified that Dr. Alexander did not fail to order an x-ray and ultrasound of the shoulder (and thereby fail to meet the standard of the profession), as he did do so. However, Dr. Alexander otherwise failed to maintain the standard of practice of the profession regarding patient Y as described in Dr. Phillips's report.

### **Disgraceful, Dishonourable or Unprofessional Conduct**

9. In the course of communicating with the College regarding the cases reviewed by Dr. Phillips, Dr. Alexander, through his counsel, forwarded to the College a copy of a patient agreement for opioid therapy pertaining to patient Q. Dr. Alexander's counsel advised that this agreement was signed in 2009. However, the agreement had a copyright date of 2011 on it from the pharmaceutical company and referred to the 2010 Canadian Guideline ("Guideline") for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.
10. The College obtained three complete patient charts in respect of patients Z, Q, and R, all of whose care was reviewed by Dr. Phillips. Despite the fact that all three agreements contained a 2011 copyright date and references to the Guideline, the agreement for opioid therapy for each of the three patients was dated before 2011, as follows: patient Z's agreement was dated November 21, 2009; patient R's agreement was dated February 27, 2008, and patient Q's agreement was dated April 11, 1996.
11. Dr. Alexander back-dated each of the three patient agreements for opioid therapy referred to above, which constituted disgraceful, dishonourable or unprofessional conduct. When he provided patient Q's agreement to the College with the assertion that it had been signed in 2009, when it was dated 1996 and signed at some time during or after 2011, it was misleading.
12. Dr. Alexander advised a College investigator that he could not identify when any of the agreements were signed, but that it would have been in or after 2011 and many years after

they were dated. Dr. Alexander further stated that he back dated the agreements to reflect approximately when he would have first started prescribing narcotics to the patient, and their initial dosage. He said that this is not his current practice, but represents something that he did in the past.

### **Admission**

13. Dr. Alexander admits the facts set out above, and admits that, based on these facts,
  - (a) he failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), and
  - (b) 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, contrary to paragraph 1(1)33 of O. Reg. 856/93.

### **FINDING**

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Alexander’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, and in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

### **AGREED STATEMENT OF FACTS REGARDING PENALTY**

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

### **Dr. Alexander's Discipline History**

1. Dr. Alexander Michael Alexander has been the subject of two prior findings by the Discipline Committee of the College.
2. In June 1991, the Discipline Committee found that Dr. Alexander engaged in disgraceful, dishonourable or unprofessional conduct by failing to report an incident of abuse to the Children's Aid Society. Dr. Alexander was reprimanded. A copy of the Decision and Reasons for Decision of the Discipline Committee is at Tab 1 [to the Agreed Statement of Facts Regarding Penalty].
3. In April 2012, the Discipline Committee found that Dr. Alexander failed to maintain the standard of practice of the profession in his care of twenty-eight patients. The Discipline Committee ordered that Dr. Alexander submit to an assessment of his practice and abide by the assessor's recommendations. It also ordered a reprimand and costs. A copy of the Decision and Reasons for Decision of the Discipline Committee is at Tab 2 [to the Agreed Statement of Facts Regarding Penalty].
4. The 2013 assessment of Dr. Alexander's practice by Dr. Kimberly Wintemute, found at Tab 1 to the Agreed Statement of Facts and Admission, was conducted pursuant to the Discipline Committee's 2012 order.

### **Dr. Alexander's Complaints Committee/Inquiries, Complaints and Reports Committee History**

5. In August 1995, the Complaints Committee required Dr. Alexander to attend in person for a caution regarding: the importance of proper wound management, including thorough cleansing, especially in animal bites where there is a high potential for infection; improper dosage of prescribed medication; the need for clear follow-up instructions; and, his basic knowledge of rabies management. The decision arose from a complaint about Dr. Alexander's care of a four-year old boy who had been bitten by a



dog. A copy of the August 1995 decision of the Complaints Committee is at Tab 3 [to the Agreed Statement of Facts Regarding Penalty].

6. In January 1999, the Complaints Committee cautioned Dr. Alexander to consider the utility of a cardiogram when investigating undiagnosed abdominal and arm pain. A copy of the Complaints Committee's January 1999 decision is at Tab 4 [to the Agreed Statement of Facts Regarding Penalty].
7. In April 2010, the Inquiries, Complaints and Reports Committee of the College (the "ICRC") required Dr. Alexander to attend in person for a caution regarding his premature destruction of patient records before the time period after which it is allowed by law. A copy of the ICRC's April 2010 decision is at Tab 5 [to the Agreed Statement of Facts Regarding Penalty].
8. In December 2014, the ICRC required Dr. Alexander to attend in person for a caution regarding filling out Special Diet Forms (and other medical forms) without proper investigation regarding the patient's eligibility for the benefit. A copy of the ICRC's December 2014 decision is at Tab 6 [to the Agreed Statement of Facts Regarding Penalty].

### **Interim Undertaking and Subsequent Clinical Supervision**

9. On May 24, 2017, Dr. Alexander entered into an interim undertaking, which was accepted by the ICRC in lieu of making an interim order under the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*. The undertaking has been in place pending the Discipline Committee's decision regarding the allegations against him, and is attached at Tab 7 [to the Agreed Statement of Facts Regarding Penalty]. Among other things, it has required that Dr. Alexander practise under the guidance of a clinical supervisor, who must meet with him weekly to review ten to fifteen patient charts and must also observe no fewer than ten of his patient encounters for no less than one-half day per month.

10. As a result of his interim undertaking, Dr. Alexander has been practising under the clinical supervision of Dr. James Kleiman. Dr. Kleiman has made numerous recommendations for practice improvement to Dr. Alexander. He has noted that Dr. Alexander has made improvements in many of the areas in issue. Dr. Kleiman continues to make recommendations in some of these areas. Dr. Kleiman's reports, received by the College under the terms of the interim undertaking, are attached at Tab 8 [to the Agreed Statement of Facts Regarding Penalty].

### **Dr. Alexander's Subsequent Education**

11. Dr. Alexander has completed the following education since the allegations of professional misconduct were referred to the Discipline Committee in 2017:
- (a) The University of Toronto Medical Record Keeping course, completed in June 2017. Dr. Alexander's certificate of completion for this course is attached at Tab 9 [to the Agreed Statement of Facts Regarding Penalty].
  - (b) The 48<sup>th</sup> Annual Winter Refresher Course for Family Medicine at the University of Wisconsin completed January 31-February 2, 2018. Dr. Alexander's certificate of completion for this course is attached at Tab 10 [to the Agreed Statement of Facts Regarding Penalty].
  - (c) The Endocrinology in Primary Care course offered by Medical Education Resources Inc., completed March 9-11, 2018. Dr. Alexander's certificate of completion for this course is attached at Tab 11 [to the Agreed Statement of Facts Regarding Penalty].

### **PENALTY AND REASONS FOR PENALTY**

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

The proposed order, which the Committee accepted, included the following:

- a suspension of Dr. Alexander's certificate of registration for six months, commencing November 1, 2018;
- the imposition of a number of terms, conditions and limitations on Dr. Alexander's certificate of registration as outlined in the order;
- a public reprimand; and
- a requirement that Dr. Alexander pay costs to the College, in the amount of \$6,000.00, within thirty (30) days of the date of the Order.

The Committee is aware that the Supreme Court of Canada in its decision in the case of *R. v. Anthony-Cook*, 43 SCC 2016 made it clear that a joint submission on penalty must be accepted, unless to do so would bring the administration of justice into disrepute, or would otherwise be contrary to the public interest.

The Committee's determination on penalty was based, first, on the guiding and most important principle of protection of the public. The Committee was also mindful that the penalty should serve as a general deterrent to the profession and a specific deterrent to the member, that it should express the profession's denunciation of the misconduct, be proportionate to the misconduct, uphold the integrity of the profession and maintain confidence in the College's ability to regulate the profession in the public interest, and where appropriate, rehabilitate the member.

The Committee accepts the general principle of fairness that like cases should be treated alike. In determination of the appropriate penalty, the Committee considered the specific facts of the case before it and the nature of the misconduct. The Committee recognized that it is not required to impose the "least restrictive" penalty (see *CPSO v. McIntyre* (2017)).

### **Case Law**

Counsel reviewed four prior decisions of the Discipline Committee. Three cases (*CPSO v. Fenton*, 2017 ONCPSD 16; *CPSO v. Kakar*, 2017 ONCPSD 8; and *CPSO v. Baranick*, 2017 ONCPSD 35) proceeded by an agreed statement of facts and a joint submission on penalty. The

penalty in those cases included a suspension, ranging from two to six months. The fourth case, *CPSO v. Kamermans* (2016) was a contested hearing. The Committee found that Dr. Kamermans failed to maintain the standard of practice of the profession and also found he was incompetent. Dr. Kamerman's certificate of registration was revoked. An important distinguishing feature in Dr. Kamermans' case was that Dr. Kamermans lacked insight into his issues and displayed a rigidity of thinking that made him not amenable to remediation.

While the Committee appreciates that prior decisions of the Discipline Committee may be of assistance in its determination of an appropriate penalty, the Committee is not bound by those decisions. Each case before it is unique and the Committee must carefully consider the specific facts of the case, the nature of the misconduct, as well as any mitigating and aggravating factors. While the previous decisions are not directly comparable, the Committee accepted the joint submission and found that the proposed penalty was appropriate, fair, proportionate and just.

### **Analysis**

In considering the appropriateness of the proposed penalty, the Committee took into consideration the following aggravating and mitigating factors.

### ***Aggravating Factors***

The professional misconduct was serious.

Dr. Alexander backdating of narcotic contracts and misleading College investigators is a serious act of professional misconduct.

The medical care concerns involved numerous patients and Dr. Alexander's deficiencies spanned a number of areas, including his treatment of chronic diseases, medical record keeping, physical examination, developing treatment plans and prescribing, all of which failed to maintain the standard of practice of the profession.

Dr. Alexander has a previous history with the College dating back to 1991:

- At his first discipline hearing in 1991 it was found that he failed to report an incident of child abuse to the Children's Aid Society.
- In his 2012 appearance before the Discipline Committee, Dr. Alexander was found to have failed to maintain the standard of practice of the profession in his medical record keeping practices, management of diabetes, the management of a patient with presumed coronary artery disease, the follow-up of an abnormal echocardiogram, his approach to narcotic patients and lack of knowledge of the investigation and management for H. Pylori. When Dr. Alexander's practice was reassessed pursuant to the 2012 Discipline Committee Order, the assessor identified practice deficiencies that were similar to those identified at the 2012 hearing. Further, many of the deficiencies noted in the 2012 hearing and decision of the Discipline Committee were noted in the current case.
- There have been four complaints to the College between 1995 and 2014. In 1999, the then Complaints Committee cautioned Dr. Alexander in writing. On three other occasions in 2010, 2014 and 2017, Dr. Alexander was required to appear before the ICRC for a verbal caution.

Dr. Alexander failed to remediate, despite having been made previously aware of his deficiencies during his various attendances with the College.

### ***Mitigating Factors***

Dr. Alexander admitted that he has failed to maintain the standard of practice of the profession, which reduced the cost and time of a contested hearing, including the need to call witnesses.

With the exception of providing misleading information in regard to backdating narcotics contracts, which he was later forthright in admitting, Dr. Alexander cooperated with the College;

Dr. Alexander acknowledged the serious deficiencies in his clinical practice and took voluntarily steps to remediate, which included completing three courses that focused on deficiencies identified in his practice;

Dr. Alexander, in lieu of an order under section 37 of the Code, voluntarily entered into an undertaking dated May 14, 2017, to practise only under the guidance of a clinical supervisor. Although his Clinical Supervisor, Dr. Kleiman, continues to make recommendations in regard to Dr. Alexander's clinical practice, he has indicated that Dr. Alexander has made improvements in many areas of concern.

The Committee concluded that the jointly proposed penalty satisfied all of the guiding principles to be considered in the determination of an appropriate penalty.

The paramount responsibility of the College is to protect the public interest. The College does so by ensuring that physicians maintain the standard of practice of the profession. The jointly proposed order demonstrates to the public that the Committee takes its responsibility of regulating the profession in the public interest very seriously, by disciplining members who transgress those standards.

Dr. Phillips' report of her reassessment of Dr. Alexander's clinical practice on December 9, 2016 indicated that Dr. Alexander did not maintain the standard of practice of the profession in 13 out of 15 charts reviewed. Dr. Alexander was found to have demonstrated a lack of knowledge in 10 out of 15 charts, a lack of skill in 14 out of 15 charts and a lack of judgment in 14 out of 15 charts.

The deficiencies noted in Dr. Phillips' report were not isolated to one aspect of Dr. Alexander's clinical practice. Dr. Phillips highlighted a number of areas of concern including: a lack of knowledge in regard to the proper care of patients with diabetes; laboratory reports not being acknowledged or addressed in a timely fashion; deficiencies in prescribing; a lack of skill in charting patient encounters; a lack of knowledge in the examination of the musculo-skeletal system; the assessment and management of epigastric pain; and in regard to obesity and physical

abuse, the ordering of unnecessary and extensive bloodwork; a lack of judgment in prescribing, including the prescribing of narcotics, treatment plans which were inadequate or absent; failure to take appropriate steps to manage infection control and deficiencies in clinical reasoning.

While the Committee noted that Dr. Phillips' report indicates that there was no apparent immediate harm or injury to patients arising from Dr. Alexander's deficiencies in his clinical practice, she noted in her report that there was a possibility of long-term harm to patients.

Having current knowledge and skill is a fundamental commitment that physicians must make to their patients. Dr. Alexander has been made aware of the deficiencies in his clinical practice for a number of years. Many of the deficiencies, which were noted in Dr. Wintemute's 2013 reassessment report, were also noted in Dr. Phillips' December 9, 2016 reassessment report.

Over the years, Dr. Alexander has been given more than one opportunity to remediate his deficiencies which included individualized education plans and periods of clinical supervision. The Committee notes based upon a letter of reference submitted by Dr. Ivan Petrov on Dr. Alexander's behalf that beginning in 2010, Dr. Alexander was registered as a member of a McMaster problem based small group learning program (PBSG) facilitated by Dr. Petrov. It is a concern to the Committee that despite Dr. Alexander having been given opportunities to remediate and despite having participated in a PBSG, many deficiencies in his clinical practice were noted in 2016.

However, the Committee also considered that, following Dr. Phillips' reassessment report, Dr. Alexander signed an undertaking dated May 24, 2017 that required him to practise under the guidance of a clinical supervisor. Dr. Kleiman, has served as Dr. Alexander's clinical supervisor since July 8, 2017. Dr. Kleiman's most recent report is dated September 8, 2018. While Dr. Kleiman's report indicated that Dr. Alexander continues to make recommendations for improvement in Dr. Alexander's clinical practice, Dr. Kleiman has noted that Dr. Alexander's clinical notes and his management of chronic medical conditions has improved. It is also noted that Dr. Alexander has maintained the improvements noted previously in his clinical skills, history taking, clinical examination, assessment, differential diagnosis, and choices regarding investigation, and treatment plans.

While the Committee accepts that Dr. Alexander has made improvements in his knowledge and clinical skills under the supervision of Dr. Kleiman, the Committee recognized that unlike a lack of knowledge or skill, a lack of judgment in a physician is much more difficult to remediate. Despite having demonstrated some insight by acknowledging his misconduct and engaging in additional remediation, the Committee took into account that this is not Dr. Alexander's first appearance before the Discipline Committee. Dr. Alexander had been previously found by the Discipline Committee to have failed to maintain the standard of practice of the profession. The practice deficiencies found in the 2012 Discipline Committee's decision are strikingly similar to the deficiencies found in this case. It is of particular concern to the Committee that Dr. Alexander's past remedial efforts failed to address many of his previously identified deficiencies.

The six month suspension of Dr. Alexander's certificate of registration will serve to achieve both specific and general deterrence, by sending an unequivocal message to Dr. Alexander and the profession that failing to maintain the standard of practice of the profession is unacceptable and will not be tolerated. The suspension will also serve to maintain public confidence in the profession by demonstrating that the College takes seriously its responsibility to protect the public and will take action to ensure that physicians are maintaining the standard of practice of the profession.

An important element of the penalty order is that Dr. Alexander is required to practise under the guidance of a clinical supervisor for an additional twelve months following his suspension. The supervision will begin at a moderate level for at least three months, and involve weekly meetings with the supervisor, to include a review of 10-15 patient charts selected by the supervisor on the basis of the areas of concern identified in the report of Dr. Phillips. In addition, the Clinical Supervisor will observe 10 of Dr. Alexander's patient encounters per month for no less than one half day. Approximately six months after completing the clinical supervision, there will be a reassessment of Dr. Alexander's clinical practice by a College appointed Assessor. The reassessment will allow the College to verify that Dr. Alexander's remediation efforts have been successful and that the concerns identified have been resolved through clinical supervision of his practice. In addition to clinical supervision of his practice, Dr. Alexander will be required to successfully complete all aspects of an Individualized Education Plan that will continue to focus



on his clinical deficiencies. The Committee was re-assured that these two important elements of the Order - the requirement for clinical supervision and practice re-assessment- will serve to protect the public in the circumstances of this case.

Another important element of the order is that Dr. Alexander is required to practise only in a practice setting that has been approved by the College and that Dr. Alexander shall engage in professional encounters with no more than eight patients every two hours. In addition, he will engage in patient encounters for no more than seven hours a day for no more than five days a week, plus one additional day per week every other week.

The Committee is satisfied that the terms, conditions and limitations placed upon Dr. Alexander's certificate of registration serve the purpose of rehabilitation, and serve to protect the public, by ensuring that the necessary improvements in his clinical practice have been achieved and maintained and that the care that Dr. Alexander provides to patients maintains the standard of practice of the profession.

Integrity is a central pillar of the profession. Dr. Alexander demonstrated a lack of integrity. Dr. Alexander backdated narcotic contracts in the medical records of some of his patients and as a result, provided misleading information to the College. The information contained in a medical record must accurately reflect each patient encounter. Misleading the College is a serious act of professional misconduct which undermines the functioning of the College in its mandate to protect the public. Such behaviour is not consistent with proper professional behaviour, will not be condoned by the public or the profession, and warrants a significant sanction. In addition to the lengthy suspension and a reprimand, Dr. Alexander is required to complete an individualized medical ethics course. The public reprimand will express the abhorrence of the profession for Dr. Alexander's professional misconduct.

## **Conclusion**

The Committee has found that Dr. Alexander failed to maintain the standard of the profession and by misleading the College engaged in an act or omission relevant to the practice of medicine

that having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or profession. After considering the aggravating and mitigating factors, as well as the breadth and seriousness of the misconduct found to have taken place, the Committee accepted the joint submission of the parties on penalty. The Committee recognizes that the penalty constitutes a sizeable commitment on Dr. Alexander's part in regard to remediation, but anything less would leave the public at risk. The message to the profession and the public must be clear that such misconduct will not be tolerated and that serious consequences will follow a serious finding of professional misconduct.

Finally, while Dr. Alexander appears to have taken positive steps in regard to his remediation as documented in Dr. Kleiman's recent report, Dr. Alexander needs to exert diligence in making the additional improvements in his practice that are recommended by the Clinical Supervisor, demonstrate that the improvements are sustained and that he is maintaining the standard of practice of the profession.

### **Costs**

The Committee has the jurisdiction to award costs as outlined in s. 53.1 of the Code "in an appropriate case" and in a fair and reasonable amount. The Committee considers this to be such a case. The current daily tariff rate for a one-day hearing is \$10,180.00. The Committee accepted the joint submission that Dr. Alexander pay costs to the College in the amount of \$6,000.00 which represents the half day required for the hearing, as well the time required for the Committee to review the documents filed by the parties prior to the hearing.

### **ORDER**

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

2. the Registrar suspend Dr. Alexander's certificate of registration for a period of six (6) months, commencing at 12:01 a.m. on November 1, 2018.

3. Dr. Alexander appear before the panel to be reprimanded.
4. the Registrar to place the following terms, conditions and limitations on Dr. Alexander's certificate of registration:

**Public Protection Prior to Suspension and Remediation**

- (a) Until the commencement of the period of suspension of his certificate of registration set out above, Dr. Alexander shall continue to be bound by the terms of the undertaking into which he entered on May 24, 2017;

**Professional Education and Clinical Supervision**

- (b) Dr. Alexander shall participate in and successfully complete all aspects of the Individualized Education Plan ("IEP") attached to the Order as Schedule "A," including all of the following professional education:
  - (i) Within six (6) months of the date of this Order, Dr. Alexander shall complete individualized instruction in medical ethics satisfactory to the College, with an instructor approved by the College. The instructor shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Alexander;
  - (ii) The period of Clinical Supervision described below at paragraph (c); and
  - (iii) Any additional professional education recommended by his Clinical Supervisor (defined below).
- (c) For a period of twelve (12) months commencing on the date that he resumes practice following the suspension of his certificate of registration described above in paragraph 2, Dr. Alexander may practice only under the guidance of a clinical supervisor or clinical supervisors (the "Clinical Supervisor") acceptable to the College, who has executed an undertaking in the form attached to the Order as Schedule "B." Dr. Alexander shall successfully complete his IEP under the guidance of his Clinical Supervisor. Dr. Alexander shall cooperate fully with the Clinical Supervision of his practice, which shall contain the following elements:

- (i) Dr. Alexander shall meet with his Clinical Supervisor at his Practice Location, or another location approved by the College, once every week for at least three (3) months. Thereafter, if recommended by the Clinical Supervisor and approved by the College, they may meet every two (2) weeks.
- (ii) At every meeting, Dr. Alexander and his Clinical Supervisor shall review ten to fifteen (10-15) of his patient charts, which shall be selected by the Clinical Supervisor independently of Dr. Alexander's participation, on the basis of areas of concern identified in the assessor's report(s) received on January 19, 2017, the Discipline Committee's decision and reasons for decision in this matter, as well as any concerns that may arise during the period of Clinical Supervision or that have arisen during the prior period of Clinical Supervision under Dr. Alexander's interim undertaking entered into on May 24, 2017;
- (iii) Once a month, the Clinical Supervisor shall observe no fewer than ten (10) of Dr. Alexander's patient encounters, for no less than one-half (1/2) a day;
- (iv) The Clinical Supervisor shall discuss with Dr. Alexander any concerns arising from the observation of patient encounters and review of patient records, as well as provide recommendations to him, if any;
- (v) The Clinical Supervisor may perform any other duties, such as reviewing other documents or conducting interviews with staff, colleagues, or patients, that the Clinical Supervisor deems necessary to the Clinical Supervision;
- (vi) The Clinical Supervisor shall submit written reports to the College at least once every month, or more frequently if the Clinical Supervisor has concerns about Dr. Alexander's standard of practice; and
- (vii) Dr. Alexander shall abide by the recommendations of his Clinical Supervisor, including but not limited to any recommended practice improvements and ongoing professional development;

- (d) If a Clinical Supervisor is unable or unwilling to continue to fulfill the terms of the Clinical Supervisor's undertaking as set out in Appendix "A" to the Order, Dr. Alexander shall, within twenty (20) days of receiving notice of the same, deliver to the College an executed undertaking in the same form from a person who is acceptable to the College;
- (e) If Dr. Alexander is unable to obtain a Clinical Supervisor in accordance with this Order, he shall cease to practise medicine until such time as he has done so, and the fact that he has ceased to practise medicine will be a term, condition, and limitation on his certificate of registration;
- (f) Dr. Alexander shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and Dr. Alexander's compliance with this Order, as well as the monitoring thereof;

**Practice Reassessment**

- (g) Approximately six (6) months after completion of the period of Clinical Supervision set out above, Dr. Alexander shall undergo a reassessment of his practice by a College-appointed assessor or assessors (the "Assessor"). The reassessment shall include direct observation by the Assessor of Dr. Alexander's patient encounters. The Assessor shall report the results of the reassessment to the College;
- (h) Dr. Alexander shall consent to the disclosure to the Assessor of the reports of the Clinical Supervisor, and shall consent to the sharing of all information between the Clinical Supervisor, the Assessor, and the College, as the College deems necessary or desirable;

**Practice Restrictions**

- (i) Dr. Alexander shall practice only in a practice setting that has been approved by the College;

- (j) Dr. Alexander shall engage in professional encounters with no more than eight (8) patients every two (2) hours.
- (k) Dr. Alexander shall engage in professional encounters with patients for no more than seven (7) hours per day;
- (l) Dr. Alexander may engage in professional encounters with patients five (5) days per week, and one (1) additional day every second week;

**Monitoring of Compliance**

- (m) Dr. Alexander shall cooperate with unannounced inspections of his practice and shall consent to monitoring by a College representative(s) of claims that he submits to the Ontario Health Insurance Plan (“OHIP”), for the purpose of monitoring and enforcing his compliance with the terms of this Order;
- (n) Dr. Alexander shall keep a log of all patient encounters, in the form set out at Schedule “C,” which will include at least the following information:
  - (i) the date of the patient encounter, including the day of the week;
  - (ii) the name of the patient with the chart/file number, if any;
  - (iii) the start time of the patient encounter;
  - (iv) the end time of the patient encounter; and
  - (v) Dr. Alexander’s initials.
- (o) Dr. Alexander shall submit the original log of patient encounters to the College on a monthly basis, and shall maintain his own copy of the log of patient encounters at all times, making it available to the College upon request;

**Other**

- (p) Dr. Alexander shall be responsible for any and all costs associated with implementing this Order.

5. Dr. Alexander pay the College its costs of this proceeding in the amount of \$6,000 within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Alexander 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 September 25, 2018**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. ALEXANDER MICHAEL ALEXANDER**

Dr. Alexander,

You received your certificate of independent practice in 1988 and within three years the Discipline Committee found you to have engaged in disgraceful, dishonourable or unprofessional conduct. Your negative interaction with the College since that time has continued to recur to the present time including another prior discipline hearing and complaints before the Investigation, Complaints and Reports Committee of the College. This is an appalling record. The profession, the public and your patients expect and deserve more. Your conduct is inexcusable.

What further aggravates the situation is the back dating of your narcotics contracts. Integrity is a central pillar of your profession and by misleading the College you have demonstrated a lack of integrity that cannot be countenanced.

The panel has accepted an agreed submission on penalty, that is intended to address the many short comings that you have previously failed to remediate through prior undertakings.

We urge you to take full advantage of the terms of the order including the supervision requirements to bring your practice to an acceptable level. Your patients deserve nothing less. An important element of this penalty is a lengthy suspension. It is our expectation that you have finally learned from this process and you will never appear before this Committee again.