NOTICE OF PUBLICATION BAN

In Bryan Edward Williams and the College of Physicians and Surgeons of Ontario, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the complainant, or other information that might tend to identify the complainant, under subsection 47(1) of the *Health Professions Procedural Code* (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991.*

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: Williams v. Ontario (College of Physicians and Surgeons of Ontario), 2018 ONCPSD 70

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Registrar to the Discipline Committee of the College of Physicians and Surgeons of Ontario, pursuant to section 73 of the Health Professions Procedural Code

BETWEEN:

BRYAN EDWARD WILLIAMS

- and -

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

PANEL MEMBERS:

DR. H. SCHIPPER
MR. J.P. MALETTE
DR. M. DAVIE
MR. J. LANGS
DR. P. BERGER

COUNSEL FOR THE APPLICANT:

MS. L. CONSTANTINE

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. C. SILVER
MS. P. NG

INDEPENDENT LEGAL COUNSEL TO THE DISCIPLINE COMMITTEE:

MR. R.W. COSMAN

PUBLICATION BAN

Reinstatement Application Hearing Date:	**October 26, 2018**
Reinstatement Application Decision Date:	**December 11, 2018**
Written Decision Date:	**December 11, 2018**

DECISION AND REASONS FOR DECISION

Dr. Bryan Edward Williams (Dr. Williams) made an application to the College of Physicians and Surgeons of Ontario (the 'College') for reinstatement of his certificate of registration. His certificate had been revoked for professional misconduct on June 11, 2012. The Registrar referred the application for reinstatement to the Discipline Committee and the Committee heard the application on October 31, 2018. At the conclusion of the hearing, the Committee reserved its decision with written decision and reasons to follow.

REVOCATION OF CERTIFICATE OF REGISTRATION

On June 11, 2012, the Discipline Committee made a finding that Dr. Williams committed an act of professional misconduct, in that: he sexually abused a patient under paragraph 51(1)(b.1) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*; and 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 under paragraph 1(1)33 of Ontario Regulation 856/93 made *under the Medicine Act 1991*.

Dr. Williams admitted the allegations and his discipline hearing proceeded by way of an agreed statement of fact and a joint submission on penalty.

The sexual abuse of Patient A by Dr. Williams included the act of sexual intercourse, and consequently, the Committee imposed the mandatory penalty order of revocation of his certificate of registration. In such a case, section 72(3) of the Code provides that an applicant may not make an application for reinstatement for five years from the date of the revocation order.

A finding of disgraceful, dishonourable or unprofessional conduct was also made with respect to Dr. Williams' involvement in a recantation letter that he drafted for Patient A, which he encouraged her to send to the College, as well as a false entry he made in Patient A's chart.

APPLICATION FOR REINSTATEMENT

Section 72 of the Code provides as follows:

Applications for reinstatement

72 (1) A person whose certificate of registration has been revoked or suspended as a result of disciplinary or incapacity proceedings may apply in writing to the Registrar to have a new certificate issued or the suspension removed. 1991, c. 18, Sched. 2, s. 72 (1).

Time of application, sexual abuse cases

(3) An application under subsection (1), in relation to a revocation for sexual abuse of a patient, shall not be made earlier than,

(a) five years after the date on which the certificate of registration was revoked; or

(b) six months after a decision has been made in a previous application under subsection (1). 2007, c. 10, Sched. M, s. 52.

Notice where complainant

(4) The Registrar shall give the complainant in the original proceeding notice of an application under subsection (1). 2007, c. 10, Sched. M, s. 52.

Reasons for reinstatement

(5) The person making the application under subsection (1) shall provide reasons why the certificate should be issued or the suspension be removed. 2007, c. 10, Sched. M, s. 52.

Referral to Committee

73 (1) the Registrar shall refer the application, if the revocation or suspension was on the grounds of,

(a) professional misconduct or incompetence, to the Discipline Committee; or

(b) incapacity, to the Fitness to Practise Committee.

Under section 73(5) of the Code, the Committee may dismiss the application or make an order as follows:

Order

(5) A panel may, after a hearing, make an order doing any one or more of the following:

1. Directing the Registrar to issue a certificate of registration to the applicant.
2. Directing the Registrar to remove the suspension of the applicant's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the applicant's certificate of registration. 1991, c. 18, Sched. 2, s. 73 (1-5).

Dr. Williams' application for reinstatement was made five years and one day after the revocation of his certificate of registration. The Committee was informed by counsel that the complainant had been notified in writing of the application as is legally required. Prior to the hearing, Dr. Williams submitted an Application Record to the Committee, which included transcripts and exhibits from the June 11, 2012 discipline hearing and affidavits in support of the application. In compliance with Rule 15 of the Rules of the Discipline Committee, counsel for Dr. Williams presented to the Committee a proposed order with an individual education program (IEP) addressing re-entering practice policies of the College.

The College agreed that the preconditions for an application for reinstatement had been met and the Committee has the legal authority and jurisdiction to hear Dr. Williams' application for reinstatement. The College took no position on the merits of Dr. Williams' application for reinstatement; the College neither supported nor opposed the application.

TEST FOR REINSTATEMENT

The burden of proof is on Dr. Williams to prove, on the balance of probabilities, that he is suitable for reinstatement. The Code does not provide statutory guidance with respect to the factors that the Committee must consider in determining whether reinstatement is appropriate. Additionally, it is agreed that the general requirements for a certificate of registration as set out

in section 2 of Ontario Regulation 865/93 under the Medicine Act 1991, S.O 1991, c.30 are applicable:

Section 2(1) provides that:

It is a non-exemptible standard and qualification for a certificate of registration that an applicant's past and present conduct afford reasonable grounds for belief that the applicant,

a) is mentally competent to practice medicine;
b) will practice with decency, integrity and honesty and in accordance with the law;
c) has sufficient knowledge, skill and judgement to engage in the kind of medical practice authorized by the certificate; and
d) can communicate effectively and will display an appropriately professional attitude.

In addition to the non-exemptible requirements, there are other factors for the Committee to consider on an application for reinstatement, which are set out in *Manohar v. CPSO* (2013). That case establishes there are two tests to be considered on an application for reinstatement:

1. What is the risk of further misconduct, and if there is a risk is it manageable with terms, conditions and limitations?
2. Is the applicant suitable to practice both in terms of protection of the public and the confidence of the public in the regulation of the profession?

There are other factors to consider as set out in the reinstatement cases *of Kulkarni v. CPSO* (2004) and *Kernerman v. CPSO* (2010) including:

a) the facts giving rise to the misconduct;
b) changes in the physician's circumstances since the time of revocation;
c) the success of rehabilitation including the degree of insight into past inappropriate conduct;
d) the physician's current mental health and future prognosis;

e) the physician's current knowledge skill and judgement;
f) the physicians present character i.e. decency, integrity, honesty;
g) the impact of the physicians readmission on the reputation of the profession; and
h) protection of the public.

EVIDENCE

The Committee heard oral evidence from Dr. Williams in addition to the documentary evidence contained in the Application Record. The College did not call any witnesses or tender any documentary evidence.

The Application Record contained the Notice of Application, the June 11, 2012 decision of the Discipline Committee, the hearing and reprimand transcripts, numerous letters of support from Dr. Williams' professional community as well as the following:

- the Affidavit of Dr. Michael Myers, psychiatrist and independent medical assessor and his reports of April 23, 2012 and June 11, 2018;
- the Affidavit of Rachel Henry, Dr. Williams' treating psychiatrist, her psychiatric assessment of Dr. Williams dated July 11, 2012 and her summary of care report dated May 8, 2017;
- the Affidavit of Dr. Dawn Martin, professional communications expert, and her report of August 22, 2017;
- the Affidavit of Dr. Maris Andersons, Dr. Williams' addiction physician, and his report of May 15, 2017;
- the Affidavit of Judi Platt, Clinical Coordinator of the Physician Health Program (PHP), and her report of April 27, 2017;
- the Affidavit of Sean Sydor, Clinical Coordinator of the PHP;
- the Affidavit of Dr. Mark Wilkins, Chief of Staff, town Hospital and his report of May 19, 2017;
- the Affidavit of Dr. James Vigars, Dr. Williams' personal physician;

- a Brief of Letters of Support from Mayor Dean Backer, Tanya Belanger NP, Vala Monestime Belter RN, Colleen Hartwick RN, Ben Holst, Dr. Frederic Loutfi, Fr. Tim Moyle, Jeremy Stephenson CEO town Hospital and Daniel Sigouin.

SUMMARY OF THE FACTS LEADING TO THE REVOCATION OF DR. WILLIAMS' CERTIFICATE OF REGISTRATION

Patient A became Dr. Williams' patient in approximately 1991. She remained his patient until March, 2008. During the doctor-patient relationship, Dr. Williams treated Patient A for, among other things, anxiety, depression, and suicidal ideation. In the course of treatment, he prescribed anti-anxiety and anti-depressant medication. In addition, Dr. Williams treated Patient A during each of her five admissions to the Hospital for anxiety, depression or suicidal ideations in October, November and December of 2006 and September 2007. As her family doctor, he was also made aware of other emergency department visits in November and December of 2006, January 2007 and September 2007.

In February and March 2007, Dr. Williams had sexual intercourse with Patient A on approximately two occasions.

On or about September 29, 2007 and October 1, 2007, Patient A disclosed to various health professionals that she and Dr. Williams engaged in sexual intercourse during their doctor-patient relationship. This disclosure resulted in a mandatory report to the College.

On or about April 11, 2008, the College investigator received an anonymous letter. The author of the letter recanted her previous statements that her physician sexually abused her. The doctor was identified by the case file number to be Dr. Williams. On or about April 25, 2008, Patient A was interviewed by the College investigator and she acknowledged she sent the letter after Dr. Williams had drafted it for her. Dr. Williams admitted to drafting the letter.

Additionally, Dr. Williams admitted to making a false chart entry dated March 20, 2008 pertaining to Patient A.

At that time, Dr. Williams was suffering from a number of medical and personal issues, including depression in 2007 and 2008, substance abuse and marital breakdown. Dr. Williams recognized and indicated to the Committee on this application that these were neither excuses nor justifications for his behaviour with respect to Patient A.

TESTIMONY OF DR. WILLIAMS

Dr. Williams appeared before the Committee and testified at the hearing of his reinstatement application. He expressed his gratitude at the opportunity to make an application for reinstatement. He testified that he attended the University of Toronto from 1983 to 1985 for undergraduate studies and then Medical School from 1985 to 1989. He completed a one year rotating internship at Scarborough General Hospital in Toronto. He moved to a town to practice as a general practitioner when he received his certificate for independent practice in 1990.

Dr. Williams married in 1989 and he and his wife moved to the town in 1990. They had five children in eight years. They separated for a time in 2001, but reconciled in September 2001 when one of their son's received a diagnosis of leukemia. They separated for good in May 2002.

Dr. Williams described his practice of medicine in the town He loved his job; the challenge, the responsibility and the bond with patients. He chose a small town because he wanted that responsibility. The town is small with a population of approximately 2,000. There is a level 1 eighteen-bed hospital, with an Emergency Room and doctors' offices on site. The medical staff comprised only four physicians who share the 24 hour call of one day in four and every fourth weekend Friday, Saturday and Sunday. Call was not busy, perhaps 20 patients a day. In addition to call, Dr. Williams had a family practice office in town where he saw patients two or three days a week. He also worked at the nursing home in town, was a Medical Director of a nursing home in North Bay, and was a surgical assist for a weekly overnight shift at the hospital in North Bay.

Dr. Williams also had administrative roles as part of his job. He was Chief of Staff of the town Hospital for two years in the 1990's and was the President of the medical staff for eleven years until his revocation in 2012. He described the medical staff of four physicians, RNs, LPNs and

health care aids as very collegial and supportive. He stated that residents who came for training commented on how well everyone worked with each other in contrast to their experiences at other training hospitals.

Dr. Williams has been sober now for eleven years, since October 2007. He began to have troubles with drinking in 1999, when he was "drinking if I wasn't working." His drinking progressed and in late 2002, he voluntarily entered a residential program at Homewood for 35 days. Upon discharge, he entered into a five year contract with the Physician Health Program (PHP).

His abstinence slipped in 2005 when he started to "cheat." He knew that on a long weekend, he wouldn't be tested until Tuesday so he began to have alcohol on Fridays of long weekends, and that stretched to all Fridays. When his contract was completed in 2007, he stopped the program. He stated that "sadly, I said 'I don't need you' and started drinking again." During this time, he was suffering from vertebral disc problems with severe back pain, requiring prescription narcotics. He underwent two surgeries in 2004 and 2007. In addition, he has suffered from depression and has been on antidepressants since 2000 and has been followed regularly by a psychiatrist.

Dr. Williams testified that by October of 2007, he realized he needed help and enrolled with the PHP again and has been sober since. He maintains his sobriety with the help of: weekly AA meetings; Caduceus Group support in Toronto; attendance with his addiction specialist, Dr. Andersons; regular attendance with Dr. Henry, his psychiatrist; and; "a lot of reading, meditation and self-care."

Dr. Williams became emotional when describing that he admitted to sexually abusing his patient, asking her to recant and falsifying his patient's chart. When asked how he feels, he stated he couldn't believe he had done it, he made a terrible mistake and then compounded it. He stated she had been his patient for years and their children were friends. Patient A had come over to drop off her child. He had been drinking. He asked Patient A if she wanted to return for some

fun, she said yes. She returned and they had intercourse. Then two weeks later, he asked her to come over again, they drank and had intercourse.

With respect to the recantation letter, Dr. Williams testified that Patient A came to him and told him she had told a physician about their relationship. He knew the consequences of this and he "broke down." He stated that she asked what can she do and he said she could recant. When asked why he falsified Patient A's chart, Dr. Williams replied it was "stupid" and "the answer would be: to corroborate my other story."

Dr. Williams testified that he admitted his misconduct because it would be easier on everybody. He also testified that he settled a civil action for the same reason. He is embarrassed, ashamed and appalled at his behaviour. It is surreal and he can't believe he did it. He now thinks about how the patient would feel with this betrayal of trust and doesn't know how she dealt with it. On cross examination and in redirect, he clarified that his journey from denial to admission was a process; he first tried to deny it, and then erase it, then became angry and finally admitted his misconduct.

With respect to boundary violations, Dr. Williams testified that he has since learned a great deal. Dr. Myers recommended a course which he attended in 2013 at Vanderbilt University. He also attended the CPSO boundaries course at Western University. His interactions with his treating psychiatrist, Dr. Henry, included reading the *CPSO Dialogue* together and learning about the repercussions and consequences to others of such misconduct. Also, his meetings with Dr. Martin, a communications expert, have helped him learn more and to respect boundaries. Through his readings of the sexual abuse task force report and numerous cases, and speaking to physicians, Dr. Williams testified that he now has a clear understanding of the devastating effects of boundary violations. Such misconduct affects patients, the patient's family, colleagues, the community, and the hospital. The effects are "ubiquitous," he said.

Dr. Williams testified that he now understands that "sexual abuse is devastating to a patient; to be taken advantage of with such a breach of trust is very, very, significant." He stated that there is a standard that he knows he failed to live up to and it is an embarrassment to the profession. It

is embarrassing to his little town and the hospital. He claims to have learned about the repercussions and has gained insight. He takes responsibility for his actions. He says he has "learned, he knows there was a power differential and the effects were devastating all around." He "wants a chance to prove" himself.

While Dr. Williams has not been practising, he has been pursuing continuing medical education. He began in earnest in 2014, after the death of his father, reading colleagues' journals, and then began attending CME conferences, and conducted online reading of *MD Briefcase* and *UptoDate*. In 2014, he was hired by the town Hospital as a physician recruiter. He attended recruitment fairs and conducted the tours, and helped the hospital to recruit a new physician.

Dr. Williams understands that he must prove he is ready to return to practice and states he will do whatever it takes. He feels he is healthy now. He has signed a new five year contract with the PHP. To prevent a recurrence, Dr. Williams stated that he will continue with PHP, continue with his psychiatrist, Dr. Henry, and also continue attending weekly AA meetings and the Caduceus Group with Dr. Andersons. He testified that he will continue to take care of himself to avoid a relapse. Dr. Williams acknowledged that there is always a risk of relapse, but he testified that he knows now he is "completely different" than he was when he last relapsed. It has been eleven years. He has worked with his psychiatrist to be "healthy of mind." With the PHP, he has admitted to cheating in the past and the new contract now has much closer monitoring of urine samples and a hair sample can be taken at any time. He spoke of his strong support system in the community, at the hospital and with family.

On cross examination, Dr. Williams further outlined his practice before his revocation, with office hours in town, and ER shifts in town, as well as surgical assisting shifts in North Bay, and nursing home responsibilities in town and North Bay. He acknowledged he was working many hours; he "had five kids to raise." He sees now that this was too much and he acknowledges that, should he return to work, he will start with 35-38 hours. He testified that the Emergency Room in town is low volume with 5,000 patient visits per annum. He testified that in contrast to his previous situation, he is not fresh out of rehab but rather he is healthy now. He is ready to return to practice in a stepwise fashion, with close supervision and limited hours, as outlined in the

proposed order. He is aware that his progression will depend on his performance and he is ready to work with his supervisors.

AFFIDAVIT EVIDENCE

Dr. Michael Myers

Dr. Michael Myers is a psychiatrist with extensive experience in physician health who was engaged to provide a psychiatric assessment and make recommendations for treatment of Dr. Williams. On April 23, 2012, based on a review of documentation and several meetings with Dr. Williams, Dr. Myers concluded that Dr. Williams;

a) did not and does not meet the criteria for a personality disorder;
b) he was impaired at the time of the sexual activity with his patient due to both depression and substance abuse (alcohol, opiates and marijuana);
c) he is not a sexual predator;
d) he would likely be fit to return to the practice of medicine, provided he pursued education and rehabilitation.

Dr. Myers met with Dr. Williams again on May 12, 2018 and conducted telephone interviews with Judi Platt of the PHP; Father Tim Doyle; Dr. Mark Wilkins, a colleague and chief of staff at the town Hospital; Dr. Rachel Henry, Dr. Williams' treating psychiatrist; Dr. Dawn Martin, psychologist, and communications/boundary violations specialist; Dr. Maris Andersons, Dr. Williams' addiction specialist; and Dr. Jim Vigars, Dr. Williams' family physician. He also reviewed the Discipline decision of June 11, 2012, and the reports and notes of Dr. Williams' treating health professionals. Based on that investigation, Dr. Myers made the DSM V diagnosis for Dr. Williams of:

a) Major Depressive Disorder in full remission;
b) Substance-Related Disorders (alcohol, opiates, cannabis) in sustained remission.

Dr. Myers concluded that Dr. Williams has received good treatment for the illnesses and stresses. This has been a mix of his psychiatric treatment with Dr. Henry, his addiction work with Dr. Andersons, his counselling with Dr. Martin, his completed course at Vanderbilt on boundaries, and his recovery and monitoring with the PHP via Ms. Judi Platt. He has been a model patient and has gained a high level of understanding into himself and what triggers to watch for.

Dr. Myers is of the opinion that Dr. Williams is at a very low risk of violating the integrity of the doctor-patient relationship should he return to practice. He believes Dr. Williams is fit to return to practice. He believes Dr. Williams has the mental competency and insight to practise medicine with integrity, decency and honesty and in accordance with the law. He also believes Dr. Williams communicates effectively and displays an appropriate professional attitude.

Dr. Rachel Henry

Dr. Henry has been Dr. Williams treating psychiatrist since July 11, 2012. At the beginning of treatment, Dr. Henry noted that Dr. Williams' was in a sustained full remission of substance abuse disorder, that he had a pre-existing diagnosis of Major Depressive Disorder and that he was eager to engage in psychotherapy to help him address the issues that led him to his decision to engage in a sexual relationship with a patient and also to address the issues that have underpinned his history of substance abuse and depression.

Initially, Dr. Williams was seen weekly. From the beginning, he expressed remorse and responsibility for his actions. Over the six years, it is the opinion of Dr. Henry that Dr. Williams has developed insight into his vulnerabilities and has developed his capacity to create and sustain a healthy, balanced life for himself.

Dr. Henry's present diagnosis for Dr. Williams is:

a) Major Depressive Disorder, recurrent, in remission; and
b) Alcohol Use Disorder, in sustained full remission.

It is her opinion that he is mentally competent to practise medicine and it is extremely unlikely he would ever cross the doctor-patient sexual relations boundary again. She opines that she can discharge him from her practice as he no longer needs ongoing psychotherapy, but will continue to see him with supportive psychotherapy as a condition of reinstatement.

Dr. Dawn Martin

Dr. Dawn Martin is a physician educator and coach and has been the primary communications consultant for the CPSO for many years. She met with Dr. Williams face to face or over Skype on eight occasions. The program for Dr. Williams was based on the key competencies of the CanMED2015 Professional Role as it related to the specifics of his situation. She spent many hours with Dr. Williams to ensure that he understands how he contributed to the process and what his obligations are as a professional moving forward. She is confident the Dr. Williams has engaged the right resources to obtain the necessary support and feedback. He has identified realistic strategies for example, she asks physicians three questions: stop doing? start doing? and keep doing? Dr. Williams provided answers indicating he has self-awareness and has developed practical strategies.

Dr. Martin concluded that Dr. Williams has demonstrated the necessary self-awareness and insight into his professional responsibilities to be considered for reinstatement as an active and contributing member of the profession. He has made the necessary changes in his life to make sure there is no risk of repetition, and he has demonstrated the commitment and ability to sustain the changes.

Dr. Maris Andersons

Dr. Maris Andersons is an addiction specialist who first saw Dr. Williams in August 2012 when he was referred by the PHP. He has followed Dr. Williams individually and as part of the Caduceus Group he facilitates for six years. He notes in his report that Dr. Williams has shown a strong recovery program. He has found him to be consistently honest and trustworthy, and has described his significant guilt, sadness and regret. Dr. Andersons found his regret and insight to

be genuine. He will undertake to continue to be Dr. Williams' addiction physician and Caduceus group leader.

Ms. Judi Platt

Ms. Judi Platt is a retired Addiction Registered Nurse and Adler Trained Coach. Until June 2018, she was a clinical coordinator at the PHP. Her report notes that Dr. Williams has been compliant with his PHP contract. She found Dr. Williams to have insight into his substance disorder and to be committed to his on-going sobriety. She notes the PHP will assist Dr. Williams return to practice in a gradual stepwise fashion if he is to be reinstated.

Mr. Sean Sydor

Mr. Sean Sydor is a registered psychotherapist and has been at the PHP as a clinical coordinator since 2011. He took over Dr. Williams' case when Ms. Judi Platt retired in June 2018. He confirmed that from June 2018 until October 2018, Dr. Williams has remained fully compliant with his PHP Monitoring Contract. He confirms that the PHP will continue to monitor Dr. Williams in accordance with the Monitoring Contract.

Dr. Mark Wilkins

Dr. Mark Wilkins is a family physician, emergency physician and the chief of staff at the town General Hospital. He also served as Dr. Williams' PHP primary care physician until care was transferred to Dr. Vigars in 2018. He encouraged Dr. Williams to participate in an observer role during his ER shifts and in his office beginning in January 2017. Dr. Williams did not touch, treat or interview patients. Through the observer-ship, Dr. Wilkins was able to assess Dr. Williams' medical knowledge and found it to be current and exemplary. In addition, he found him to be professional at all times.

Dr. James Vigars

Dr. James Vigars is a primary care family physician in North Bay. He has been Dr. Williams' family physician as part of his clinical team under his PHP addiction monitoring contract since 2018. He assessed Dr. Williams on April 20, 2018 and found him to be in good physical health.

ANALYSIS

Dr. Williams' counsel reviewed the affidavits in the application record, drawing the Committee's attention to the numerous reports indicating support for Dr. Williams' return to the practice of medicine. Additionally, she highlighted for the Committee reports indicating Dr. Williams' acceptance of responsibility, his demonstrated insight, and continued engagement in abstinence.

The Committee considered and applied the test for reinstatement as outlined in *Manohar v. CPSO* (2013). It found that the reports filed indicated that Dr. Williams met the non-exemptible requirements for a certificate of registration. Specifically, that Dr. Williams is mentally competent, has demonstrated sufficient knowledge, skill and judgement in family practice and in an E.R. setting as proposed in the Independent Education Program (IEP) set out in the proposed order. The proposed IEP is a stratified, stepwise approach prepared with the assistance of the CPSO. There is a high level of supervision contemplated with Dr. Williams not acting as the most responsible physician for patient care for at least the first month, depending on his supervisors' reports. Lastly, of the non-exemptible requirements, Dr. Williams' treating/assessing physicians agree he can communicate effectively and professionally. As Dr. Williams testified, he defers to the CPSO and will do whatever it takes to succeed at returning to practice.

The Committee also found that Dr. Williams's circumstances have changed significantly and that genuine growth and learning has taken place. He is now sober eleven years. While he acknowledges that alcohol abuse and mood disorder are not an excuse for his misconduct, the Committee considered it was a contributing factor to his poor judgement in the past.

The Committee accepted the submission of Dr. Williams' counsel that Dr. Williams is on a personal growth journey and now understands the pain and destruction caused by his sexual abuse of Patient A. The Committee is of the view that stringent monitoring with the PHP with third party reports, his IEP and supervision will serve to mitigate the risk of recurrence and protect the public.

The College is not opposing Dr. Williams' reinstatement provided that certain terms, limitations and conditions specified in the draft order filed are placed on his certificate of registration. The College submitted that the proposed order contains the minimum terms. While the Committee independently assessed the application of Dr. Williams in light of the appropriate factors and tests, the Committee takes comfort in the fact that the College does not oppose the application for reinstatement. If the College had been of the view that Dr. Williams should not have his certificate of registration reinstated, it would have led evidence and made submission in opposition, which it did not do.

The Committee carefully considered the vulnerability of Patient A and that her sexual abuse by Dr. Williams was the most serious misconduct. It also considered Dr. Williams' involvement in the recantation letter to be an aggravating factor. The recantation and the deceit with the false chart entry affected the honour and reputation of the profession.

The College focused in their submissions on the specifics of the proposed order and highlighted that the mandatory attendance with the PHP will ensure Dr. Williams continues in treatment and will be supported with monitoring, which will lower the risk to the public. Limitation on Dr. Williams' hours of practice is a necessary and appropriate safeguard. As well, ensuring he work only in a group setting with a supervisor, workplace monitor and education program, as specified in the proposed order, will ensure Dr. Williams is monitored closely. Finally, the requirement of a reassessment in twelve months will be a further safeguard to the protection of the public.

The Committee accepted Dr. Myers' 2012 report, where he stated, "Addiction is a lifelong disease and the risk of relapse, although diminishing with each year of sobriety, is never zero."

DECISION AND REASONS ON REINSTATEMENT

The Committee's paramount priority in this decision is, as in all cases, protection of the public. Dr. Williams committed the most egregious act of misconduct by having sexual intercourse with a very vulnerable patient and he compounded it with his subsequent deception. For his misconduct, the Committee imposed on Dr. Williams the most significant penalty this Committee can order, revocation of his certificate of registration. The RHPA legislation contemplates that some professionals can learn from their mistakes, can grow to be better and consequently, are given the right to reapply for registration under section 72 of the Code. After careful consideration of the evidence provided to the Committee at this reinstatement hearing, and after serious deliberation, the Committee is of the unanimous opinion that Dr. Williams' certificate of registration should be reinstated subject to stringent terms, conditions and limitations on his certificate of registration.

In coming to this conclusion the Committee carefully considered the tests as outlined in *Manohar v. CSPO (2013)*. Two broad questions must be considered.

1. **What is the risk of further misconduct, and if there is a risk, is it manageable with terms, conditions and limitations**?

Dr. Williams' misconduct, as already stated, was of the most serious kind. It must be taken into account that he aggravated the misconduct with his dishonesty in 2007. However, over the six years since his revocation, he has displayed regret and genuine remorse and has taken responsibility for his actions. Given the significant triggering factor of alcohol abuse, his abstinence since 2007 is reassuring to the Committee of his commitment to avoid further misconduct. While no one believes the risk of substance abuse relapse is zero, there are individuals who have a very low risk and Dr. Williams' treating team is of the view he is amongst that group. An order specifying College-approved, stepwise supervision in his IEP, the PHP monitoring of his abstinence, the regular supervisor reports requiring approval from the College and the need for a full reassessment in twelve months, will serve to manage this low risk to the public.

2. Is the applicant suitable to practise both in terms of protection of the public and maintaining the confidence of the public in the regulation of the profession?

The Committee is impressed with Dr. Williams' very wide support from his community as evidenced by the letters from co-workers and community leaders. Impressive to the Committee was the confidence his colleagues afforded him by appointing him to be the recruiter for a new physician to the town hospital in 2014. In addition, in preparation for his reinstatement over the last couple of years, two of his colleagues, Dr. Wilkins and Dr. Latoufi, spent time, with patient permission, to allow Dr. Williams to observe and discuss their medical practice, thus adding significant credibility to their statements that they believe he is ready at this time and suitable to practise medicine.

The reports from Dr. Myers, Dr. Henry and Dr. Martin all express their opinion that Dr. Williams is suitable to practise medicine. In terms of protection of the public, all assessors are of the opinion that Dr. Williams is unlikely to transgress the boundaries of the doctor-patient relationship again.

Dr. Williams acknowledged that recovery and acceptance are a process. Dr. Williams was already five years sober by the time of his disciplinary hearing in June 2012. Dr. Williams seems to have begun the personal work to improve himself right from the start of his penalty after his discipline hearing, by engaging in another PHP contract, by seeking the opinion of Dr. Myers and following his advice with respect to psychiatric treatment and boundary and communications learning. He has diligently worked with his treating psychiatrist since July 2012 and his depression and alcohol use disorder are in remission. He is willing to follow any terms, conditions and limitations placed on his certificate of registration to be able to return to practise. He humbly and remorsefully speaks of the real damage and suffering his misconduct caused Patient A and demonstrates a true understanding of the position of power and the inherent imbalance in a doctor-patient relationship.

The Committee had concerns regarding the very small nature of the community in which Dr. Williams lives and works. Such small communities, unlike urban centres, do not afford

physicians anonymity in their personal lives. It is very likely that physicians will cross paths with patients in their regular daily activities outside of the office and hospital. Dr. Williams must keep his emotional and personal distance from his patients. By his responses to questioning from the panel, the Committee concluded he is clearly aware of this. For example, his new family physician, Dr. Vigars, practises outside of the town community, in North Bay.

Regulation of the profession in the public interest is paramount to public protection. It is the responsibility of the College to ensure that the very high standards of the profession are maintained. Regulation must also be fair and just. Dr. Williams has clearly served a serious penalty for his serious transgression. He has not practised medicine for five years. He has also worked hard, as he was encouraged to do, to better himself so that he might return to practise. There are significant safeguards in place with the proposed order filed with the Committee, containing stringent terms, conditions and limitations on his certificate. It is the view of this Committee that Dr. Williams' is exactly the type of case the legislation contemplated in section 72 of the Code, outlining the requirements and conditions to satisfy to gain re-entry into the profession after revocation.

Of the many other factors to consider as set out in the reinstatement cases *of Kulkarni v. CPSO* (2004) and *Kernerman v. CPSO* (2010) the Committee came to the following conclusions.

a) the facts giving rise to the misconduct

The agreed statement of facts regarding events in 2007, from the discipline hearing of June 11, 2012, make it clear that Dr. Williams took advantage of Patient A without regard for her or the consequences of his conduct, on two occasions. This took place while he was under the influence of alcohol and exercising impaired judgement. It is also clear that in his panic regarding being caught he compounded his misconduct with deceit and manipulation.

b) changes in the physician's circumstances since the time of revocation;

It is abundantly clear to the panel from the evidence provided that Dr. Williams at the time of the misconduct was unwell with substance abuse and depression. By the time of the revocation in 2012, Dr. Williams had already been addressing the issue of his sobriety and other issues, through a new contract with the PHP. It is evident to the Committee that he had begun to take responsibility for his actions. Since that time, as itemized in Dr. Myers' report, Dr. Henry's report and Dr. Andersons' report, Dr. Williams' substance abuse is in remission. Dr. Williams has worked to understand his misconduct, maintain his sobriety, and set his sights towards returning to medical practice. Additionally, he has learned about boundaries, through his work with Dr. Martin, and the courses he has taken. He accepts that it is his responsibility to respect doctor-patient boundaries. He has learned what devastating effects on patients boundary violations can have.

c) the success of rehabilitation including the degree of insight into past inappropriate conduct;

All Dr. Williams' treating and assessing reports clearly indicate that he is in remission with his depression and alcohol use disorder and that he has genuine insight into his transgressions.

d) the physician's current mental health and future prognosis;

Psychiatric reports of Dr. Henry, his treating psychiatrist, and Dr. Myers, his assessing psychiatrist, indicate that Dr. Williams is in sustained remission and has a reasonable future prognosis of a low risk of relapse. They accept he is not a sexual predator.

e) the physician's current knowledge, skill and judgement

Dr. Williams, through his extensive continuing medical education and observer-ships, has worked hard to maintain his medical knowledge and skills and has demonstrated to all who have

assessed him that he now displays good professional judgement. The proposed IEP will serve to ensure that he is closely supervised and that his knowledge, skills and judgement meet the requirements of registration in Ontario.

f) the physician's present character i.e. decency, integrity, honesty

The Committee reviewed Dr. Williams' Reinstatement Application materials before the reinstatement hearing, including many very glowing letters of support. Dr. Williams' counsel suggested we could make a decision on the written record alone. This was not opposed by the College. The Committee requested to have *viva voce* testimony from Dr. Williams. Dr. Williams presented himself in a very professional manner; he spoke well and with humility. He was realistic and straightforward in acknowledging that the onus is on him to prove he is ready to return to practise and he is ready to "do whatever it takes." He has a plan moving forward to avoid relapse and acknowledges that the risk is not zero, and so he both requires and welcomes the great support he has from his professional community.

g) the impact of the physician's readmission on the reputation of the profession

The reputation of the profession must be upheld. Serious sanctioning in cases of sexual abuse of a patient serves to protect the public and uphold the reputation of the profession. That is why the Discipline Committee revoked Dr. Williams' certificate of registration in 2012. All cases must be considered on their own facts. Given all of the facts in this case, Dr. Williams has concertedly and with humility admitted his transgression, improved his health, maintained his medical knowledge and skill and learned about boundaries and communications in ways that have been exemplary to his assessors over the years since revocation of his certificate of registration for his misconduct. He has no other breaches of professionalism in his career of 22 years of practice. Regulation of the profession must be rigourous but also fair to uphold the reputation of the profession. As stated above, there is a provision in the legislation that provides for the re-entry of suitable candidates. The legislation provides that a physician whose certificate of registration has been revoked for sexual abuse is legally entitled to apply for reinstatement after five years from the revocation of his certificate. Recognizing that readmission to practice is a high hurdle for a

physician who has committed sexual abuse of a patient, the Committee is of the opinion Dr. Williams is an appropriate candidate.

h) protection of the public.

The Committee is confident that the public will be protected by the changes made by Dr. Williams in his personal life and by the significant terms, conditions and limitations to be imposed on Dr. Williams' certificate of registration.

CONCLUSION

Dr. Williams has gained an understanding and insight into his misconduct. Since his revocation he has shown compliance with his therapy and a clear appreciation of the harmful impact his actions had on Patient A. The Committee concludes that if reinstated, he poses no substantive risk to patients. He has shown good character and honesty, as evidenced by the exemplary reports from his treating and assessing physicians, and in letters from his colleagues and community. The proposed re-entry to practise with continuing treatment and a very detailed monitoring and supervision is safe and reasonable. It is for all of the above reasons that the Committee grants Dr. Williams' application for reinstatement, and imposes the following terms, conditions and limitations on his certificate of registration.

ORDER

The Committee orders and directs that:

1. The Registrar issue a certificate of registration to Dr. Williams.

2. The Registrar impose the following terms, conditions and limitations on Dr. Williams' certificate of registration:

    a. Dr. Williams shall practise only in a group practice setting.

b. Dr. Williams shall limit his practice hours based on the recommendations of his PHP (as defined below) and as approved by the College.

Clinical Supervision

c. For a period of no less than eight (8) months, Dr. Williams shall practise under the guidance of two (2) clinical supervisors: (a) Dr. John Philip Seguin ("**Dr. Sequin**"); and (b) Dr. Frederic Farid Loutfi ("**Dr. Loutfi**") ("**Clinical Supervision**"). Dr. Seguin and Dr. Loutfi are herein collectively referred to as the "**Clinical Supervisors**", or individually as a "**Clinical Supervisor**").

d. Prior to re-entering practice, Dr. Williams shall arrange for Dr. Seguin and Dr. Loutfi to sign an undertaking in the form attached to this Order as **Schedule "A"**.

High Level Supervision

e. For an initial period of no less than one (1) month, Dr. Williams shall practise under high level supervision ("**High Level Supervision**"), during which time Dr. Williams shall practise only at the following locations and on the following terms:

   i. Dr. Williams shall practise with Dr. Seguin at least one full day each week at Dr. Seguin's practice location at 506 Astorville Road, Astorville, Ontario ("**Astorville Practice**");

   ii. Dr. Williams shall practise with Dr. Loutfi at the following practice locations:

      1. Group Family Medicine Practice at 217 Turcotte Park Road, Mattawa, Ontario ("**Mattawa Family Practice**");

      2. Algonquin Nursing Home at 231 10th Street S., Mattawa, Ontario ("**Algonquin Nursing Home**");[1] and

      3. Mattawa Hospital Emergency Room at 217 Turcotte Park Road, Mattawa, Ontario ("**Mattawa Hospital ER**").

f. During the period of High Level Supervision, at least one of the Clinical Supervisors shall, at minimum:

   i. Meet with Dr. Williams, in person, at least once per week;

   ii. Be the Most Responsible Physician ("**MRP**") for all patients with whom Dr. Williams interacts, regardless of whether the Clinical Supervisor is physically

[1] The address of the Algonquin Nursing Home is expected to change to a location adjacent to the Mattawa Hospital when the new nursing home facility opens in late 2018 or early 2019. Upon this change, Clinical Supervision will continue in accordance with all other terms of this Order at the new location.

present during the patient encounter with Dr. Williams:

1. Dr. Seguin shall be the MRP for all patients with whom Dr. Williams interacts at the Astorville Practice; and
2. Dr. Loutfi shall be the MRP for all patients with whom Dr. Williams interacts at the Mattawa Family Practice, Algonquin Nursing Home, and Mattawa Hospital ER locations;

iii. Be available on-site during all times that Dr. Williams is interacting with patients; provided, however, Dr. Loutfi shall be the Clinical Supervisor available (on-site) for all patients with whom Dr. Williams interacts at the Algonquin Nursing Home and Mattawa Hospital ER locations;

iv. Initially, directly observe all of Dr. Williams' patient encounters until the Clinical Supervisor is satisfied that Dr. Williams should be able to see patients without direct supervision. After the Clinical Supervisor makes a determination that Dr. Williams should be able to see patients without direct supervision, the Clinical Supervisor shall continue to directly observe at least one (1) of Dr. Williams' patient encounters each day. With respect to this direct observation, each month,

1. At least three (3) of such observations shall be by Dr. Loutfi at the Algonquin Nursing Home;
2. At least three (3) of such observations shall be by Dr. Loutfi at the Mattawa Hospital ER;
3. At least three (3) of such observations shall be by either Clinical Supervisor at either the Mattawa Family Practice or Astorville Practice locations; and
4. The remainder of such observations may be at any of the Algonquin Nursing Home, Mattawa Hospital ER, Mattawa Family Practice or Astorville Practice locations, and may be observed by either Clinical Supervisor;

v. Directly observe Dr. Williams when Dr. Williams is performing any procedures that he has not already performed under supervision. If Dr. Williams performs any new procedures at the Algonquin Nursing Home or

the Mattawa Hospital ER, Dr. Loutfi shall be the directly observing Clinical Supervisor; and

vi. Review daily with Dr. Williams all patient charts for all patients seen by Dr. Williams and approve, or modify if necessary, all management plans.

g. During the period of High Level Supervision, each Clinical Supervisor shall, after his first meeting/observation of Dr. Williams and at least monthly thereafter, provide the College with a report containing:

i. A list of all charts reviewed with patient identifiers, with an overview of the types of presenting problems addressed in the charts and discussed with Dr. Williams;

ii. Identification of any concerns;

iii. Identification of the Clinical Supervisor's recommendations and Dr. Williams' success in implementing any changes into his practice; and

iv. The Clinical Supervisor's opinion as to whether Dr. Williams is ready to transition to Moderate Level Supervision (as defined below).

h. After no less than one (1) month of High Level Supervision, and upon recommendation by either or both of the Clinical Supervisors, the College may, in its sole discretion reduce the degree of Clinical Supervision to a moderate level of supervision ("**Moderate Level Supervision**").

Moderate Level Supervision

i. If the transition is recommended by either or both of the Clinical Supervisors, and approved by the College in its sole discretion, Dr. Williams shall practice under Moderate Level Supervision for a period of no less than four (4) months, during which time:

i. Dr. Williams shall practice only at the following locations:

1. Mattawa Family Practice at 217 Turcotte Park Road, Mattawa, Ontario;
2. Algonquin Nursing Home at 231 10th Street S., Mattawa, Ontario; and
3. Mattawa Hospital ER at 217 Turcotte Park Road, Mattawa, Ontario.

ii. Dr. Williams may be the MRP for patients cared for by Dr. Williams;

iii. At least one of the Clinical Supervisors shall be available by telephone during

all times that Dr. Williams is interacting with patients; provided, however, Dr. Loutfi shall be the Clinical Supervisor available (by telephone) for all patients with whom Dr. Williams interacts at the Algonquin Nursing Home and Mattawa Hospital ER locations;

iv. For Dr. Williams' emergency room practice ("**ER Practice**"), supervision shall be in accordance with the College's Policy, "Expectations of Physicians not Certified in Emergency Medicine Intending to Include Emergency Medicine as Part of Their Rural Practice – Changing Scope of Practice Process";

v. Each Clinical Supervisor shall, at minimum, meet separately with Dr. Williams at least once per month, in person (if an in person meeting is not possible, this meeting may occur through another form of visual and audio communication that accords with the College's Telemedicine Policy), to review 10 to 15 patient charts to comment on documentation and care. Each such review of 10 to 15 patient charts shall include at least two (2) examples from each of Dr. Williams' three practice settings (Algonquin Nursing Home, Mattawa Hospital ER, and Mattawa Family Practice); and

vi. Each Clinical Supervisor shall, at least every two (2) months, provide the College with a report containing:

1. A list of all charts reviewed with patient identifiers, with an overview of the types of presenting problems addressed in the charts and discussed with Dr. Williams;
2. Identification of any concerns;
3. Identification of the Clinical Supervisor's recommendations and Dr. Williams' success in implementing any changes into his practice; and
4. The Clinical Supervisor's opinion as to whether Dr. Williams is ready to transition to Low Level Supervision (as defined below).

j. After no less than four (4) months of Moderate Level Supervision, and upon recommendation by either or both of the Clinical Supervisors, the College may, in its sole discretion reduce the degree of Clinical Supervision to a Low Level of Supervision ("**Low Level Supervision**").

Low Level Supervision

k. If the transition is recommended by either or both of the Clinical Supervisors, and approved by the College, Dr. Williams shall practice under Low Level Supervision, for a period of no less than three (3) months, during which time:

   i. Dr. Williams shall practice only at the following locations:

      1. Mattawa Family Practice at 217 Turcotte Park Road, Mattawa, Ontario;

      2. Algonquin Nursing Home at 231 10th Street S., Mattawa, Ontario; and

      3. Mattawa Hospital ER at 217 Turcotte Park Road, Mattawa, Ontario;

   ii. Dr. Williams may be the MRP for patients cared for by Dr. Williams;

   iii. At least one of the Clinical Supervisors shall be available to Dr. Williams by telephone (but not necessarily in real time during Dr. Williams' patient interactions); provided, however, Dr. Loutfi shall be the Clinical Supervisor available (by telephone) for all patients with whom Dr. Williams interacts at the Algonquin Nursing Home and Mattawa Hospital ER locations;

   iv. For Dr. Williams' ER Practice, supervision shall be in accordance with the College's Policy, "Expectations of Physicians not Certified in Emergency Medicine Intending to Include Emergency Medicine as Part of Their Rural Practice – Changing Scope of Practice Process";

   v. Each Clinical Supervisor shall, at minimum, meet separately with Dr. Williams at least once every other month (such that Dr. Williams meets with one of the Clinical Supervisors each month), in person (if an in person meeting is not possible, this meeting may occur through another form of visual and audio communication that accords with the College's Telemedicine Policy), to review 10 to 15 patient charts to comment on documentation and care. Each such review of 10 to 15 patient charts shall include at least two examples from each of Dr. Williams' three practice settings (Algonquin Nursing Home, Mattawa Hospital ER, and Mattawa Family Practice); and

   vi. Each Clinical Supervisor shall, at least every three months, provide the College with a report containing:

1. A list of all charts reviewed with patient identifiers, with an overview of the types of presenting problems addressed in the charts and discussed with Dr. Williams;
2. Identification of any concerns;
3. Identification of the Clinical Supervisor's recommendations and Dr. Williams' success in implementing any changes into his practice; and
4. The Clinical Supervisor's opinion as to whether Dr. Williams is ready to transition to an unsupervised practice, subject to the College-directed assessment of practice (as described below).

Other Elements of Clinical Supervision

l. Throughout the period of Clinical Supervision, Dr. Williams shall abide by all recommendations of the Clinical Supervisors.

m. Throughout the period of Clinical Supervision, Dr. Williams shall, with respect to each patient for which Dr. Williams provides care:

i. In each patient chart, record the name of the MRP; and

ii. Obtain copies of reports from other health-care/medical providers that are relevant to the patient's ongoing care and ensure that such reports are reviewed and included in a patient care follow-up plan.

Assessment of Practice

n. After no less than three (3) months of Low Level Supervision, and upon recommendation by either or both of the Clinical Supervisors that Dr. Williams may be ready to transition to an unsupervised practice, Dr. Williams shall undergo an assessment of his practice (the "**Assessment**") by a College-appointed assessor or assessors (the "**Assessor**"). For clarity, until the Assessment is complete and the College approves Dr. Williams' entry into unsupervised practice, Dr. Williams shall continue to practice under Low Level Supervision. However, during the Assessment, the Clinical Supervisors shall no longer be required to continue providing reports to the College unless a Clinical Supervisor has concerns about Dr. Williams or his practice.

o. The Assessment shall include all of Dr. Williams' three practice settings (Algonquin Nursing Home, Mattawa Hospital ER, and Mattawa Family Practice). The

Assessment may include (at the College's discretion) a review of Dr. Williams' patient charts, direct observation of Dr. Williams' practice, an interview with Dr. Williams, interviews with colleagues and coworkers, feedback from patients, consultations with Dr. Williams' treating psychiatrist(s) and other treating physicians, and any other tools deemed necessary by the College. Dr. Williams shall abide by all recommendations made by the Assessor.

p. The Assessor shall be provided with a copy of this Order, the Discipline Committee's Reasons for Decision in this matter, and the copies of the reports of the Clinical Supervisors referred to above.

q. The Assessor shall submit a written report to the College regarding Dr. Williams' standard of practice and this report may form the basis for further action by the College.

r. The College shall review the final assessment report of the Assessor and make a determination, in its sole discretion, as to whether Dr. Williams can enter unsupervised practice. For clarity, Dr. Williams shall not enter unsupervised practice unless and until the College approves him to do so.

Monitoring Terms

s. Dr. Williams shall cooperate, and shall not interfere with, unannounced inspections of his practice by the College and to any other activity the College deems necessary for the purpose of monitoring Dr. Williams' compliance with the terms of this Order.

t. Dr. Williams shall provide the College with his irrevocable consent to make appropriate enquiries of the Ontario Health Insurance Plan, and/or any person(s) or institution(s) that may have relevant information, in order for the College to monitor his compliance with the terms of this Order.

Education

u. Dr. Williams shall participate in, and successfully complete, all aspects of the detailed Individualized Education Plan ("**IEP**"), attached hereto as **Schedule "B"**, including but not limited to all of the following professional education ("**Professional Education**"):

   i. Clinical Supervision;

ii. During the period of High Level Supervision, Dr. Williams shall review, and discuss with one of his Clinical Supervisors, The College of Family Physicians of Canada three-part article on patient centred interviewing (Can. Fam. Physician Vol. 35: January 1989):

1. Patient-Centred Interviewing, Part I: Understanding Patients' Experiences;
2. Patient-Centred Interviewing, Part II: Finding Common Ground; and
3. Patient-Centred Interviewing, Part III: Five Provocative Questions;

iii. During the period of High Level Supervision, as part of each Clinical Supervisor's direct observation of Dr. Williams' patient encounters, the Clinical Supervisor shall discuss patient-centred questioning with Dr. Williams;

iv. During all periods of Clinical Supervision, every other month, Dr. Seguin shall assign topics for Dr. Williams to study. The topics for study shall include but are not limited to:

1. Patient-Centred Interviewing;
2. Antibiotics: Anti-Infective Guidelines for Community-Acquired Infections;
3. Narcotics: Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain;
4. Diabetes;
5. Medical Record Keeping;
6. ER Practice Issues; and
7. Nursing Home Practice Issues.

With respect to each such topic, Dr. Williams shall study the relevant and applicable guidelines and shall discuss such guidelines with Dr. Seguin;

v. With the assistance of a Clinical Supervisor, Dr. Williams shall collect and review different templates and approaches to disease prevention, and Dr. Williams shall discuss these with his Clinical Supervisor;

vi. With the assistance of a Clinical Supervisor, Dr. Williams shall meet with support staff at each of his practice locations to optimize patient call-backs,

patient charting, and follow-up when patients fail to attend for important results; and

vii. Dr. Williams shall:

1. Prepare a proposed personal continuing professional development ("**CPD**") program that includes continuing professional development relevant to each of Dr. Williams' three practice settings (Algonquin Nursing Home, Mattawa Hospital ER, and Mattawa Family Practice/Astorville Practice) (the "**Proposed CPD Program**");
2. Discuss the Proposed CPD Program with Dr. Seguin and modify the proposed CPD Program pursuant to Dr. Seguin's recommendations, if any (the "**CPD Program**");
3. Complete the CPD Program during the twelve (12) months following receipt of Dr. Seguin's recommendations to the Proposed CPD Program; and
4. Within one (1) month of completing the CPD Program, provide proof to the College of his successful completion of the CPD Program.

v. The College shall determine, in its sole discretion, whether Dr. Williams has successfully completed the Professional Education.

Other Elements of Clinical Supervision, Professional Education and Assessment

w. If, prior to completion of Clinical Supervision, either Clinical Supervisor is unwilling or unable to continue in that role for any reason, Dr. Williams shall retain a new College-approved Clinical Supervisor who shall sign a College-approved undertaking in a similar form to the undertaking at Schedule "A". If Dr. Williams fails to retain a Clinical Supervisor on the terms set out above (including obtaining an executed undertaking in the similar form to Schedule "A") within 20 days of receiving notification that a former Clinical Supervisor is unwilling or unable to continue in that role, Dr. Williams shall cease practicing medicine until such time as he has obtained a Clinical Supervisor acceptable to the College and who has signed the appropriate undertaking. If Dr. Williams is required to cease practice as a result of this paragraph, this shall constitute a term, condition and limitation on Dr. Williams' certificate of registration and such term, condition and limitation shall be

included on the public register of the College.

x. Dr. Seguin and Dr. Loutfi shall communicate with each other on an as-needed basis, but in any event no less than monthly. Dr. Seguin and Dr. Loutfi shall copy each other, and Dr. Williams, on their reports to the College.

y. The patient charts reviewed by the Clinical Supervisors pursuant to this Order shall be selected by the reviewing Clinical Supervisor based on the educational needs identified in the IEP, attached to this Order as Schedule "B", and based on any concerns that may arise during the period of Clinical Supervision.

z. Dr. Williams shall consent to the disclosure and sharing of information between the Clinical Supervisors, the Assessor(s) and the College as any of them deem necessary or desirable in order to fulfill their respective obligations.

aa. Any person who acts as a Clinical Supervisor or Assessor for Dr. Williams shall be provided with and read copies of this Order and the Discipline Committee's Reasons for Decision in this matter, and shall immediately report to the College any failure to maintain the terms of this Order.

Other

bb. Prior to re-entering practice, Dr. Williams shall enter into a five (5) year contract as a licensed physician with the Physician Health Program of the Ontario Medical Association ("**PHP**").

cc. Dr. Williams shall continue to receive treatment from, and shall comply with all treatment recommendations of his psychiatrist, Dr. Rachel Henry, or with another therapist acceptable to the College ("**Psychotherapist**"). Dr. Williams shall provide to his Psychotherapist a copy of this Order and the Discipline Committee's Reasons for Decision. Dr. Williams shall attend with the Psychotherapist at least once every four (4) months and the Psychotherapist shall submit reports to the College every four (4) months. Those reports shall include information relevant to Dr. Williams' fitness and/or capacity to practise medicine. Additionally, if the Psychotherapist forms an opinion that Dr. Williams' continued practice poses a risk of harm to patients or the public, she shall report that information to the College immediately. Dr. Williams shall arrange for his Psychotherapist to sign an undertaking (in a form acceptable to the College) confirming her willingness and ability to comply with the

above.

dd. Dr. Williams shall continue to receive treatment from, and shall comply with all treatment recommendations of his addiction medicine physician, Dr. Maris Andersons, or with another addiction specialist acceptable to the College ("**Addiction Specialist**"). Dr. Williams shall provide to his Addiction Specialist a copy of this Order and the Discipline Committee's Reasons for Decision. Dr. Williams shall attend with the Addiction Specialist at least once every six (6) months. The Addiction Specialist shall submit reports to the College every six (6) months. Those reports shall include information relevant to Dr. Williams' fitness and/or capacity to practise medicine. Additionally, if the Addiction Specialist forms an opinion that Dr. Williams' continued practice poses a risk of harm to patients or the public, he shall report that information to the College immediately. Dr. Williams shall arrange for his Addiction Specialist to sign an undertaking (in a form acceptable to the College) confirming his willingness and ability to comply with the above.

ee. Dr. Williams shall continue to attend and participate in therapy with:

i. Alcoholics Anonymous, with regular attendance at weekly meetings, and in any event attendance at no less four (4) meetings each month;

ii. Caduceus Group, with regular attendance at meetings and in any event attendance at no less than one (1) meeting every month.

At least once every four (4) months, Dr. Williams shall provide to the College proof of his compliance with this subparagraph (ee).

2. Dr. Williams shall be solely responsible for any and all fees, costs, charges, expenses, etc. associated with implementing the terms of this Order.

3. The results of this proceeding to be included on the public register of the College.

SCHEDULE "A"

UNDERTAKING OF DR. _____ TO THE COLLEGE

SCHEDULE "A"

UNDERTAKING OF DR. _____
TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

1. I am a practising member of the College, certificate of registration number _____.

2. I have read the Order of the Discipline Committee dated _____ regarding the reinstatement of Dr. Bryan Williams' certificate of registration (number 60817) (the "**Order**") and the Discipline Committee's Reasons for Decision in respect of same.

3. I understand the terms, conditions and limitations that the Discipline Committee directed the Registrar of the College to impose upon Dr. Williams' certificate of registration, as set forth in the Order. I also understand the concerns regarding Dr. Williams' return to practice.

4. I will review, as soon as practicable, any additional materials provided to me by the College, including the College's Guidelines for College-Directed Clinical Supervision.

5. I undertake that commencing from the date I sign this undertaking, I shall act as one of Dr. Williams' two Clinical Supervisors ("**Clinical Supervisor**"), for at least eight (8) months ("**Clinical Supervision**"), as outlined in the Order (including the Individualized Education Plan ("**IEP**") attached as Schedule "B" to the Order). My obligations shall include, at a minimum:

   (a) ***High Level Supervision***

      (i) Initially, I will supervise Dr. Williams at a high level of supervision ("**High Level Supervision**").

      (ii) During the period of High Level Supervision, either the other Clinical Supervisor or I will:

         1) Be the most responsible physician for all patients with whom Dr. Williams interacts;

         2) Meet with Dr. Williams at least once per week;

         3) Be available on-site during all times that Dr. Williams is interacting with patients;

         4) Initially, directly observe all of Dr. Williams' patient encounters and, at minimum, directly observe at least one of Dr. Williams' patient encounters each day;

         5) Directly observe Dr. Williams when Dr. Williams performs any procedures that he has not already performed under supervision; and

6) Review daily with Dr. Williams all patient charts for all patients seen by Dr. Williams.

(iii) During the period of High Level Supervision, after my first meeting/observation with Dr. Williams, and each month thereafter, I will provide the College with a written report regarding the Clinical Supervision. Such reports shall be in reasonable detail and shall contain all the information I believe might assist the College in evaluating Dr. Williams' standard of practice, as well as Dr. Williams' compliance with the Order.

(b) ***Moderate Level Supervision***

(i) After no less than one (1) month of High Level Supervision, if the other Clinical Supervisor and/or I report to the College that satisfactory progress has been made during the period of High Level Supervision, the College may, in its discretion, reduce the degree of supervision to a moderate level of supervision ("**Moderate Level Supervision**").

(ii) During the period of Moderate Level Supervision:

1) I will meet with Dr. Williams at least once per month to review at least ten (10) patient charts; and

2) Either the other Clinical Supervisor or I will be available by telephone during all times that Dr. Williams is interacting with patients;

(iii) During the period of Moderate Level Supervision, at least every two months, I will provide the College with a written report regarding the Clinical Supervision. Such reports shall be in reasonable detail and shall contain all the information I believe might assist the College in evaluating Dr. Williams' standard of practice, as well as Dr. Williams' compliance with the Order.

(c) ***Low Level Supervision***

(i) After no less than four (4) months of Moderate Level Supervision, if the other Clinical Supervisor and/or I report to the College that satisfactory progress has been made during the period of Moderate Level Supervision, the College may, in its discretion, reduce the degree of supervision to a low level of supervision ("**Low Level Supervision**").

(ii) During the period of Low Level Supervision:

1) I will meet with Dr. Williams at least once every other month to review at least ten (10) patient charts; and

2) Either the other Clinical Supervisor or I will be available by telephone to Dr. Williams.

(iii) During the period of Low Level Supervision, at least every three (3) months, I will provide the College with a written report regarding the Clinical Supervision. Such reports shall be in reasonable detail and shall contain all the information I believe might assist the College in evaluating Dr. Williams' standard of practice, as well as Dr. Williams' compliance with the Order.

6. I further undertake that during the period of Clinical Supervision, I will, at minimum:

(d) Facilitate the education program set out in the Individualized Education Plan ("IEP") attached as Schedule "B" to the Order;

(e) Be solely responsible for selecting all charts to be reviewed by me, independent of Dr. Williams' participation, on the basis of the educational needs identified in the IEP attached as Schedule "B" to the Order and any concerns that arise during the period of Clinical Supervision;

(f) Discuss with Dr. Williams any concerns arising from such chart reviews;

(g) Make recommendations to Dr. Williams for practice improvements and ongoing professional development and inquire into Dr. Williams' compliance with my recommendations;

(h) Communicate with the other Clinical Supervisor as-needed, but in any event, no less than monthly; and

(i) Perform any other duties, such as reviewing other documents or conducting interviews with staff or colleagues, that I deem necessary to Dr. Williams' Clinical Supervision.

7. I undertake that I shall <u>immediately</u> notify the College if I am concerned that:

(a) Dr. Williams' practice may fall below the standard of practice of the profession;

(b) Dr. Williams may not be in compliance with the provisions of the Order; or

(c) Dr. Williams' patients may be exposed to risk of harm or injury.

8. I acknowledge that Dr. Williams has consented to my disclosure to the College and all other Clinical Supervisors and Assessors of all information relevant to any of the following:

(a) the Order;

(b) the provisions of this, my Clinical Supervisor's undertaking;

(c) any Assessment of Dr. Williams' practice;

(d) monitoring compliance with the Order.

9. I acknowledge that all information that I become aware of in the course of my duties as Dr. Williams' Clinical Supervisor is confidential information and that I am prohibited, both during and after the period of Clinical Supervision, from communicating it in any form and by any means except in the limited circumstances set out in section 36(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "RHPA").

10. I undertake to notify the College and Dr. Williams in advance wherever possible, but in any case immediately following, any communication of information under section 36(1) of the RHPA.

11. I understand that Clinical Supervision shall cease only upon approval from the College.

12. I undertake to immediately inform the College in writing if Dr. Williams and I have terminated our Clinical Supervision relationship, or if I otherwise cannot fulfill the provisions of my undertaking.

Dated at _____, this _____ day of _____, 2018

_____

Dr.

_____ _____

Witness *(print name)* Witness *(Signature)*

SCHEDULE "B"

INDIVIDUALIZED EDUCATION PLAN FOR DR. BRYAN WILLIAMS

Individualized Education Plan for Dr. Bryan Williams Date: Oct 23, 2018
CPSO Number: 60817
Staff:

This Plan takes into account the current CME undertaken by Dr. Williams as summarized in the letter to the College attached at Schedule "B".

EDUCATIONAL NEED/ CANMEDS ROLE	***OUTCOMES (GOALS)***	***PROPOSED EDUCATIONAL METHOD***	***ASSESSMENT METHOD***
Medical Expert	Practice that meets the standard of a competent family physician in the Province of Ontario	Meet with the CPSO-approved clinical supervisor(s), Dr. Loutfi and Dr. Seguin, for 8 months to 1 year[1] as described herein, commencing on or about November_____, 2018. Clinical supervision will be graded, commencing at a high level and then transition to moderate and then low supervision on the recommendation of the clinical supervisor and approval of the College. This proposal contemplates the involvement of two Clinical Supervisors both of whom will actively participate during high level supervision. Unless otherwise approved by the College, the supervisors will consist of: • Dr. F. Loutfi; and • Dr. J. Seguin. This proposal using two Clinical Supervisors provides for a number of benefits, including: • Strong continuity of patient care for the Patients seen in Mattawa (where Dr. Williams intends to ultimately practice independently, upon successful completion of supervision) under the supervision of Dr. Loutfi; • Supervision and guidance from a Senior Clinician, Dr. Seguin; • Variety of perspectives provided by two physicians; and • No need for a backup supervisor, because they can cover each other's absences.	As confirmed by the clinical supervisor in his report(s) to the CPSO. As assessed by the CPSO-directed assessment of Dr. Williams' practice at the conclusion of clinical supervision. Assessment to be arranged to take place approximately 8 to 12 months following the commencement of Clinical Supervision.

[1] Subject to approval by the CPSO based on the reports from the clinical supervisor.

		The Clinical Supervisors will communicate with each other on an as-needed basis, but in any event, at least monthly and shall copy each other (and Dr. Williams) on their reports to the College. **Practice Locations** During the initial one month of high level supervision[2], Dr. Williams will practice in accordance with the following terms at the following practice locations: With Dr. Loutfi (In November and December 2018)[3]: • Group Family Medicine Practice located at 217 Turcotte Park Road, Mattawa ON. • Algonquin Nursing Home, 231 10th S Mattawa ON. • Mattawa Hospital ER, 217 Turcotte Park Road Mattawa For Dr. Williams' reintegration into ER, following high supervision, subsequent supervision will be in accordance with the College's policy: *Expectations Of Physicians Not Certified In Emergency Medicine Intending To Include Emergency Medicine As Part Of Their Rural Practice - Changing Scope Of Practice Process* (attached as Schedule "A"). With Dr. Seguin (at least one full day per week): • 506 Astorville Road Astorville ON During moderate level supervision and low level supervision, Dr. Williams may be the MRP and will practice in accordance with the following terms of the following practice locations: • Group Family Medicine Practice located at 217 Turcotte	

[2] High level supervision will last for a minimum of one month.

[3] Dr. Loutfi will be practising in Mattawa at these locations until December 18, 2018.

		Park Road, Mattawa ON. • Algonquin Nursing Home, 231 10th S Mattawa ON. • Mattawa Hospital ER, 217 Turcotte Park Road Mattawa **During all Levels of Supervision:** Every other month, Dr. Seguin will assign special topics for Dr. Williams to study the guidelines and discuss the guidelines with the Dr. Seguin. Topics will include, but are not limited to: Patient-Centred Interviewing; • Antibiotics: Anti-infective Guidelines for Community-Acquired Infections; • Narcotics: Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-cancer Pain; • Diabetes; • Medical Record Keeping; • ER Practice Issues; and • Nursing Home Practice Issues. **High Level Supervision:**[4] During high level supervision, one of the Clinical Supervisors will: • be the MRP for all patient interactions,[5] regardless of whether the Clinical Supervisor is physically present during the patient encounter with Dr. Williams; • be available on-site during all times of patient interactions[6]; • review daily all patient records for patients seen by Dr. Williams with Dr. Williams and approve (or if necessary, modify) all management plans in each of the three practice settings;	

[4] For a minimum of 1 month, subject to confirmation from the supervisor and approval from the College to transition to moderate supervision.

[5] During high level supervision, Dr. Loutfi will be MRP for the patients seen by Dr. Williams in Mattawa, Dr. Seguin will be the MRP for patients in Astorville.

[6] During high level supervision, Dr. Loutfi will be the available Clinical Supervisor for the patients seen by Dr. Williams in the nursing home and ER practice settings.

		• directly observe Dr. Williams during all patient encounters:
		  ○ until such time as the Clinical Supervisor is satisfied that Dr. Williams can see patients without direct observation;
		  ○ once the Clinical Supervisor is satisfied that Dr. Williams can see patients without direct observation, the Clinical Supervisor will continue to directly observe Dr. Williams in at least one patient encounter each day;
		  ○ With respect to the direct observations, each month:
		  ▪ at least three will be in each of the nursing home and ER setting to be observed by Dr. Loutfi;
		  ▪ at least three will be in the family practice setting to be observed by either Clinical Supervisor; and
		  ▪ the remainder may be in any of the practice settings to be observed by either Clinical Supervisor.
		• directly observe Dr. Williams when Dr. Williams is performing any new procedures that he has not already performed under supervision (if any);
		• each Clinical Supervisor to provide a report to the College after the first meeting/observation of Dr. Williams and report monthly thereafter with a report containing:
		  ○ a list of all charts reviewed with patient identifiers, with an overview of the types of presenting problems addressed in the charts and discussed with Dr. Williams;
		  ○ identification of any concerns;
		  ○ identification of any recommendations by the supervisor, and Dr. Williams' success in implementing any changes into his practice; and
		  ○ the clinical supervisor's opinion as to whether Dr.	

		Williams can transition to moderate level supervision.
		
		Moderate Level Supervision:[7]
		During moderate level supervision, which shall last for a minimum of 4 months:
		
		• Dr. Williams may be the MRP;
		• One of the Clinical Supervisors will be available by telephone during all times of patient interactions;
		• For Dr. Williams' ER practice, supervision will be in accordance with the College's Policy *Expectations Of Physicians Not Certified In Emergency Medicine Intending To Include Emergency Medicine As Part Of Their Rural Practice - Changing Scope Of Practice Process*.
		
		During moderate level supervision, each of the Clinical Supervisors will:
		
		• meet with Dr. Williams once a month[8] in person or using a method of telecommunication that satisfies the security requirements of the College's Telemedicine Policy to review 10 – 15 charts (which shall include at least two examples from each of the office, ER and nursing home practice settings) to comment on documentation and care;
		• provide a report to the College every two months containing:
		  ○ a list of the charts reviewed with patient identifiers, with an overview of the types of presenting problems addressed in the charts and discussed with Dr. Williams;
		  ○ identification of any concerns;	

[7] For a minimum of 4 months, subject to confirmation from the supervisor and approval from the College to transition to low supervision.

[8] This means that Dr. Williams will have a separate meeting with each supervisor once a month during moderate supervision and will discuss 10-15 charts at each meeting with each supervisor.

		○ identification of any recommendations by the supervisor, and Dr. Williams' success in implementing any changes into his practice; and ○ the Clinical Supervisor's opinion as to whether Dr. Williams can transition to low level supervision. **Low Level Supervision** During low level supervision, which will last for a minimum of 3 months and will continue until such time as the College has completed its assessment of Dr. Williams' practice and has notified Dr. Williams that low level supervision has been satisfactorily completed: • Dr. Williams may be the MRP; • One of the Clinical Supervisors will be available by telephone, but not necessarily in real time; • For Dr. Williams' ER practice, supervision will be in accordance with the College's Policy *Expectations Of Physicians Not Certified In Emergency Medicine Intending To Include Emergency Medicine As Part Of Their Rural Practice - Changing Scope Of Practice Process*. During the period of Low Level Supervision, each of the Clinical Supervisors will: • meet with Dr. Williams every other month[9] in person or using a method of telecommunication that satisfies the security requirements of the College's Telemedicine Policy to review 10 – 15 charts (which shall include at least two examples from each of the office, ER and nursing home practice settings) to comment on documentation and care; • will provide a report to the College every three months containing: ○ a list of the charts reviewed with patient identifiers,	

[9] This means that Dr. Williams will be meeting monthly with one of the Clinical Supervisors.

		with an overview of the types of presenting problems addressed in the charts and discussed with Dr. Williams; ○ identification of any concerns; ○ identification of any recommendations by the supervisor, and Dr. Williams' success in implementing any changes into his practice; ○ the clinical supervisor's opinion as to whether Dr. Williams can transition to an unsupervised practice, subject to the CPSO-directed assessment of practice by CPSO-appointed assessor at the conclusion of clinical supervision.	
Communicator (Medical Record Keeping)	Documentation that meets the standard of a competent Family Physician in the Province of Ontario	See above comments for this section. Dr. Williams completed the classroom portion of the CPSO medical record keeping course in June 2017. Dr. Williams' patient charting will be part of the review by the clinical supervisor during all levels of supervision.	As confirmed by the clinical supervisor in his report(s) to the CPSO.
Communicator (Non-Record Keeping)	Demonstrate an understanding of general principles in effective communication for a family physician in Ontario	The Clinical Supervisors will observe a minimum of 12 patient encounters each month (which shall include at least three examples from each of the office, ER and nursing home practice settings) during the period of high level supervision to directly observe and discuss patient-centred questioning. During the period of high supervision, Dr. Williams will review and discuss the following literature with one of his Clinical Supervisors: • CFPC Parts I, II and III: Patient-Centred Interviewing: ○ https://www.cfpc.ca/uploadedFiles/Education/Patient%20Centred%20Interviewing.pdf ○ https://www.cfpc.ca/uploadedFiles/Education/Finding%20Common%20Ground.pdf	As confirmed by the clinical supervisor in his report(s) to the CPSO.

		○ https://www.cfpc.ca/uploadedFiles/Education/Five%20Provocative%20Questions.pdf	
Collaborator	Demonstrate effective ongoing collaboration skills	Dr. Williams will: • document in the chart who is MRP; • obtain copies of reports that are relevant to the patient's ongoing care and acknowledge review and a follow-up plan.	As confirmed by the clinical supervisor in his report(s) to the CPSO. As assessed by the CPSO-directed assessment of Dr. Williams' practice at the conclusion of clinical supervision.

EDUCATIONAL NEED/CANMEDS ROLE	***OUTCOMES (GOALS)***	***PROPOSED EDUCATIONAL METHOD***	***ASSESSMENT METHOD***
Health Advocate	Practice that meets the standard of a competent Family Physician in the Province of Ontario	With the assistance of a Clinical Supervisor, Dr. Williams will collect and review different templates and approaches to disease prevention, and discuss these with his clinical supervisor.	As confirmed by the clinical supervisor in his report(s) to the CPSO.
Leader	Leadership and practice management that meets the standard of a competent Family Physician	With the assistance of a Clinical Supervisor, Dr. Williams will meet with support staff to optimize call-backs, charting, and follow-up for no shows for important results.	Evidence from CPSO-directed assessment of practice by CPSO-appointed assessor at the conclusion of clinical supervision.

Professional	Demonstration of an understanding of acceptable professional behaviour by a physician in the Province of Ontario	Dr. Williams has already successfully completed a detailed program of study and one-on-one education with Dr. Dawn Martin, as confirmed in the affidavit and report of Dr. Martin.	Affidavit and report of Dr. Martin already submitted to the CPSO.
Scholar-CPD	Participation in CPD that meets the requirements as outlined in the CPSO's Quality Assurance Regulation	Dr. Williams will: • prepare a proposed personal CPD program for CPD to take place during the next 12 months that meets the requirements of the CPSO and which includes CPD relevant to each of the office, nursing home, and ER practice settings; and • discuss the proposed CPD program with Dr. Seguin and modify the proposed CPD program pursuant to the recommendations of the Dr. Seguin, if any.	Provide CPSO with current certificate(s) of participation from a recognized body.

Plan Drafted by: Choose an item.
Plan Reviewed by: Choose an item.

Schedule "A"

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXPECTATIONS OF PHYSICIANS NOT CERTIFIED IN EMERGENCY MEDICINE INTENDING TO INCLUDE EMERGENCY MEDICINE AS PART OF THEIR RURAL PRACTICE

CHANGING SCOPE OF PRACTICE PROCESS

BACKGROUND

The CPSO "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice" policy states that "physicians must only practice in the areas of medicine in which they are educated and experienced." The policy is available at **www.cpso.on.ca** under Policies and Publications.

The policy indicates a physician's scope of practice is determined by a number of factors, including:

- → education, training and certification;
- → patients the physician cares for;
- → procedures performed;
- → treatments provided;
- → practice environment.

Traditionally many patient visits in Ontario's Emergency Departments have been managed by physicians who have no formal certification in Emergency Medicine (EM). These physicians have gained knowledge and experience in Emergency Medicine through their internship, residency and/or through practice experience. At the same time, the practice of EM has evolved. Certification in EM through the Royal College or the College of Family Physicians of Canada (CFPC) has been available for about 30 years and is becoming increasingly more prevalent. Most Emergency Departments (EDs) in larger centres are staffed by physicians with certification from one of these bodies.

<u>Emergency Departments in Smaller Centres and Rural Communities</u>

The College has always expected and continues to expect that patients will receive care that meets the standard of practice irrespective of where that patient is seen. The College also recognizes that an ED in an urban centre is a much different place from an ED in a rural centre. There are many differences in the patient populations, the availability of resources and the approach to management of patient problems between these two types of practice locations. For example, a rural ED may differ from an urban ED with regard to its approach to the management of an acute myocardial infarction due to differences in the availability of human and facility resources.

EDs in smaller centres and particularly in rural communities are more likely to be staffed by physicians without EM certification. Access to resources (e.g. personnel and health care services) is typically limited and the need for critical patient transport resources can pose

additional challenges. Still, these communities often have well-established supports in place that can offset the complexities associated with this type of environment. These supports include: mentoring networks, telemedicine and other technology, credentialing committees which can map physician competencies to community needs, as well as relationships with larger centres. The CPSO recognizes the informal support system and other supports available to physicians practising in EDs in smaller centres or rural communities.

While recognizing the particular challenges of working in an ED in a rural setting, the CPSO seeks to ensure the competence of all physicians. To work in an ED safely in any setting (urban or rural), a physician must have competence in the set of critical skills needed in that practice setting.

Purpose of this document

This document serves as a guide for physicians without certification in EM who wish to work in the ED in a rural environment[1]. The goal of this process is to ensure that physicians who plan to include ED work as part of their rural practice are equipped to meet the standard of practice of the profession, in the context of the particular challenges associated with their proposed practice location.

This document DOES NOT apply to:

- **Physicians who already include Emergency Medicine as part of their practice prior to the establishment of this document.**
- **Family Medicine residents graduating from accredited Canadian Residency Programs.**

Document Development Process

A Working Group comprised of family physicians and emergency physicians from both rural and urban settings developed this framework to assist physicians, hospitals, and the College in developing a plan for physicians to safely transition to including working in the ED as part of their practice.

The main reason for developing this framework is to ensure consistency in how such requests to change scope of practice are managed by the CPSO.

1 A 'rural' community in Ontario has a population of less than 30,000 that is greater than 30 minutes away in travel time from a community with a population of more than 30,000: Rural and Northern Health Care Framework/Plan Stage 1 Report – Final Report by the Rural and Northern Health Care Panel, Ministry of Health and Long-Term Care.

GUIDELINES ON CHANGING SCOPE OF PRACTICE TO INCLUDE EM

Physicians without formal certification in EM who are contemplating including working in the ED as part of their rural practice are expected to undergo a period of **low-level** clinical supervision. This low-level supervision is similar to the informal mentorship relationships that already exist in many communities and is intended to tap into those existing relationships.

Generally, the physician is required to retain a Clinical Supervisor[2] who is expected to provide supervision reports to the CPSO on a quarterly basis for a period of six to 12 months. **Each case is considered on an individual basis** and therefore the length and frequency of supervision will be determined by the CPSO based on consideration of:

- A physician's prior training and/or practice experience in EM[3];
- A description of the physician's **proposed practice** location, in particular, acuity of cases, volume of patients, staffing needs of location, proximity to and relationships with larger centres etc.

During the period of low-level supervision the following elements are required, subject to individualization as noted above:

1. There must be a formal system of back-up for the first three months of practice. Experienced physician colleagues must be available to assist with all patients who are seriously ill or injured.
2. In the first three months there will be a review of 10 charts per month to comment on the quality of documentation and care. Additionally, this review must include a review of all patients cared for by the supervised physician who:
    a. Were triaged as a CTAS level 1
    b. Required a life-saving intervention (emergency intubation or other invasive airway management, emergency non-invasive ventilation, cardiopulmonary resuscitation, central line placement, inotropic support, cardioversion, placement of thoracostomy tubes)
    c. Required transfer to another centre for higher level care.
3. The Clinical Supervisor will submit a report to the College after three months, summarizing his/her review of the above cases.
4. Subsequently, and on approval from the College, chart reviews and reports based on the above parameters may occur quarterly (every three months).
5. During this phase of supervision it is expected that the hospital's normal system of back-up continue to be in place.

The Working Group also identified a set of Mandatory Courses and Desired Clinical Experiences

2 Two physicians are recommended as this takes the burden of responsibility off a sole physician. The Clinical Supervisors are not meant to be working with the physician at the same time.

3 If a physician has had previous training and/or practice experience, then letters from Program Directors and/or Chiefs of Staff attesting to the training and/or practice experience, etc. would be required.

(see 'Appendix A') for EM practice; this includes courses that a physician must complete prior to practicing independently in EDs, as well as a guideline for physicians and Clinical Supervisors with respect to the types of procedures in which the physician should try to obtain experience during the course of supervision.

Evidence of Competence

The College relies on demonstration of competence through regular narrative reports from Clinical Supervisor(s). These reports will also be utilized by the CPSO as a basis for determining the physician's readiness for practice assessment (if applicable).

Once the supervision is complete, the physician may have to undergo an assessment of practice prior to approval of the change in scope of practice. The determination for a need for an assessment is made by the Quality Assurance Committee (QAC). While the changing scope of practice process generally involves training, supervision and assessment, all of these components *may not* apply in every case. In arriving at a decision, the QAC will review each physician's individual circumstances.

In some cases, where the supervision reports have been of high quality and uniformly positive, the QAC *may* be content to approve the change in scope without requiring a formal practice assessment. Where a formal practice assessment is required, College staff seeks to retain an assessor who has a background and/or practice experience with similarities to that of the physician being assessed. The assessment will generally involve a review of charts, interviews with the physician, as well as colleagues and coworkers, and some time spent on direct observation in the Emergency Department.

Appendix A -
MANDATORY COURSES AND DESIRED CLINICAL EXPERIENCES TO PRACTICE EMERGENCY MEDICINE

Mandatory Courses

In order for a physician to move from a supervised program to independent practice, he or she **must** have completed the following:

1) Current ACLS and ATLS or equivalent
2) Advanced pediatric resuscitation course (Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS)

Alternatively, the College may consider completion of comprehensive rural-focused critical care courses such as the CARE (Comprehensive Approach to Rural Emergencies) Course or the CALS (Comprehensive Advanced Life Support) program as equivalent to the above courses. Each physician will be considered independently.

While it is desirable to have these courses completed before beginning supervised work, that determination should be informed by the local hospital's credentialing process.

Desired Clinical Experiences

Physicians and Clinical Supervisors should refer to the list of clinical experiences (below) to inform them on the types of clinical encounters in which physicians should either have direct clinical experience or to which they should gain exposure during the period of supervision. These experiences need not take place exclusively in the ED setting. For example, if a physician is experienced in the use of non-invasive ventilation for in-patients, these skills and experiences are transferable to the Emergency Department. Similarly, there are helpful online resources for radiographic and cardiogram interpretation.

a) Critical Care resuscitation with significantly abnormal vital signs (e.g. cardiac arrest, sepsis, shock, acute respiratory distress)
b) Trauma Resuscitation (multisystem with abnormal vital signs and/or GCS)
c) Acute airway management, including Emergency intubations
d) Use of Non-Invasive Ventilation
e) Emergency Vascular Access, including central line and intraosseous placement
f) Insertion of chest tubes/percutaneous thoracostomy
g) Fracture/dislocation management, e.g. Colles fracture, shoulder dislocation
h) ECG interpretation
i) Interaction with Poison control
j) CritiCall and Transport
k) Slit lamp

S

CONSTANTINE
LEGAL

SCHEDULE "B"

October 11, 2018

VIA EMAIL
Gillian Slaughter
Lisa Wilson
College of Physicians and
Surgeons of Ontario
80 College St.
Toronto, ON M5G 2E2

Dear Ms. Slaughter and Ms. Wilson:

Re: Bryan Williams

Further to my discussion with Ms. Slaughter on October 11, 2018, I am writing to provide you with background information concerning Bryan Williams which may be relevant to your consideration of the return to entry provisions, in the event that the Discipline Committee agrees to reinstate Dr. Williams' license.

As described more fully below, Dr. Williams has undertaken an extensive amount of CME involving:

- self-study including journal reviews and publications;
- organized CME; and
- observerships

in order to support an effective and safe return to practice.

Self-Study

It is not an exaggeration to say that Dr. Williams has spent hundreds and hundreds of hours dedicated to effective self-study, in order to maintain and expand his knowledge and remain fully up-to-date with respect to all clinical protocols relevant to the practice of Family and ER medicine.

For the last three years, Dr. William self-study has included regular reviews of the following:

- Peds and Child
- CMAJ
- CFP
- Can J of Diagnosis
- Up to Date (nearly daily review since 2017)
- Review of CPSO Guidelines:

  - Buprenorphine Guideline for the Treatment of Opioid Dependence
  - Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain
  - Evidence-Based Recommendations for Medical Management of Chronic Non-Malignant Pain
  - Guidelines for College-Directed Supervision
  - Infection Prevention and Control for Clinical Office Practice
  - Implementation of Task Force Recommendations on Sexual Abuse
- CMPA Good Practice Guide (reviewed in full)
- CanMEDS Physician Competency Framework (reviewed in full)
- CCFP Self Learning Booklets, 2014 – 2018
- MD Briefcase Online:
  - adult immunization
  - antithrombotic
  - onychomycosis
  - diabetes and CVD
  - DM and faster acting insulins
  - nutrition myths and cholesterol
  - pneumococcal vaccination
  - post prandial hyperglycemia
  - adult asthma
  - dermatitis
  - chronic venous disease
  - obesity -related comorbidity management
  - nicotine replacement therapy
  - pharmacogenomics

Observerships

In 2017 and 2018, Dr. Williams spent over 100 days observing other family physicians and specialists during their patient encounters and discussing patient cases with those clinicians following the patient encounter. All observerships were done with the full consent of patients and at no time did Dr. Williams practice medicine.

As confirmed by Dr. Wilkins, Hospital Chief of Staff, ER Physician and Family Physician (affidavit attached):

> *Beginning in January 2017, I agreed to and encouraged Dr. Williams to participate in an observer role during my ER shifts and in my office. He participated with the consent of patients and in my presence at all times. He did not touch, treat, or interview any patients.*
>
> *Through these observer experiences, I was able to assess Dr. Williams' medical knowledge through discussions with him following my patient encounters. I found*

Dr. Williams' medical knowledge to be both current and exemplary. His professionalism was evident at all times.

Organized CME

Dr. Williams' CME has also included the following:

- Vanderbilt Boundaries Course (2013)
- National Capital Conference on Emergency Medicine (February 2017)
- Hospital for Sick Children Pediatric Update (April 2017)
- Primed Canada Family Medicine Update (May 2017)
- University of Toronto Medical Record Keeping Course (June 2017)
- Adult ADHD Management
- ACLS Training and Certification (November 2017)
- North York General Hospital Emergency Medicine Update (April 2018)
- Primed Family Medicine Conference (May 2018)
- DVT Management (May 2018)
- 11th Annual Primary Care Update (October 2018)
- PALS Training/Certification (Pending)
- ATLS Recertification (Pending)

I look forward to discussing these issues with you in greater detail on October 22, 2018. Counsel to the Discipline Committee, Robert Cosman, has asked that we be ready with a draft order including return to practice terms, by October 24 in anticipation of the October 31, 2018 hearing.

In the meantime, should you require any additional information, please do not hesitate to contact me.

Sincerely,
*Lisa M. Constantine**

Lisa M. Constantine

*Lisa M. Constantine Professional Corporation

c. Carolyn Silver (CPSO)