NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Michel Ronald Prévost, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names of Dr. Prévost's patients or any information that could disclose the names or identities of patients 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: Ontario (College of Physicians and Surgeons of Ontario) v. Prévost, 2015 ONCPSD 14

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. MICHEL RONALD PRÉVOST

PANEL MEMBERS:

DR. P. CHART (CHAIR)
D. DOHERTY
DR. R. MACKENZIE
DR. E. ATTIA (Ph.D.)
DR. P. CASOLA

Hearing Date: February 2, 2015
Decision Date: February 2, 2015
Release of Written Reasons: April 14, 2015

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 February 2, 2015. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and that the member is incompetent and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Prévost 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.

The Notice of Hearing also alleged that Dr. Prévost is incompetent as defined by subsection 52(1) of the Code.

RESPONSE TO THE ALLEGATIONS

Dr. Prévost admitted the allegations in the Notice of Hearing, that he failed to maintain the standard of practice of the profession and that he is incompetent.

THE FACTS

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

A. AGREED STATEMENT OF FACTS

The College of Physicians and Surgeons of Ontario (the "College") and Dr. Michel Ronald Prévost ("Dr. Prévost") agree to the following facts:

Background

1. Dr. Prévost is an RCPSC specialist in obstetrics and gynaecology who, at the relevant time, practiced in City X, Ontario. He has held a certificate of registration authorizing independent practice from the College since July 1, 1994.

Investigation into Dr. Prévost's Clinical Care

2. In response to certain concerns brought to the attention of the College by the Chief of Staff and a family doctor at Hospital 1 about Dr. Prévost's practice in obstetrics and gynecology, the College commenced an investigation into Dr. Prévost's practice in obstetrics and gynecology under s. 75(1)(a) of the Health Professions Procedural Code, being Schedule 2 to the Regulated Health Professions Act, 1991.

3. Dr. Prévost has also been practising in Ontario in the area of hair transplants since 2008 and non-surgical medical aesthetics since 2007. These areas of Dr. Prévost's practice were not the subject of the College's investigation or the allegations in this matter.

4. In the course of the s. 75(1)(a) investigation into Dr. Prévost's obstetrics and gynecology practice, the College appointed a Medical Inspector to provide an opinion about whether Dr. Prévost met the standard of practice of the profession and/or lacked knowledge, skill or judgment in his care and treatment of patients in the charts selected by the College.

5. The Medical Inspector found that in his care and treatment of 28 patients, Dr. Prévost did not meet standard of practice of the profession and lacked knowledge, skill or judgment. The Medical Inspector identified a number of specific concerns pertaining to Dr. Prévost's obstetrics and gynecology practice, including breaches of the standard of practice of the profession and lack of judgment related to the following areas:
   (a) his medical termination practice;
   (b) obtaining weights and urine dips in his pre-natal patients;

(c) charting pre-operatively and post-operatively;

(d) obtaining or documenting informed consent;

(e) obtaining appropriate pre-operative medical and/or anesthetic consults when indicated;

(f) following up appropriately and in a timely manner in his gynecological and obstetrical practice; and

(g) communicating with physician and nursing colleagues about his availability and/or lack of availability and/or when he was or was not taking responsibility for his patients who presented at or were admitted to hospital.

6. In the course of the College's investigation, Dr. Prévost voluntarily entered into an Undertaking with the College signed January 23, 2013 to cease to prescribe Methotrexate and/or Misoprostol for the purpose of terminating pregnancies. A copy of Dr. Prévost's Undertaking signed January 23, 2013 is attached at Schedule 1 [to the Agreed Statement of Facts and Admission].

7. Upon referral of the allegations set out in the Notice of Hearing to the Discipline Committee, Dr. Prévost entered into an Undertaking with the College signed November 20, 2013 in lieu of the imposition of an Order under s. 37 of the Health Professions Procedural Code, being Schedule 2 to the Regulated Health Professions Act, 1991. A copy of Dr. Prévost's Undertaking signed November 20, 2013 is attached at Schedule 2 [to the Agreed Statement of Facts and Admission].

Dr. Prévost's Medical Termination Practice

8. The Medical Inspector made the following comments in respect of medical terminations and Dr. Prévost's medical termination practice:

9. The Society of Obstetricians and Gynecologists of Canada Induced Abortion Guidelines (the "SOGC Guideline") regarding the termination of pregnancy states that medical abortion is considered an option at less than or equal to 8 weeks

gestation. The protocol for medical termination is set out in the SOGC Guideline. A copy of this SOGC Guideline is attached at Schedule 3 [to the Agreed Statement of Facts and Admission] and forms part of this Agreed Statement of Facts.

10. Seven patient charts were reviewed where patients had been treated by Dr. Prévost with a view to providing medical terminations. The following issues were noted:

(a) In all cases, the dose of Methotrexate is stated at 100 mg IM and no weight or height is documented on the chart. Accordingly, the dose was not calculated on the basis of body surface area, and is arbitrary and non-protocol;

(b) In most cases, the timing of the dose(s) of Misoprostol are not stated in the chart;

(c) Two of the patients would be high risk for non-compliance as one had significant mental health issues (Patient 6) and one had a demonstrated history of non-compliance for colposcopy (Patient 4);

(d) Two of the women were beyond the recommended gestational cutoff (Patient 4 and Patient 7) of less than or equal to 8 weeks;

(e) In all cases the nature of the consent obtained and directions given to the patients are not fully documented so it is not clear if they were informed that:

(i) this was an off-label use of the drugs;

(ii) there is a need for intense follow up; and

(iii) there are risks to an ongoing pregnancy;

(f) The intensity of the attempts to track down patients lost to follow up is not well documented. There appears to be only a single notation of attempt by phone without documenting the number of calls, and no letters are sent to either family doctors or the patients. Given the severity of the risks

involved, especially in the instance of an ongoing gestation, consideration should be given to sending registered letters to confirm receipt;

(g) Four of the patients had ongoing viable gestations: two of these had surgical terminations and two resulted in live births;

(h) The recommended pre-screening is not evident on the charts and in no cases were there noted results of STD screening. There was inconsistent screening in the history or bloodwork for liver disease, renal disease, coagulation defects, or Rh typing; and

(i) Post procedure BHCG results are frequently missing.

11. In each of these 7 cases, Dr. Prévost's care fell below the standard of practice of the profession in failing to comply with the SOGC Guideline (Schedule 1 to the Agreed Statement of Facts and Admission). He displayed a lack of judgment and patients were exposed to harm or injury. In the cases of on-going gestations, the patients' fetuses were exposed to risk of harm. There are documented fetal abnormalities in the two pregnancies that went to term. Whether or not the abnormalities were caused by the medications administered for the purpose of terminating the pregnancies was not the subject of the College's investigation because it is not necessary for the proof of the allegations set out in the Notice of Hearing.

12. The facts supporting the admissions pertaining to patients 1-7 are set out in Schedule 4, attached [to the Agreed Statement of Facts and Admission].

Re: Patient 1, Patient 2, Patient 3, Patient 4, Patient 5, Patient 6, Patient 7

13. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in these cases in administering doses of Methotrexate which were not calculated in accordance with the patients' height and weight, in not documenting the dose of Misoprostol that he provided to these

patients, and in not fully documenting the nature of the consent obtained and the instructions given to these patients.

14. The patients were exposed to risk of harm in that the dose of Methotrexate administered was not calculated on the basis of their respective body surface areas.

In addition Re: Patient 4

15. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case in failing to screen this patient with a demonstrated history of non-compliance as being an inappropriate candidate for a medical abortion, in performing a medical abortion where the pregnancy was beyond 56 days gestation, and in failing to follow up with the patient when he was aware that she had an ongoing gestation.

16. The patient was exposed to risk of harm in that she was provided with treatment that she should not have been and in that she was not contacted to advise that she had an ongoing gestation. The fetus was exposed to risk of harm in that it was exposed to Methotrexate and Misoprostol. An ultrasound conducted at 7 weeks gestation reported an extrachorionic hematoma; this ultrasound predated the administration of the medications to terminate the pregnancy. The live infant was noted to have fetal anomalies.

In addition Re: Patient 5

17. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case in failing to follow up with the patient when he was aware that she had an ongoing gestation.

18. The patient was exposed to risk of harm in that she was not contacted to advise that she had an ongoing gestation.

In addition Re: Patient 6

19. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case in failing to screen this patient with significant mental health issues as being an inappropriate candidate for a medical abortion, and in failing to follow up with the patient when he was aware that she had an ongoing gestation.

20. The patient was exposed to risk of harm in that she was provided with treatment that she should not have been, and in that she was not contacted to advise that she had an ongoing gestation which resulted in the patient having a surgical termination at 19 weeks+ gestation. The fetus was exposed to risk of harm in that it was exposed to Methotrexate and Misoprostol and was noted to have fetal anomalies by ultrasound.

In addition Re: Patient 7

21. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case in performing a medical abortion where the pregnancy was beyond 56 days gestation, and in failing to follow up with the patient when he was aware that she had an ongoing gestation.

22. The patient was exposed to risk of harm in that she was provided with treatment that she should not have been, and in that she was not contacted to advise that she had an ongoing gestation. The fetus was exposed to risk of harm in that it was exposed to Methotrexate and Misoprostol. At birth, the infant was noted to have fetal anomalies.

The Balance of Dr. Prévost's Obstetrics and Gynecology Practice

23. The facts supporting the admissions pertaining to patients 8-28 are set out in Schedule 4, attached [to the Agreed Statement of Facts and Admission].

Patient 8

24. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case. The standard of practice would include weight and urine dips, along with the other parameters at every prenatal visit (or almost every visit). There was no recognition of obesity as a risk factor. There are charting issues with the diagnosis of postpartum hemorrhage omitted.

25. The patient was exposed to risk of harm as a failure to recognize risk factors can place a patient at increased risk. Failure to note excessive or inadequate weight gain could place either mother or fetus at risk. Inaccurate charting increases risk of errors as decisions are based on inaccurate or incomplete information.

Patient 9

26. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case in terms of charting and monitoring weight and urine.

27. The patient was exposed to risk of harm as a failure to recognize risk factors can place a patient at increased risk. Failure to note excessive or inadequate weight gain could place either mother or fetus at risk.

Patient 10

28. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case as the indication for Methotrexate is not clear given no functioning trophoblastic tissue, the workup prior to giving Methotrexate is incomplete and the information to calculate the dose is not on the chart. Her prior history of endometriosis and intra-abdominal adhesions is not documented in her preoperative history and it is not documented that the increased risks related to this were discussed with the patient.

29. The patient was exposed to risk of harm as Methotrexate has significant toxicity so should be chosen only with an appropriate indication. If Dr. Prévost was not

aware of her history of endometriosis and adhesions, this would place the patient at increased risk of operative injury. This would not provide her with as much information upon which to make an informed decision when consenting to the surgery.

Patient 11

30. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in this case in terms of charting and monitoring weight and urine.

31. Failure to note excessive or inadequate weight gain could place either mother or fetus at risk.

Patient 12

32. Dr. Prévost did not maintain the standard of practice of the profession and displayed either a lack of knowledge or judgment in this case as the patient's exogenous estrogen should have been discontinued and her endometrium sampled prior to proceeding with her hysterectomy. No anesthetic or medical preoperative consultations were ordered and she had significant risk issues.

33. This patient was exposed to risk of harm. If this patient had endometrial cancer, then bilateral salpingo-oophorectomy should have been performed. Thus she might have undergone the wrong procedure. Failure to adequately assess anesthetic risk issues placed her at increased risk of anesthetic complications.

Patient 13

34. Dr. Prévost failed to maintain the standard of care and displayed a lack of judgment as, in view of the patient's BMI, a pre-operative anesthetic consult was warranted. On the day of surgery the anaesthesiologist assessed the patient, obtained her consent to anaesthesia and proceeded with administering anaesthesia for the surgery.

35. Failure to obtain a pre-operative anesthetic consult prior to the day of surgery in the appropriate circumstances could expose the patient to a risk of harm, namely failure to obtain an adequately informed consent to anaesthesia.

Patient 14

36. Dr. Prévost did not maintain the standard of practice of the profession. The patient's use of Imuran, a teratogen, is only noted after she becomes pregnant. In addition, preconception advice regarding smoking and folic acid supplementation appears to have been overlooked. When attempting a second pregnancy, the patient is given a script for Clomiphene citrate (fertility medication) at the same time as she is diagnosed with high-grade cervical dysplasia. The standard of care would be colposcopic assessment prior to attempting pregnancy.

37. Dr. Prévost displayed a lack of knowledge in that a complete medication and social history was not taken at pre-conception visits, hence the opportunity to mitigate the teratogenicity was lost. Dr. Prévost also displayed a lack of judgment in his decision to proceed with treatment with Clomid when the patient has not yet been worked up for cervical dysplasia.

38. This patient was exposed to risk in the delay in biopsy or treatment of the cervical dysplasia, which increases the risk of progression to cancer in situ or invasive cancer. The delay in taking the patient off Imuran, having her stop smoking, and the delay in initiating folic acid supplementation all increase the risk of pregnancy injury or loss.

Patient 15

39. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment in that there is a lack of documented concern regarding this patient's factor 5 Leiden nor any management plan for this thrombophilia antepartum, intrapartum or postpartum. The incomplete obstetrical history would also not be standard of care.

40. The patient was exposed to an increased risk for venous thromboembolic problems.

Patient 16

41. Dr. Prévost did not maintain the standard of practice of the profession pertaining to his medical terminations as described with respect to patients 1-7. In addition, the tubal ligation in this patient results in significant complications and it is not clear that these were discussed in advance with the patient. There is no preoperative documentation on her hospital chart of her gynecologic history, which placed her at increased risk for complications. There is no documentation of her thalassemia, which would be an anesthetic risk. There is no discharge summary despite the significant complications. The complications and associated changes in the procedure are not documented on the front sheet of the chart. The charting does not meet standard of care.

42. Dr. Prévost displayed a lack of judgment in his lack of documentation of surgical risk factors, hospital charting and discharge summary.

43. The patient had an increased risk of surgical complications but there was no bowel prep, no documented discussion in advance with the patient, and no communication with the family physician about the complications.

Patient 17

44. Dr. Prévost did not maintain the standard of practice of the profession. The patient's obstetrical history is not clearly documented.

Patient 18

45. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment as nowhere in the chart is there objective confirmation of the gestational age of the pregnancy, which is important when planning procedures for termination of pregnancy.

46. The patient was exposed to risk of harm because, with the gestational age unconfirmed, the risk would be the wrong choice of procedure or instruments which would increase the risk of complications.

Patient 19

47. Dr. Prévost did not maintain the standard of practice of the profession. An ultrasound with abnormal Doppler (S/D ratio) should have been followed up on and was not. Failure to do so increased the fetal risk of complications. The patient's presentation with fever in labour should have been treated as chorioamnionitis and not just GBS prophylaxis. The previously discussed failure to meet standard of care when weights and urine tests are not done regularly would again apply.

48. Dr. Prévost displayed a lack of judgment due to the above.

49. The lack of ultrasound follow-up would place the fetus at increased risk. The lack of full treatment for chorioamnionitis would place both the patient and her fetus at increased risk of sepsis.

Patient 20

50. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment. The previously discussed issues about incomplete charting apply with respect to this patient. There was also a delay of 2 weeks in following up on abnormal ultrasound findings noted at 24 weeks.

Patient 21

51. Dr. Prévost did not maintain the standard of practice of the profession and displayed a lack of judgment. The aforementioned concerns about incomplete charting including the lack of weights and urine testing apply on both the antenatal 1 and 2. The finding of an echogenic focus in the heart is not followed up with another ultrasound for about 10 weeks. The window of opportunity to intervene was largely lost because of the long delay. Dr. Prévost was not available when he

was on-call, was the physician for this patient, and was aware that she was in active labour.

52. There was a risk to the fetus in this case because if there was a cardiac issue that needed additional workup, the opportunity to intervene was lost. Furthermore, Dr. Prévost's failure to be available to this patient and his lack of effective communication with labour and delivery nurses presents a safety risk.

Patient 22

53. Dr. Prévost failed to maintain the standard of practice of the profession and displayed a lack of judgment by failing to document a psychosocial history, failing to perform appropriate assessments given a 40 lb weight gain and a failure to conduct regular urine testing.

54. The significant weight gain exhibited by this patient carries an increased risk of hypertension and diabetes. Failure to monitor weight and urinary protein could delay a diagnosis of pre-eclampsia with increased risk to both mother and fetus.

Patient 23

55. Dr. Prévost failed to maintain the standard of practice of the profession in his assessments and charting and in his communication with nursing staff and other physicians regarding who was responsible for the patient.

56. It is a risk to patients when nursing staff are not aware of who is responsible for the patient.

Patient 24

57. Dr. Prévost failed to maintain the standard of practice of the profession with respect to his lack of clarity of coverage and his lack of documentation.

58. It is a risk to patients when nursing staff are not aware of who is responsible for the patient.

Patient 25

59. Dr. Prévost failed to maintain the standard of practice of the profession and displayed a lack of judgment by his delay of one hour and twenty five minutes to advise labour and delivery that he was not going to assume responsibility for this patient in preterm labour who could not safely deliver at this hospital or in failing to attend to the patient to have her transferred. This is not within the SOGC recommended response times for a Level 1 centre.

60. The patient was exposed to harm as preterm labour can progress rapidly. A long delay in answering might cause the loss of the window for safe transfer of the patient to another facility.

Patient 26

61. Dr. Prévost failed to maintain the standard of practice of the profession and displayed a lack of judgment in his inadequate documentation regarding this patient's operative vaginal delivery.

Patient 27

62. Dr. Prévost failed to maintain the standard of practice of the profession and displayed a lack of judgment in his charting, which was disorganized and, at times, inaccurate, and in telling a patient to self-refer to an outside clinic, which is not a firm follow through plan for a failed medical abortion.

63. The lack of a firm follow through plan for a failed medical abortion increases the risk of the pregnancy going forward with damage to the fetus should the medical abortion be unsuccessful.

Patient 28

64. Dr. Prévost failed to maintain the standard of practice of the profession and displayed a lack of judgment in providing a medical termination where there was a

twin pregnancy and in his use of a non-standard regimen of Cytotec in his attempt to terminate the surviving twin.

B. ADMISSION

65. Dr. Prévost admits the facts specified above and in Schedule 2 [to the Agreed Statement of Facts and Admission], and admits that, based on these facts, he failed to maintain the standard of practice of the profession and is incompetent in his practice of obstetrics and gynecology.

FINDINGS

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. Prévost'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 found him incompetent under subsection 52(1) of the Code in that his care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

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 Committee is aware that a joint submission should be accepted unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute. The Committee is also aware of the accepted principles that guide the determination of an appropriate penalty. First and foremost is protection of the public from further misconduct by the physician. The penalty must also provide both specific and general deterrence. In addition, the penalty must reflect the profession's disapproval of the misconduct and maintain public confidence in the College's ability to regulate its members. Aggravating and mitigating factors must be considered, and, where appropriate, the potential for rehabilitation of the physician.

As part of the penalty order in this case, Dr. Prévost signed an undertaking to resign his certificate of registration with the College and not to apply or re-apply for registration as a physician to practise medicine in Ontario. Dr. Prévost also agreed never to practise obstetrics or gynecology in any jurisdiction after his resignation.

The factors of most concern to the Committee in the determination of penalty include, but are not limited to:

- a glaring lack of clinical judgment across the entire spectrum of his obstetrics and gynecology practice,
- a blatant disregard for the welfare of his patients and for patient safety,
- a cavalier attitude towards both patient care and relationships with colleagues,
- a failure to follow accepted clinical practice guidelines expected of a competent specialist,
- a failure to document and therefore obtain informed consent for medical treatments that carried significant material risks to patients,
- the very real and potential harm to patients including failed pregnancy terminations, infants born with congenital anomalies and abandoning patients in critical medical situations,
- inadequate, often non-existent medical recordkeeping,
- a failure to follow up on serious test results, and
- a failure to communicate with colleagues with respect to transfer of care.

The Committee considered the submissions of both counsel in support of the jointly proposed penalty order.

Counsel for the College highlighted the issues surrounding the seven cases involving medical termination of pregnancy. Since this is a relatively new specialty area of medicine not necessarily well understood by physicians or public members of the Committee, she reviewed in some detail the Society of Obstetricians and Gynecologists of Canada (SOGC) clinical practice guidelines pertaining to this practice. Most importantly, the physician providing the treatment must:

- counsel patients on the risks of the procedure and obtain informed consent,

- ensure that the gestation of the pregnancy is less than 56 days,
- calculate the appropriate dose of methotrexate based on the patient's body surface area,
- monitor the bloodwork, most importantly the serial Beta HCG measurements,
- communicate with the patient regarding the results of the continuing bloodwork,
- communicate with the patient should she not obtain the appropriate bloodwork in a timely fashion,
- arrange further treatment if the termination is unsuccessful,
- since both Methotrexate and Misoprostol are teratogenic, it is imperative to arrange surgical follow up if medical termination is unsuccessful, and
- schedule a final appointment to do a pelvic examination and initiate contraception.

In the seven cases presented to the Committee, Dr. Prévost failed to follow these guidelines. There is no record that he provided either counselling to or obtained informed consent from any of these patients. In two cases, the patient was beyond the 56 day gestation period. Dr. Prévost never calculated the dose of methotrexate based on height and weight. He did not document the dosage of misoprostol prescribed. In at least four of the cases, he failed to follow up on the abnormal serial Beta HCG levels or ensure they were done in a timely fashion. In two cases where patients were lost to follow-up, the medical termination was unsuccessful and they were ultimately referred to another physician for surgical termination of the pregnancy. In the other two cases, the failed terminations were not recognized until the late stages of pregnancy and the patients delivered live infants with multiple congenital anomalies.

The issues of concern with respect to the balance of Dr. Prévost's Obstetrics and Gynecology practice are set out in the Agreed Statement of Facts and Admission. The case of Patient 25 was of particular concern to the Committee. This patient presented to the hospital in premature labour at 34 weeks gestation. That hospital was not equipped to deal with preterm infants of this gestation which necessitated transfer to a tertiary centre. The nursing staff called Dr. Prévost to notify him of the patient's admission. He was obviously aware of the situation as he left admission orders with the nurse. An hour and a

half later the hospital staff called and requested that Dr. Prévost attend the patient and initiate the transfer. His office was located across the street from the hospital. Dr. Prévost's office assistant advised that Dr. Prévost could not attend on the patient and advised that the obstetrician on call be notified. That physician responded that he was more than an hour away and arranged for a third obstetrician who was not on call, but available in the hospital to assume the care. The third physician subsequently assessed the patient, arranged for the transfer and actually accompanied the patient in the ambulance.

The Committee was frankly shocked at Dr. Prévost's blatant disregard for the welfare of this patient. In the remainder of the cases cited in the Agreed Statement of Facts and Admission, this cavalier approach to his patients and colleagues is evident throughout.

The Committee was presented with two Victim Impact Statements: one from patient Patient 5 and one from Patient 4, both describing the profound emotional impact of Dr. Prévost's misconduct.

Counsel for Dr. Prévost argued that the failures described in the Agreed Statement of Facts and Admission were inadvertent, not deliberate. She also submitted that, although clearly below the standard of care, Dr. Prévost's individual deficiencies were relatively minor in nature. Apart from the four pregnancy terminations that were unsuccessful, she submitted that the remaining cases may have involved real potential risks to patients but that no actual complications occurred. She also submitted that the joint submission should be considered as evidence that Dr. Prévost has demonstrated insight into his deficiencies and that he has demonstrated remorse and regret by admitting to the allegations. Dr. Prévost's counsel also filed four letters of support from colleagues of Dr. Prévost for the Committee's consideration.

The Committee was not persuaded by these arguments. It does not accept that any of the misconduct described in the evidence could be characterized as minor. The sheer volume and repetitive nature of his failings are nothing short of egregious. Although the Committee is prepared to accept that Dr. Prévost has gained a measure of insight into his behaviour as a result of these protracted discipline proceedings, the fact that he was well aware of his pregnancy termination failure rate and subsequent failures in follow up,

demonstrates to the Committee that he chose not to learn from his experiences. The Committee does in no way characterize his misconduct as inadvertent.

With respect to the letters of support, none of the authors acknowledge awareness of the allegations against him or his admission to them. Accordingly, the Committee accords these little or no weight in mitigation of the penalty.

Counsel for Dr. Prévost submitted that he could have brought forward evidence at a penalty hearing to suggest that a lengthy suspension and remediation may have been a viable alternative inasmuch as there was no evidence before the panel that Dr. Prévost lacks skill or knowledge. The Committee accepts that deficiencies in skill and knowledge can often be remediated, but lack of judgment is much more difficult.

In summary, the Committee concluded that due to the serious, repetitive and egregious nature of the misconduct set out in the Agreed Statement of Facts and Admission, the Committee accepted the Joint Submission on Penalty and Costs. The only remedy that can adequately address the issue of public safety and fulfill the other penalty principles is removal of Dr. Prévost from practice. Had Dr. Prévost not agreed to voluntarily resign, this Committee would undoubtedly have revoked his certificate of registration. It is satisfied that the undertaking signed is an appropriate alternative, since it provides not only that he withdraw from the practice of medicine, but also he has given up the opportunity to apply for reinstatement at a later date.

ORDER

The findings of the Committee and the terms of its order as to penalty and costs are set out in the Order of the Committee dated February 2, 2015. The terms of the Order as to penalty and costs are set out below:

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

4. Dr. Prévost pay to the College costs in the amount of $4,460.00 within 60 days of the date of this Order.

5. the results of this proceeding be included in the register.

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

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Prévost, 2015 ONCPSD 14

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B E T W E E N:

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- and -

DR. MICHEL RONALD PRÉVOST

PANEL MEMBERS:

DR. P. CHART (CHAIR)
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DR. P. CASOLA

Hearing Date:	February 2, 2015
Decision Date:	February 2, 2015
Reprimand Date:	February 2, 2015
Release of Written Reasons:	April 14, 2015

PUBLICATION BAN

TEXT of PUBLIC REPRIMAND
Delivered February 2, 2015
in the case of the
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
and
DR. MICHEL RONALD PRÉVOST

Right up front, I want there to be no misunderstanding that had you not resigned and agreed not to reapply, this Committee, based on the statement of facts submitted, would have revoked your Certificate of Registration.

The facts admitted to are nothing short of appalling. Not only has there been neglect of patients, and failure to practice within accepted guidelines, but your care has resulted in tragic consequences to mothers and babies.

Sloppy practice, acts of omission and commission, fly in the face of the support letters you provided. Your lack of responsibility and professionalism are inconsistent with medical practice, and nothing short of separating you from the profession will allow this Panel to discharge its duty.

That is the end of the reprimand. You may now sit down.