NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. William Andrew Roy, 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. Roy, 2018 ONCPSD 66

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. WILLIAM ANDREW ROY

PANEL MEMBERS: **DR. P. CHART (CHAIR)**
MAJOR A.H. KHALIFA
DR. I. ACKERMAN
MR. J. LANGS
DR. S. WOODER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS A. CRANKER

COUNSEL FOR DR. ROY:

MR. M. VENEZIANO

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

PUBLICATION BAN

Hearing Date: **September 27, 2018**
Decision Date: **September 27, 2018**
Written Decision Date: **November 27, 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 27, 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. The Order set out the Committee's penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. William Andrew Roy 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 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.

RESPONSE TO THE ALLEGATIONS

Dr. Roy admitted the allegation in the Notice of Hearing, 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 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:

PART I —FACTS

Background

1. Dr. Roy is a 73-year-old General Practitioner, practising in Toronto. Dr. Roy obtained his Independent Practice Certificate in 1971.

2. The College of Physicians and Surgeons of Ontario (College) received information from the Narcotics Monitoring System (NMS) identifying Dr. Roy as having prescribed, in 2015, eight or more patients at least 650 oral morphine equivalents (OMEs) per day and issued at least one prescription exceeding 20,000 OMEs. This prescribing exceeds the recommended watchful dose of 200 OMEs per day as set out in The Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (v 5.6, April 30, 2010).

3. In total, 19 patients were flagged by the NMS.

4. Dr. Karen Ferguson, a family physician certified by the College of Family Physicians of Canada (CFPC) was retained by the College to review this matter. Dr. Ferguson, in her report, attached at Tab 1 to the Agreed Statement of Facts and Admission, concluded that Dr. Roy failed to meet the standard of practice of the profession in 13 of the 20 charts reviewed. She concluded:

    - the main areas of concern are his prescriptions for very high doses of opioids, often in combination with high doses of benzodiazepines, poor record keeping with respect to opioid prescribing, and lack of monitoring of patients with prescriptions for high doses of opioids.

    - Dr. Roy "displayed a lack of knowledge in 2 charts" as evident in situations where he indicated that he prescribed two different long-acting opioids as one did not appear to

be effective, and where a patient was currently using intravenous street drugs but he felt that the patient would still require prescription opioids for his pain.

- displayed "a lack of skill in 5 charts" as evident by his management of patients who demonstrated inappropriate behaviour or features of misuse.

- displayed "a lack of judgment in 10 of the charts reviewed", which was evident in the management of patients who were prescribed high doses of opioids and benzodiazepines without adequate monitoring for safety and effectiveness.

5. Dr. Ferguson concluded that in 7 of the 20 charts reviewed, Dr. Roy exposed patients to a potential risk of harm. The risk of harm was due to the extremely high doses of opioids that were prescribed in combination with high doses of benzodiazepines and not monitoring the patients closely enough to ensure that they were taking the medications safely.

June 2017 Undertaking

6. As a resolution to the above described investigation, Dr. Roy entered into an undertaking with the College in June of 2017, attached at Tab 2 to the Agreed Statement of Facts and Admission, requiring, amongst other things, that Dr. Roy practise under the guidance of a clinical supervisor acceptable to the College. If unable to obtain a clinical supervisor, Dr. Roy is required to cease to prescribe narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and all other monitored drugs.

7. Dr. Roy obtained a clinical supervisor, Dr. T. Libby, on July 19, 2017. A potential conflict of interest arose and accordingly on August 29, 2017, Dr. Roy was notified that Dr. Libby was no longer a suitable clinical supervisor. Dr. Roy was provided with fourteen days to obtain a new clinical supervisor.

8. Dr. Roy did not propose a suitable supervisor within the time limit set out in the undertaking. Dr. Roy was reminded on September 12, 2017, that, in accordance with the

terms of the undertaking, he would have to cease prescribing by the end of the day unless a supervisor was proposed and approved. An extension was provided until September 15, 2017 after a request was made by counsel for Dr. Roy.

9. Dr. Roy was unable to find a suitable clinical supervisor by the extended deadline. In accordance with the terms of the undertaking, and the terms, conditions and limitations on his certificate of registration effective September 19, 2017, Dr. Roy was required to cease prescribing narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and all other monitored drugs until such time as he has obtained a clinical supervisor acceptable to the College. This restriction appeared on the public register.

10. On October 13, 2017, Dr. Erica Weinberg was approved to be Dr. Roy's clinical supervisor. On October 18, 2017, Dr. Weinberg wrote to the College. She noted that she had met with Dr. Roy for an initial meeting earlier that day and that Dr. Roy had stated, during the meeting, that he had continued to prescribe controlled substances during the period of time when he did not have a supervisor.

11. The Compliance Case Managers selected 13 patient names from Dr. Roy's prescribing log and obtained copies of the prescriptions and physician's notes from the corresponding charts. NMS data, attached at Tab 3 to the Agreed Statement of Facts and Admission, was obtained with respect to the 13 patients. The data demonstrates that Dr. Roy continued to prescribe monitored drugs between the period of September 19, 2017 and October 18, 2017.

PART II —ADMISSION

12. Dr. Roy admits the facts above and admits that the above conduct described in paragraphs 6-11 constitutes professional misconduct, in that he 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, dishonorable, or unprofessional, contrary to paragraph 1(1)33 of Ontario Regulation 856/93 made under the Medicine Act, 1991.

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. Roy's admission and found that he committed an act of professional misconduct, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

PENALTY AND REASONS FOR PENALTY

Parties' Submissions

Counsel for the College and counsel for Dr. Roy agreed that an appropriate penalty should incorporate a reprimand, individualized ethics education and an order for the costs of a one-day hearing. They also agreed that a suspension should be included in the penalty, but differed on the length of the suspension and date of onset of the suspension, with the College proposing a three-month suspension starting immediately and counsel for Dr. Roy proposing a one-month suspension starting in two weeks. At the hearing, College counsel agreed to a two week delay in the commencement of the suspension in order for Dr. Roy to manage his practice.

The Committee accepted as appropriate the elements of the penalty which were agreed to by the parties. After considering the submissions of counsel, aggravating and mitigating factors and the case law cited, the Committee determined that a three-month suspension was appropriate in this matter.

Analysis

In making its decision on penalty, the Committee considered the well-established penalty principles which guide the determination of an appropriate sanction. Foremost is protection of the public. In this matter, denunciation of the misconduct, specific and general deterrence, maintaining public confidence in the profession and the College's ability to regulate the profession effectively in the public interest, as well as rehabilitation of the member, are all relevant.

In addition the Committee considered the following.

Nature and Context of the Misconduct

The Committee considered failure to comply with an undertaking made to the College to be a very serious act of professional misconduct, in that such failure has the potential to undermine the public's confidence in the College's ability to govern the profession in the public interest. Compliance with an undertaking made by a member to the College is crucial and of paramount importance in the regulation of the profession in the public interest.

Dr. Roy understood the undertaking he signed and intentionally breached the conditions set in place to protect the public. The undertaking was put in place because of concerns that Dr. Roy not only failed to adhere to accepted narcotic prescribing guidelines, but prescribed high doses of narcotics mixed with other drugs. Dr. Roy did not carefully monitor his patients and his prescribing patterns made drug diversion possible.

The Committee is aware of the current opioid crisis in the community and the major threat it poses to the public. Physicians must not contribute to this health crisis. In this case, Dr. Roy not only breached the June 2017 Undertaking, the number and doses of opioids he prescribed in the short period of time of his breach was shocking and could potentially pose a public safety concern if drugs were diverted. In the Committee's view, such misconduct requires a significant period of suspension.

Aggravating Factors

The Committee noted the following aggravating factors in this case:

1. The June 2017 Undertaking, which Dr. Roy signed and subsequently breached, was clear and unambiguous. There is no suggestion that Dr. Roy was confused or had an honest but mistaken understanding of his obligations;

2. Due to the College's significant concerns regarding safety, the level of oversight and monitoring outlined in the June 2017 Undertaking which Dr. Roy breached was high. There were a number of safety concerns giving rise to the June 2017 Undertaking, including repeated prescriptions of very high doses of narcotics and benzodiazapines without appropriate monitoring. which is posed significant risk of harm to patients and the general public;

3. Despite its short duration of only three (3) weeks, numerous prescriptions of high doses of opioids were written during the time Dr. Roy was in breach of his Undertaking thus exposing his patients and the public to a significant potential for harm.

Mitigating Factors

Dr. Roy has agreed to cease prescribing opioids, which will ensure that there will be no risk to his patients and the general public in the future regarding his prescription of opioids. Dr. Roy admitted to the allegation of professional misconduct and in doing so, saved the time and expense of a contested hearing. This is also Dr. Roy's first appearance before the Discipline Committee.

Case Law

Previous cases involving a breach of the undertaking to the College were provided by both counsel.

In *CPSO v. Yu*, 2017 ONCPSD 54, the misconduct involved a breach of an undertaking whereby Dr. Yu renewed drug prescriptions for controlled substances on three separate occasions after he had entered into an undertaking with the College to abide by modified prescription privileges. In that case, the renewals were inadvertent (unlike the present case), although in that case Dr. Yu had breached an undertaking before. The Committee ordered a three-month suspension of Dr. Yu's certificate of registration.

CPSO v. Maytham, 2011 ONCPSD 18 also involved a breach of an undertaking with respect to controlled drug prescription restrictions. Dr. Maytham had been before the Discipline Committee on two previous occasions, however, the breach of the undertaking in 2007 was due solely to failure to log his prescriptions in the narcotics register as required. Thus, as in the *Yu* case, there was a discipline history not present in this case, but the nature of the breach was also not as serious as in the present case. A suspension of four months was ordered.

In *CPSO v. Attuah*, 2013 ONCPSD 30, the physician's repeated breach of an undertaking involved failure of the physician to comply with the requirement to limit his scope of practice to his own specialty, to limit his patient volume and to be monitored monthly. Dr. Attuah had no discipline history. A three-month suspension was ordered.

Dr. Roy's counsel submitted four cases dealing with physicians repeated breach of undertakings: *CPSO v. Egles*, 2015 ONCPSD 18, *CPSO v. Yu*, 2017 ONCPSD 54, *CPSO v. Carroll*, 2009 ONCPSD 5, and *CPSO v. Rosenhek*, 2017 ONCPSD 51. The penalties ordered in those cases included a suspension of the physician's certificate of registration from one and four months. Dr. Roy's counsel submitted that in order for there to be a suspension of more than one month, the member would have to have acted in a cavalier manner, have entered into an undertaking that was a sham, or there would have to be multiple breaches of and undertaking or order, or there would have to be multiple attendances before the Discipline Committee. Because this is the first and only breach on Dr. Roy's part and there was no discipline history, counsel for Dr. Roy submitted that Dr. Roy's certificate of registration should be suspended for one month only.

Length of Suspension

The Committee found that a three-month suspension of Dr. Roy's certificate of registration is appropriate in this case and falls within the range of suspensions ordered in other similar cases presented to the Committee. The Committee did not accept the submission that as this was Dr. Roy's one and only breach, a one-month suspension was fair and reasonable. The Committee found that a one-month suspension did not reflect the seriousness of the misconduct, not only because there was a breach of the Undertaking, but also because of the serious concerns about risk to his patients and the general public which underlay the need for the undertaking, as well as his opioid prescribing in the brief time of his breach. As such, the Committee found that a one-month penalty was insufficient to act as a specific deterrent to Dr. Roy or a general deterrent to other members of the medical profession in the circumstances of this case.

In the current environment and in light of the previous cases reviewed, the Committee found a three-month suspension is appropriate and just and serves the interest of public protection.

Costs

The Committee concluded that this was an appropriate case for Dr. Roy to pay to the College the costs of a one-day hearing at the tariff rate.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of September 27, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. the Registrar suspend Dr. Roy's certificate of registration for a period of three (3) months, commencing October 15, 2018.

3. Dr. Roy appear before the panel to be reprimanded.

4. Dr. Roy 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.

5. Dr. Roy participate in and successfully complete one-on-one individualized educational instruction in ethics with an instructor approved by the College, and provide proof thereof to the College within six (6) months of the date of this Order.

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