

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Alexander Milton Haines, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity or any information that could disclose the identity of the 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 or 47... 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: Haines, A. M. (Re)

**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 MILTON HAINES

PANEL MEMBERS:

DR. E. STANTON (CHAIR)
S. BERI
DR. P. CHART
DR. E. ATTIA (Ph.D.)
DR. H. SCULLY

Hearing Date:	July 25, 2014
Decision Date:	July 25, 2014
Release of Written Reasons:	August 29, 2014

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, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Haines committed an act of professional misconduct:

1. 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.

It is also alleged that Dr. Haines is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the Regulated Health Professions Act, 1991, (“the Code”).

RESPONSE TO THE ALLEGATIONS

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

FACTS AND EVIDENCE

The following facts were set out in an Agreed Statement of Facts that was filed as an exhibit and presented to the Committee:

PART I – THE FACTS

1. Dr. Alexander Milton Haines is a general practitioner in City 1, Ontario. He obtained his certificate of registration in 1989.

2. The College began an investigation into Dr. Haines's practice following the receipt of information from the Office of the Chief Coroner for Ontario regarding the death of one of his patients. The cause of the patient's death was determined to be Oxycodone toxicity.
3. As part of its investigation, the College retained medical inspector Dr. X. Dr. X is a family doctor who graduated from the University of Toronto medical school in 1975. Dr. X is also a Certificant and a Fellow of The College of Family Physicians of Canada (CCFP) Dr. X has been in active family practice since 1977 in both small town and city locations in Ontario as well as overseas. Included in Dr. X's practice are patients who are treated with opiates for chronic non-cancer pain. During the 1990s Dr. X held a licence to prescribe methadone and treated opiate-addicted patients.
4. As part of the College's investigation, Dr. X reviewed the charts of 25 of Dr. Haines's patients. The patients whose charts were reviewed had all been treated with pain control medications for chronic pain due to various causes and clinical backgrounds. As a result of this chart review, Dr. X provided two reports to the College, dated June 4, 2013 and June 28, 2013, respectively. These reports are attached to this Agreed Statement of Facts at Tabs 1 and 2.
5. In his first report, Dr. X noted that Dr. Haines's charts were generally clear to read, organized and reflected genuine concern by Dr. Haines for his patients. Dr. X wrote the following: "They were seen regularly, had investigations, consultations and support from him for their personal issues". Nonetheless, Dr. X opined that certain concerning issues recurred a number of times in Dr. Haines's practice. The areas of concern identified by Dr. X were as follows:
 1. There were on going prescriptions for opiates and benzodiazepines in patients a) with substance abuse problems as proven by urine drug testing; or b) with written concerns by other doctors who saw these patients and advised that prescribing such medications was likely causing problems for the patients. The office records did not address such concerns.

2. Combining high dose opiates and benzodiazepines. This combination is known to be a factor in opiate related deaths.
 3. Prescribing multiple opiates and multiple benzodiazepines simultaneously. This increases the risk of adverse effects without potential benefit.
 4. Two patients were given on-going prescriptions for opiates without any office assessment for over a year.
 5. Many patients had blood cholesterol testing, however Dr. X did not find any chart using the cholesterol results to calculate the patient's heart risk – the "Framingham risk score". Such a risk calculation is needed to establish the need for medication and treatment goals. Similarly, two patients with heart disease had cholesterol (LDL) levels above target.
 6. There was a lack of screening for colon cancer. Many patients came in for an Annual Health Exam and some had colonoscopy exams. Dr. X did not find any home kit Fecal Occult Blood Testing results. The standard of care in Ontario now is to utilize this test widely in patients over 50.
6. With respect to the specific patient who was the subject of the coroner's report, Dr. X opined:
- "Does not meet standard of care. Urine screens indicate active substance abuse problem at least during 2009-2011. Pharmacy records in early 2010 indicate regular Rx's for Oxycontin 40 mg TID, Percocet 140 tabs /month and Diazepam 10 mg at night. I believe this indicates a lack of skill and knowledge and is probably a danger to safety in combining benzodiazepines with moderately high opiate dosing (equivalent to 210 mg morphine/day) in patient who could unpredictably take other illicit drugs and who has shown significant impulsivity in overdosing."
7. Subsequent to Dr. X's initial review of the 25 patient charts, Dr. Haines submitted to the College updated current information from seven of the 25 charts. Dr. X found the following:
- "These updates showed systematic tapering of opiate doses, better assessment and documentation utilizing such practice tools as the Brief Pain Inventory and the Opiate Risk Score as well as more urine drug screening. This reflects much improved knowledge and skill in treating Chronic Non Cancer Pain."

8. Dr. X also interviewed Dr. Haines in June 2013. Dr. Haines told Dr. X at the interview that his answers reflected new changes in his approach and prescribing to patients with chronic non-cancer pain. Dr. X concluded from the interview that Dr. Haines answered his questions well, demonstrating a good current knowledge base.

Standard of Care

9. Overall, Dr. X concluded that of the 25 charts reviewed, the care provided in 16 did not meet the standard of practice of the profession. Dr. X's interview of Dr. Haines did not change this initial opinion.

Lack of Knowledge, Skill or Judgment

10. Dr. X concluded in his initial report that of the 25 charts reviewed, Dr. Haines's care in 7 of the charts demonstrated a lack of knowledge, skill or judgment, while a possible lack of knowledge, skill or judgement was demonstrated in 9 others.

Exposure of Patients to Likely Harm or Injury

11. Dr. X concluded in his initial report that of the 25 charts reviewed, Dr. Haines's care in 10 of the charts exposed patients to potential harm or injury, ranging from mild or minimal danger to serious safety concerns.

Interim Supervision Undertaking

12. On August 21, 2013, the Inquiries, Complaints and Reports Committee referred specified allegations pertaining to Dr. Haines to the Discipline Committee. Dr. Haines entered into an undertaking dated September 25, 2013, in response to the College's concern to protect the public. A copy of this undertaking is attached at Tab 3.
13. Further to the undertaking, Dr. Haines was required, pending the Discipline hearing, to practice under the guidance of a clinical supervisor acceptable to the College and to keep a log of all prescriptions for Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances.

14. Dr. Haines retained Dr. Y (“Dr. Y”), a pain clinic physician and certified intensivist, to act as his clinical supervisor. Once a month Dr. Y reviews ten (10) of Dr. Haines’s patient charts relating to his prescribing of narcotics and meets with Dr. Haines to discuss the charts, among other things.
15. Dr. Y has consistently indicated in his monthly reports to the College that he has identified no material deficiencies with respect to Dr. Haines’s standard of practice. Attached at Tab 4 are Dr. Y’s reports dated November 2013, December 2013, January 2014 and February 2014.

Remediation

16. After learning of the College’s investigation, Dr. Haines took steps at his own initiative to update his medical knowledge and his prescribing practices in respect of narcotics.
17. To begin with, Dr. Haines advises that he implemented the following changes to his practice:
 - a. on-going reassessment of patients on narcotics to determine the appropriateness of opioid therapy and/or dosage of narcotics;
 - b. incorporating the more regular use of opioid screening tools, including the Brief Pain Inventory and the Opioid Risk Tool;
 - c. more frequent use of opioid treatment contracts;
 - d. more frequent use of urine drug screening;
 - e. instituting a narcotics prescription log;
 - f. weaning of patients on high doses of narcotics in an effort to get patients to a dose which is below the “watchful” dose of 200 mg morphine or equivalent, and/or engaging in more frequent monitoring of patients on a watchful dose;
 - g. tapering of benzodiazepines in patients being prescribed narcotics; and
 - h. changing from short-acting to long-acting opioids for better pain management with a concomitant reduction in exposure to acetaminophen.
18. In addition, throughout 2013, Dr. Haines completed the following continuing medical education programs, targeted at addressing deficiencies identified by Dr. X specifically, as well as reviewing family medicine issues generally. Attached at Tab

5 is confirmation of Dr. Haines' attendance for each of the programs listed below:

- a. February 11: Safe Opioid Prescribing, U. of T. (webinar)
- b. February 28: Case-based chronic pain management (Dr. M), City 1
- c. April 3: Safe Opioid Prescribing, U. of T. (safe opioid prescribing)
- d. April 10: Atrial fibrillation update (Dr. N), City 1
- e. April 12: Record keeping course, U. of T.
- f. May 9: Hypertension and Opioids: Challenges in Prescribing and Management (Dr. O), Primary Care conference, City 2
- g. May 9: Chronic pain in family practice needn't be a pain (Dr. P), Primary Care conference, City 2
- h. May 10: Canadian diabetic guidelines update (Dr. Q), Primary Care conference, City 2
- i. May 10: Managing opioid addiction in primary care (Dr. R), Primary Care conference, City 2
- j. May 11: Practical skills to reduce healthcare provider pain while managing chronic pain (Dr. S), Primary Care conference, City 2
- k. June 14: Safe Opioid Prescribing, U. of T. (addressing addiction)
- l. November 15: Primary Care Update Conference
- m. November 22: Canadian Heart Research Centre, Cardio-Metabolic Summit (focus on cardiology and diabetes)

19. Dr. Haines advises that he read the Clinical Textbook of Addictive Disorders, 2nd Edition, and, Managing Pain, 2nd Edition.

20. In Dr. X's second report dated June 28, 2013, he made a number of observations about Dr. Haines's generally heightened knowledge and skill, and also highlighted the various improvements in Dr. Haines's practice.

PART II - ADMISSION

21. Dr. Haines admits the facts set out above and admits that he failed to maintain the standard of practice of the profession in his care of 16 patients as detailed in the reports of Dr. X.

22. Dr. Haines admits the facts set out above constitute a failure 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.

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Haines' 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.

In making this finding the Committee notes in particular that the inappropriate prescribing of opiates in combination with other potent drugs can be a dangerous practice, and is a public health concern which impacts safe patient care.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The penalty proposed includes (i) a reprimand (ii) an overall practice assessment with a focus upon the areas of concern outlined in Dr. X's reports approximately twelve months after the date of the order, and (iii) a process for managing the results of the practice assessment. In addition, costs in the amount of \$4,460.00 for a one day hearing at tariff rate are to be paid to the College by Dr. Haines within 60 days of the date of the order.

The Committee accepted the joint submission, finding that the penalty represented an appropriate sanction in this matter. The reasons of the Committee follow.

General Principles

Where a finding of professional misconduct is made, the Committee under section 51 of the Code may impose a range of penalties. In deciding on an appropriate penalty, the Committee has regard for the need to provide protection for the public, to achieve proportionality and to be consistent with relevant case law.

In addition, where the parties have come to an agreement and have made a joint submission on penalty, as in this matter, the Committee will place significant weight on their proposed penalty order. As a matter of law, the Committee will only reject such a penalty proposal if it is contrary to the public interest and by accepting it the

administration of justice would be brought into disrepute. This is well explained in *R. v. Thompson*, [2013 ONCA 202] where reference is made to the principles stated by Justice Finlayson in *R. v. Cerasuolo*, at pp. 447-448.

The Committee is also mindful of the commonly held principles which apply to penalty in the discipline setting. Included and of particular relevance in this matter are denunciation of the misconduct, specific and general deterrence, rehabilitation of the member and upholding public confidence in the profession.

Specific Considerations

Notwithstanding the difficulties involved with the management of chronic pain in complex patients, it was clear to the Committee that Dr. Haines' practice in 2013 fell below the standard of practice in a number of ways. Of most concern was the prescription of high dose opiates in combination with benzodiazepines. Oxycodone toxicity was implicated in the death of one of Dr. Haines' patients. Dr. X's report of June 26, 2013, highlighted his concern about ongoing prescriptions for opiates and benzodiazepines in the face of patients with proven substance abuse and concerns expressed by other doctors. The Committee shared his concern. Dr. X also noted shortcomings in the application of current standards in cancer screening and the use of current tools in management of abnormal cholesterol testing.

The Committee was encouraged to see the comments of Dr. X in his report of June 26, 2013, in which he notes early action by Dr. Haines to systematically taper opiate doses and introduce practice tools such as the Brief Pain Inventory, the Opiate Risk Score and more use of urine drug testing. Dr. X comments in his June 26th report that in his opinion Dr. Haines has much improved his knowledge and skill in treating chronic non-cancer pain and demonstrates a good knowledge base. Dr. Haines' immediate action in addressing the shortcomings identified in his practice was considered a significant mitigating factor in respect of the penalty.

The Committee was of the view that Dr. Haines has demonstrated insight by his immediate action and by undertaking the remedial education which was outlined in the

Agreed Statement of Facts. This action was appropriate and responsive to the problems identified. The Committee also considered this to be a mitigating factor.

Throughout the discipline process, it was evident to the Committee that Dr. Haines cooperated with the College in the supervision of his practice. He was motivated to improve his care of patients and was sensitive to the concerns regarding his care of chronic pain patients. His desire to continue to treat these complex patients in a manner which meets the standard of practice is clear from the progressive improvement noted by Dr. Y who was engaged as his supervisor. In his latest report of February 20, 2014, Dr. Y opines: "Though we reviewed many of Dr. Haines' most challenging cases, I felt all met standard of care with appropriate responses to aberrancy, safe prescribing and appropriate monitoring".

The Committee accepted that Dr. Haines has effectively dealt with areas of concern based upon the final report of Dr. Y. Dr. Haines had changed his prescribing behaviour, introduced objective tools, referred appropriately to specialists, avoided the combination of potent opiates and benzodiazepines wherever possible and recognized the complexity of co-existent chronic pain and mood or anxiety disorders. Under these circumstances, the Committee was of the view that the elements of the proposed penalty address protection of the public.

The Committee reviewed the case law put before it by counsel and gave most weight to the two cases noted below. In *Alexander (Re)*, [2012] O.C.P.S.D. No. 15, the Committee noted similar features to the present case. These factors included an allegation of failure to maintain the standard of practice, a number of mitigating circumstances and demonstrated improvement during interim supervision. The penalty in that matter is similar to the penalty proposed in the joint submission in this case. In *Martin (Re)*, [2011] O.C.P.S.D. No. 7, there were distinguishing features which supported a harsher penalty, including significant restrictions on prescribing practices.

Elements of the Proposed Penalty

Reprimand

The reprimand in this matter afforded the Committee the opportunity to directly address Dr. Haines and to express the serious nature of failing to maintain the standard of practice of the profession. The Committee further indicated the consequences of the misconduct on the reputation of the profession. The reprimand was viewed by the Committee as a specific deterrent and the most direct means of denouncing the misconduct.

Practice Assessment

The practice assessment will address Dr. Haines' practice overall, with a focus on the specific areas of concern in this matter. It is expected that Dr. Haines will continue to engage in ongoing efforts in continuing medical education. The rehabilitation of the member achieved thus far and the practice improvements demonstrated are encouraging. The practice assessment will ensure both are sustained. The penalty order further makes provision that Dr. Haines shall abide by the reasonable recommendations made by the assessor and sets out a process to address related subsequent issues. The Committee believes this will achieve protection of the public.

Costs

In ordering Dr. Haines to pay the costs of one day of hearing, the Committee indicates that in matters such as this, the cost of the hearing is rightly borne by the member, at least in part, and not by the profession as a whole.

Further, through this penalty, general deterrence and upholding public confidence in the profession is achieved. The Committee highlighted the seriousness with which the College views a failure to maintain the standard of practice of the profession.

After considering the above, the submissions of counsel for the College and the member, the case law cited and advice of independent legal counsel, the Committee accepted the proposed penalty and made the following order.

ORDER

Therefore, having stated the finding in paragraph 1 of its written order of July 25, 2014, on the matter of penalty and costs, the Committee ordered and directed that:

2. the Registrar impose the following terms, conditions and limitations on Dr. Haines's certificate of registration:
 - a) Dr. Haines, at his own expense, to submit to an assessment of his practice by an assessor selected by the College approximately twelve months after the date of this order. The assessment shall pertain to Dr. Haines's practice overall, with a specific focus upon the areas of concern outlined in the reports of Dr. X including safe prescribing and overall preventative care. The reassessment shall include, at minimum, a full day direct observation component.
 - b) Dr. Haines shall abide by the reasonable recommendations made by the Assessor. Dr. Haines shall be permitted to make written submissions on his own behalf within 30 days of receipt of the assessment to the Inquiries, Complaints and Reports Committee. The Inquiries, Complaints and Reports Committee may or may not vary the recommendations of the Assessor upon receipt of Dr. Haines's written submissions. Any recommendations accepted by the Inquiries, Complaints and Reports Committee that are limitation(s) or restriction(s) shall constitute terms, conditions or limitations on Dr. Haines's Certificate of Registration and shall be included on the public register.
3. Dr. Haines appear before the panel to be reprimanded.
4. Dr. Haines pay costs to the College in the amount of \$4,460.00 within 60 days of the date of this order.

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