

## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Richard Kok Tiong Chan, 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. Chan,  
2018 ONCPSD 24**

**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. RICHARD KOK TIONG CHAN**

**PANEL MEMBERS:**  
**DR. P. POLDRE (CHAIR)**  
**MR. M. KANJI**  
**DR. I. ACKERMAN**  
**MR. J. LANGS**  
**DR. C. CLAPPERTON**

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

**MS A. CRANKER**

**COUNSEL FOR DR. CHAN:**

**MS. G. BURT**  
**MR. M. FLISFEDER**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MR. R. COSMAN**

**Hearing Date:** April 23, 2018  
**Decision Date:** April 23, 2018  
**Release of Written Reasons:** May 10, 2018

**PUBLICATION BAN**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 23, 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. Richard Kok Tiong Chan committed an act of professional misconduct:

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

### **RESPONSE TO THE ALLEGATIONS**

Dr. Chan admitted the allegation in the Notice of Hearing, that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

### **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:

## FACTS

1. Dr. Richard Kok Tiong Chan (“Dr. Chan”) is a neurologist with the Department of Clinical Neurological Sciences, London Health Sciences Centre.
2. Dr. Chan’s family member (Family Member 1), lives in another country. Between 2011 and 2015, Dr. Chan prescribed Fentanyl patches to Family Member 1, as set out in the following table. Enclosed at Tab 1 [to the Agreed Statement of Facts and Admission] is a copy of the Patient Medical History printout and copies of the prescriptions for Family Member 1 from Shoppers Drug Mart at Masonville Place, Richmond Street in London, Ontario. Enclosed at Tab 2 [to the Agreed Statement of Facts and Admission] is the Patient Medical History printout and copies of the prescriptions for Family Member 1 from another Shoppers Drug Mart on Adelaide Street in London, Ontario. The exhibit at Tab 2 does not include copies of the prescriptions filled on January 4, 2013 and December 3, 2013, as the College did not receive copies of these prescriptions from the pharmacy.

Date Filled	Drug	Qty	Shoppers Drug Mart Location
2011/09/18	Teva-Fentanyl/25mcg/hr/Trans Patch	5.0	Masonville Place, Richmond Street
	Teva-Fentanyl/50mcg/hr/Trans Patch	5.0	Masonville Place, Richmond Street
2011/10/24	Teva-Fentanyl/25mcg/hr/Trans Patch	15.0	Masonville Place, Richmond Street
	Teva-Fentanyl/50mcg/hr/Trans Patch	15.0	Masonville Place, Richmond Street
2013/01/04	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street
2013/03/15	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street
2013/05/27	Teva-Fentanyl/50mcg/hr/Trans Patch	30.0	Adelaide Street
2013/06/30	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street
2013/08/24	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street
2013/10/06	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street
2013/12/03	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street
	Teva-Fentanyl/25mcg/hr/Trans Patch	30.0	Adelaide Street
2014/01/23	Teva-Fentanyl/25mcg/hr/Trans Patch	30.0	Adelaide Street
	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street
	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Adelaide Street

2014/04/11	Teva-Fentanyl/25mcg/hr/Trans Patch	30.0	Adelaide Street
2014/07/02	Teva-Fentanyl/25mcg/hr/Trans Patch	45.0	Masonville Place, Richmond Street
	Teva-Fentanyl/50mcg/hr/Trans Patch	90.0	Masonville Place, Richmond Street
2014/09/16	Teva-Fentanyl/25mcg/hr/Trans Patch	45.0	Masonville Place, Richmond Street
	Teva-Fentanyl/50mcg/hr/Trans Patch	90.0	Masonville Place, Richmond Street
2014/12/19	Teva-Fentanyl/50mcg/hr/Trans Patch	100.0	Masonville Place, Richmond Street
	Teva-Fentanyl/25mcg/hr/Trans Patch	50.0	Masonville Place, Richmond Street
2015/04/15	Teva-Fentanyl/50mcg/hr/Trans Patch	100.0	Masonville Place, Richmond Street
	Teva-Fentanyl/25mcg/hr/Trans Patch	50.0	Masonville Place, Richmond Street
2015/08/10	Teva-Fentanyl/25mcg/hr/Trans Patch	45.0	Masonville Place, Richmond Street
	Teva-Fentanyl/50mcg/hr/Trans Patch	90.0	Masonville Place, Richmond Street
2015/11/27	Teva-Fentanyl/50mcg/hr/Trans Patch	60.0	Masonville Place, Richmond Street
	Teva-Fentanyl/25mcg/hr/Trans Patch	30.0	Masonville Place, Richmond Street

3. On each of these prescriptions to the extent that the information was recorded:
  - (a) the ID given for Family Member 1 was her passport number; and,
  - (b) the address given for Family Member 1 was Dr. Chan's home address in Ontario.
  
4. Dr. Chan's Family Member 2 also lives in the other country. On July 18, 2014, Family Member 2 filled a prescription for 150 tabs of hydromorphone (the Patient Medical History Report printout and a copy of the prescription are enclosed at Tab 3 [to the Agreed Statement of Facts and Admission]). This prescription was written by Dr. Chan. The prescription bore Family Member 2's passport number, and indicated her address to be Dr. Chan's home address.
  
5. Dr. Chan went personally to the drug store himself to have each of the prescriptions he wrote for his Family Member 1 and Family Member 2 filled. The Fentanyl patches he prescribed to his Family Member 1 and the hydromorphone tabs he prescribed to his Family Member 2 were provided to him by the pharmacy.
  
6. On January 13, 2016, Dr. Chan wrote a prescription for his Family Member 1 for 180 Fentanyl patches. A copy of this prescription is attached at Tab 4 [to the Agreed

Statement of Facts and Admission]. As with the previous prescriptions, it bore her passport number and indicated her address to be Dr. Chan's home address. On the prescription, Dr. Chan wrote "Patient leaving town, OK to release all supplies now". Dr. Chan submitted the prescription to the Shoppers Drug Mart ("SDM") pharmacy in Masonville Place, on Richmond Street in London, Ontario to be filled.

7. On January 15, 2016, the SDM pharmacist telephoned a number believed to be for the patient. Dr. Chan answered the pharmacist's call. Dr. Chan confirmed that he was the prescribing physician, and that he had written the prescription for his Family Member 1. The pharmacist advised Dr. Chan that the prescription he had written would not be filled because it was for a family member.
8. In a separate conversation with the pharmacy owner, it was suggested to Dr. Chan that he have the patient's family physician write the prescription.
9. On January 18, 2016, Dr. Chan asked Dr. X, a clinical fellow working under his supervision, to write a prescription for Fentanyl for his Family Member 1. Dr. Chan approached Dr. X during clinic hours and when she was between patients. He told her that Family Member 1 had been using the medication and he had been prescribing to her for years. Dr. Chan also told Dr. X that he would have asked another colleague to write the prescription, but that there were no other staff doctors around and that he needed it right away. He told her what medication to prescribe, and he specified the dose and quantity.
10. Dr. Chan told Dr. X that he had already presented a prescription for Fentanyl to the pharmacy, but the pharmacy requested that he have another physician issue the prescription.
11. Dr. X did not assess Dr. Chan's Family Member 1. Dr. X did not feel she could refuse Dr. Chan's request, as Dr. Chan was her supervisor. Dr. X wrote the prescription as

requested by Dr. Chan, attached at Tab 5 [to the Agreed Statement of Facts and Admission].

12. The same day Dr. Chan submitted the prescription written by Dr. X to the SDM pharmacy in Masonville Place, on Richmond Street in London, Ontario to be filled. The pharmacy did not fill the prescription written by Dr. X.
13. Over January 18 and 19, 2016, Drs. Chan and X exchanged the following text messages with respect to the prescription he had asked her to write:

Dr. Chan to Dr. X January 18, 2016 4:57 pm	Hi [A]. The pharmacy returned the stocks, so I ended up not ending [sic.] the prescription. Thanks anyway. I'll see you tomorrow, maybe?
Dr. X to Dr. Chan January 18, 2016 7:52 pm	Oh..so you couldn't get your [Family Member 1's] prescription? I will come tomorrow morning at 00:08 [sic]. I will have to leave for an appointment from 1:00 to 2:30.
Dr. Chan to Dr. X January 19, 2016 9:19 am	[A], don't worry about it. I will bring her to the doctor when I get home. Better this way. I feel kindness [sic.] of awkward asking you to write the script. Glad I did not need to use it.

14. On January 22, 2016, the pharmacy telephoned Dr. X to confirm whether the prescription she had written was valid. Dr. X confirmed having written it, but stated that she had not seen the patient.
15. In the course of the College's investigation into Dr. Chan's prescribing, Dr. Chan provided conflicting or inaccurate information regarding:
  - (a) Dr. Chan's contact with a physician who treated Dr. Chan's Family Member 1 in the country where she resides;
  - (b) The length of time for which he had been prescribing Fentanyl to Family Member 1;
  - (c) The number of pharmacies at which he had filled Family Member 1's Fentanyl prescriptions;
  - (d) Where and how he treated and examined Family Member 1; and

(e) How he got the Fentanyl to Family Member 1.

16. In the course of the College's investigation into Dr. Chan's prescribing, Dr. Chan provided some information that conflicted with information provided to the College by the pharmacist and/or pharmacy owner.

## **ADMISSION**

17. Dr. Chan admits the facts specified above, and admits that, based on these facts, he engaged in professional misconduct, in that he engaged in acts or omissions 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 Ontario Regulation 856/93 made under the *Medicine Act, 1991*.

## **FINDING**

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Chan'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**

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

The proposed penalty order included a reprimand, a suspension of Dr. Chan's certificate of registration for five months, and imposition of terms, conditions, and limitations on his

certificate of registration. In addition, the parties jointly submitted that Dr. Chan pay costs to the College, in the amount of \$6,000.00, within 30 days of the order.

The Committee is aware that a joint submission on penalty must be accepted, unless to do so would bring the administration of justice into disrepute, or is otherwise contrary to the public interest (*R. v. Anthony-Cook*, 2016 SCC 43).

Well-recognized penalty principles guide the Committee's decision on penalty. First, and most importantly, the penalty decision is based on the principle of protection of the public. The Committee is also cognizant that the penalty should serve as a general deterrent to the profession and a specific deterrent to the member; express the profession's denunciation of the misconduct; be proportionate to the misconduct; uphold the honour and reputation of the medical profession, maintain public confidence in the College's ability to regulate the profession in the public interest; and where appropriate, the penalty should serve to rehabilitate the member.

#### *Nature of the Misconduct*

Dr. Chan prescribed opioids repeatedly to Family Member 1 over several years and also prescribed them to Family Member 2. Dr. Chan violated well-established long-standing College policy on treating self and family members. By treating family members on repeated occasions over an extended period of time for non-emergent issues, Dr. Chan flouted the very straightforward and practical College policy with respect to treating family members.

Furthermore, Dr. Chan attempted to engage a clinical fellow who worked under his direct supervision to assist him in his professional misconduct.

Also, during the investigation, Dr. Chan provided conflicting or inaccurate information to the College (paragraphs 15 and 16 of the Agreed Statement of Facts).

*Aggravating Factors*

Dr. Chan's actions were repeated over years. At any time, he could have recognized his error and stopped, but he did not.

Dr. Chan involved a clinical fellow whom he supervised in prescribing the opioids when the pharmacist refused to fill the prescription upon finding that the medication was for the doctor's Family Member 1. Dr. Chan's actions constituted an abuse of his role as a clinical supervisor.

Like all patients, Dr. Chan's Family Member 1 and Family Member 2 deserve to have appropriate medical care. By usurping the role of a family doctor, Dr. Chan deprived them of care from an impartial and objective clinician. The College has a policy about providing treatment to family members when other physicians are not available or in emergent situations. Neither of these conditions was met in this case.

Dr. Chan provided conflicting or inaccurate information at various times during the College investigation. In doing so, he undermined the College's investigation and blatantly disregarded the role of his medical regulator in protecting the public. He also failed to live up to his own responsibility as a member of the profession to comply with College policies.

*Mitigating factors*

Dr. Chan admitted the allegations against him in the Notice of Hearing. In doing so, he has saved the College the considerable time and expense of a contested hearing. In addition, Dr. Chan has no prior discipline history with the College's Discipline Committee.

*Case Law*

The following cases were brought to the attention of the Discipline Committee to provide guidance on how similar cases were treated by other panels of the Committee.

In *CPSO v. Esmond* (2016), the Committee ordered a four month suspension, a reprimand, the imposition of terms, conditions and limitations on his certificate of registration, and hearing costs to be paid to the College. Dr. Esmond treated a family member for many years, including making diagnoses, investigating, referring to specialists, and writing prescriptions, including those for psychotropic drugs. He also had clinical care issues with prescribing narcotics to his patients and rushed to prescribe major analgesics without considering non-pharmacologic modalities or less powerful analgesics. In addition, Dr. Esmond treated and was treated by another physician whom he supervised.

In *CPSO v. Vasovich* (2015), the physician received a four month suspension, a reprimand, and was required to adhere to a College practice management policy and take the course in Understanding Boundaries and Managing the Risks Inherent in the Doctor-Patient Relationship. Dr. Vasovich, a general practitioner, was involved in a romantic relationship with Mr. X from 1996 to 2005. During that time, Dr. Vasovich provided medical care to Mr. X. For a period of time after their relationship ended in 2005, Mr. X had another family physician. However, at various points until Mr. X died in 2012, Dr. Vasovich was involved in referrals to specialists, renewing medications, attending appointments with him and interpreting consult reports. The Committee recognized that a 4-month suspension was significant, but deemed it warranted given the seriousness of the physician's disregard for College policy over an extended period of time.

The penalty in *CPSO v. Ruggles* (2016) was a two month suspension, a reprimand, as well as the imposition of terms, conditions and limitations on the physician's certificate of registration. Dr. Ruggles' misconduct was first brought to the College's attention for prescribing large quantities of OxyContin from February 2009 to August 2010 to a non-patient with whom she had a work-related association. In disposing of the investigation in 2011, the Inquiries, Complaints and Reports Committee (the "ICRC") cautioned Dr. Ruggles in writing and noted that this was an isolated incident. She agreed to appropriate remediation and was required to complete the Understanding Boundaries and Narcotics Prescribing courses. Dr. Ruggles prescribed various drugs, including narcotics and other restricted drugs, for another work related individual both before and after she completed the Understanding Boundaries and Narcotics Prescribing courses

required by the College, and both before and after the ICRC's decision cautioning her for similar behaviour. In the course of the investigation into her office practice, it was noted that Dr. Ruggles prescribed excessive amounts of narcotics at times to some patients, showing a lack of knowledge and judgment.

In *CPSO v. Irvine* (2011), the physician wrote over 100 prescriptions to his wife and her son over a period of two and a half years. Although none of the prescriptions were for narcotics, they had the potential to produce serious side effects. Dr. Irvine's penalty was a suspension of his certificate of registration for 4 months and a reprimand.

### *Conclusion*

The Committee accepted the joint submission on penalty.

In considering the above noted recent cases, the Committee is assured that the penalty proposed in this case is commensurate with the seriousness of the misconduct and is aligned with the penalties ordered in previous cases. The Committee noted that a five month suspension is appropriate on the facts and takes into account Dr. Chan's academic, mentoring and teaching role. Members of the profession are expected to comply with College policies. When professional leaders or teachers flout them, it is more egregious as it has the potential to impact negatively on those under their authority or within their sphere of influence. Also, the five month suspension indicates to both the public and the membership that being less than forthright with the College will not be tolerated. The College has an important role to regulate the profession in the public interest and it is incumbent upon all physicians to cooperate with its processes. The maintenance of the integrity of the profession and public confidence in the College as regulator is achieved by the imposition of a serious penalty order.

The public will be protected by the suspension and by the imposition of terms, conditions and limitations on Dr. Chan's certificate of registration upon his return to practice, including the requirement for a prescribing log that is available to the College for inspection, as outlined in the

Committee's order below. Through the reprimand, the Committee expressed its abhorrence of the misconduct in prescribing opioids to family members in contravention of clear College policy. The suspension and public reprimand should serve as a specific deterrent to Dr. Chan and as a general deterrent to other members of the profession in relation to misconduct of this nature. In ordering Dr. Chan to complete course work related to prescribing, ethics and professionalism, Dr. Chan has the opportunity to reflect on his misconduct and restore his professionalism.

## **COSTS**

Ordering the partial recovery of costs of the Committee and legal counsel is appropriate, fair, and reasonable in the circumstances, as this matter was scheduled as a half-day discipline hearing and required consideration in advance of the hearing of the Agreed Statement of Facts and appended documentation.

## **ORDER**

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of April 23, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Chan appear before the panel to be reprimanded.
3. the Registrar suspend Dr. Chan's certificate of registration for a five (5) month period, to commence at 12:01 a.m. on May 1, 2018.
4. the Registrar to impose the following terms, conditions and limitations on Dr. Chan's certificate of registration:

### ***Prescribing Privileges***

- (1) Dr. Chan shall issue new prescriptions or renew existing prescriptions for any of the following substances only to patients whom Dr. Chan is treating in a hospital setting (including in-patients, clinic patients, and emergency department patients):
  - (a) Narcotic Drugs (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19); and
  - (b) Narcotic Preparations (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19).

A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached as Schedule “A” to the Order dated April 23, 2018; and the current regulatory lists are attached as Schedule “B” to the Order dated April 23, 2018.

### ***Prescription Log***

- (2) Dr. Chan shall record all prescriptions he writes for the substances set out in paragraph 4.(1), and other specified information, in a prescription log or logs containing the information set out in the attached Schedule “C” to the Order dated April 23, 2018, which shall be made available to the College at the College’s request.

A copy of each prescription written by Dr. Chan for a drug set out in paragraph 4.(1) shall be maintained either in the appropriate hospital records or Dr. Chan’s office chart.

### ***Coursework***

- (3) At his own expense, Dr. Chan shall participate in and successfully complete by the end of 2018:
  - (a) A prescribing course acceptable to the College; and

- (b) The PROBE course in ethics and professionalism by obtaining an unconditional pass, or any alternate course in ethics and professionalism approved by the College. Dr. Chan will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College.

### ***Compliance***

- (4) Dr. Chan must inform the College of each and every location at which he practices or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within fifteen (15) days of commencing practice at that location.
- (5) Dr. Chan shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the terms of this Order.
- (6) Dr. Chan shall co-operate with unannounced inspections of his Practice Location(s) and patient charts by the College and to any other activity the College deems necessary in order to monitor his compliance with the terms of this Order.
- (7) Dr. Chan shall provide his irrevocable consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the *Narcotics Safety and Awareness Act, 2010* and any person or institution that may have relevant information, in order for the College to monitor his compliance with the terms of this Order.
- (8) The College may provide this Order to any Chief(s) of Staff, or a colleague with similar responsibilities, at any Practice Location where he practices or has privileges ("Chief(s) of Staff"), or other person or individual as necessary for the implementation of this Order and shall consent to the College providing to said Chief(s) of Staff, person or organization with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order.

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

At the conclusion of the hearing, Dr. Chan 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 April 23, 2018**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. RICHARD KOK TIONG CHAN**

Dr. Chan,

It is truly reprehensible that an academic physician at your mature stage of career must appear before the Discipline Committee of your College.

You seriously erred with your blind disregard of the College policy regarding the prescribing of controlled substances when you repeatedly, over many years, provided such prescriptions to two members of your family.

Our society is correctly concerned about the role that members of the medical profession have played in the opioid crisis. Your behaviour regrettably brings disrepute to the whole profession.

Your failure to fully cooperate with the College's investigation of your misdeeds demonstrated a blatant disregard for the role of your professional regulator to protect the public.

What is further disturbing to this Committee is your attempt to engage a medical trainee under your direct supervision to assist you in your misconduct when a pharmacist quite correctly became concerned about your conduct.

All academic physicians who are bestowed with the privilege of teaching the next generation of our profession must not only teach knowledge and skills, but equally teachers must be proper role models of professional behaviour.

Sadly, you have failed in this role.

You have brought disrepute to yourself through your disgraceful and unprofessional actions.

This Committee expects that you will reflect seriously on your misconduct and never appear before this Committee again.

*This is not an official transcript*