

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Paul King Shuen, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing as well as the names of physicians, except Dr. Shuen, referred to in Exhibit 6 filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the Regulated Health Professions Act, 1991.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

Every person who contravenes an order made under ... section 45... is guilty of an offence and on conviction is liable,

- (a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or
- (b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Shuen,
2018 ONCPSD 31**

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

IN THE MATTER OF IN THE MATTER OF a Hearing directed by the
Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PAUL KING SHUEN

PANEL MEMBERS:

**DR. M. GABEL (Chair)
MS G. SPARROW
DR. J. RAPIN
MR. J. LANGS
DR. P. CHART**

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

MS C. SILVER

COUNSEL FOR DR. SHUEN:

**MR. T. SUTTON
MS K. GRACE
MS S. SUGAR**

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Dates:	April 9-12, 2018
Finding Decision Date:	April 12, 2018
Penalty Decision Date:	June 25, 2018
Release of Written Reasons:	June 25, 2018

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on April 9 to April 12, 2018. At the conclusion of the hearing, the Committee stated its finding that member committed an act of professional misconduct and is incompetent. The Committee reserved its decision on penalty and costs.

THE ALLEGATION

The Notice of Hearing alleged that Dr. Paul King Shuen committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991 ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and
2. under paragraph 1(1)33 of O. Reg. 856/93 in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Shuen is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATION

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

THE FACTS

The following Agreed Statement of Facts was filed as an exhibit and presented to the Committee:

BACKGROUND

1. Dr. Shuen is a 69 year-old obstetrician/gynecologist with a subspecialty in gynecologic oncology.
2. In August 2016, the College received a letter from North York General Hospital (NYGH) reporting that Dr. Shuen had decided to retire from his hospital practice after meeting with hospital staff to discuss concerns relating to his practice. A copy of that letter dated August 24, 2016 is attached at Tab 1 [to the Agreed Statement of Facts].
3. In September 2016, investigators were appointed under section 75(1)(a) to review Dr. Shuen's practice.

Dr. Shuen's conduct leading to his resignation from NYGH

4. On February 8, 2013, Dr. Adrian Brown, then Chief of Obstetrics and Gynecology, was informed that a nurse found "a powdery tablet" in a patient's vagina that looked like prostin/misoprostol, a medication used to induce uterine contractions and labour. There were no orders for this medication in the chart.
5. Dr. Brown called Dr. Shuen to his office, and showed him what the nurse had found. Dr. Shuen denied any knowledge of it. Dr. Brown's note dated February 8,

2013 documenting what occurred at this meeting is attached at Tab 2 [to the Agreed Statement of Facts].

6. The substance found in Dr. Shuen's patient in February 2013 was not retained for analysis.
7. On August 19, 2015, Dr. Brown was informed that in August 2015, a nurse found a white powdery-tablet in the vagina of a patient, Patient A. The substance was collected but no analysis was done at that time.
8. On August 26, 2015, Dr. Brown spoke to Dr. Shuen about the findings. Dr. Shuen denied any knowledge of the substance found in the patient's vagina. He denied ever placing any medication in the patient's vagina and stated he had never done this before. Dr. Brown advised Dr. Shuen that should he find out that Dr. Shuen had placed a medication used to induce labour in a patient's vagina in his office, especially without the patient's knowledge, that would be grounds for revocation of Dr. Shuen's privileges, and potentially "battery" if the patient was unaware. Dr. Brown's note dated August 19 and 26, 2015 documenting these events and his meeting with Dr. Shuen is attached at Tab 3 [to the Agreed Statement of Facts].
9. Subsequent discussions with the patient, set out in a document from NYGH dated October 13, 2016 attached at Tab 4 [to the Agreed Statement of Facts], confirmed that the patient was unaware of and did not consent to any medication being placed in her vagina. Dr. Shuen never discussed this with her.
10. At a department meeting shortly after his discussion with Dr. Shuen on August 26, 2015, Dr. Brown reiterated to staff that using medications to induce labour in an office setting would likely result in revocation of hospital privileges.
11. NYGH policy and practice permitted the use of misoprostol only for intrauterine demise, termination of pregnancies and treatment for post-partum hemorrhaging.

NYGH policy on Misoprostol (Cytotec) for the Induction of Intra-Uterine Fetal Demise is attached at Tab 5 [to the Agreed Statement of Facts].

12. NYGH policy on Postdates Induction is attached at Tab 6 [to the Agreed Statement of Facts]. NYGH policy on Induction/Augmentation of Labour with Oxytocin is attached at Tab 7. NYGH policy on Induction of Labour is attached at Tab 8 [to the Agreed Statement of Facts].
13. On May 21, 2016, a hospital incident report dated May 21, 2016 reflected that five of Dr. Shuen's patients arrived in triage with rapid labours. One of the patients, Patient B, required an immediate caesarean section for bradycardia due to hyperstimulation. The incident report, attached at Tab 9 [to the Agreed Statement of Facts], noted:

Impact on Staff: Surge of patients with immient [sic] deliveries on Saturday when less staff and resources are around.

This type of activity is not consistant [sic] with the practice of other members of the department of OB.

Potential Safety Issues: Multiple precipitous deliveries arriving after being seen in a Physician's office. Raises questions about whether or not induction measures arev [sic] being insituted [sic] in the office. If so, this falls outside of best practices with respect to monitoring for patients.

14. In June 2016, one of Dr. Shuen's patients, Patient C, was admitted. The nurses were surprised about how quickly her labour progressed given that this was her first child. On internal examination, the nurse found white pill fragments on her glove. The hospital commenced an investigation, as documented in the notes from nursing investigative meetings, notes of an interview with the patient on July 7, 2016, and the hospital summary sheets are attached at Tab 10 [to the Agreed Statement of Facts].

15. Disclosure was made to the patient on October 4, 2016, as set out in the hospital note attached at Tab 11 [to the Agreed Statement of Facts]. The investigation confirmed that the patient was unaware of and did not consent to any medication being placed in her vagina. Dr. Shuen never discussed this with her.
16. A chemical analysis conducted on the substances found in Dr. Shuen's patients in August 2015 and June 2016 confirmed that they were misoprostol.
17. On August 18, 2016, Drs. Smith (Acting MAC Chair), McRitchie (VP Medical Affairs) and Brown met with Dr. Shuen. What transpired at the meeting is documented in the attached memo from Dr. Brown dated August 18, 2016, attached at Tab 12 [to the Agreed Statement of Facts]. Dr. Brown confronted Dr. Shuen about his prior denials when he had been asked about powdery white substances found in his patients. Dr. Brown advised that the substances found in Dr. Shuen's patients in August 2015, and June 2016 had been analysed and were in fact misoprostol.
18. At this meeting, Dr. Shuen again denied any knowledge of these labour inducing medications, and denied ever using them in his office. After a lengthy discussion, including about the potential for revocation of his privileges, Dr. Shuen admitted that he had been using misoprostol in his office for many years for out-patient inductions. Dr. Shuen defended this practice as safe and asserted that his outcomes were "better than most of his colleagues."
19. By letter dated August 18, 2016, a copy of which is attached at Tab 13 [to the Agreed Statement of Facts], NYGH provided notice to Dr. Shuen that his active staff privileges had been suspended. The letter stated:

Reasons/Factual Basis for our Immediate and Temporary Suspension
Information has recently been provided to me which raises concerns
that you have intentionally induced labour in patients through the

administration of stimulant medication by vaginal insertion, without obtaining their informed consent, advising them of the risks and potential side effects to them or their babies, or documenting such treatment in their charts. This practice is high risk and falls below the standard of care.

You were previously advised by Dr. Adrian Brown, Chief, Obstetrics and Gynaecology, and Program Medical Director, Maternal Newborn, in or about August 2015, that this practice is unacceptable, and that anyone on the Medical Staff found to be engaging in this practice could be subject to medical battery claims and/or revocation of privileges. Although you denied engaging in this practice at that time, I have new information that contradicts your previous denial. In our meeting today, we again discussed our concerns with you regarding this practice and the new information we have obtained, including the finding of misoprostol intravaginally in two of your patients. Despite this evidence to the contrary, you again denied administering any stimulant to patients to induce labour. In light of the foregoing, and based on the information currently available to me, mid-term action is being initiated as your behaviour exposes or is reasonably likely to expose patients to harm or injury, and immediate action must be taken, to protect patients. Further, based on the information currently available, I am not able to determine if any less restrictive measures can be taken in the circumstances.

20. By email to Dr. Brown dated August 21, 2016, a copy of which is attached at Tab 14 [to the Agreed Statement of Facts], Dr. Shuen stated:

I have done a great deal of soul-searching since Thursday, and can now see the seriousness of my mistakes. So I write in a spirit of sincere remorse and full responsibility for what I have done. You were right to warn me before, and I do

not blame you for calling the disciplinary hearing, which I deserved.

I have no desire or intention to fight the Hospital's ruling.

That said, I humbly write to ask if there might be even a slight possibility for a very limited clemency so that I might see my current patients to delivery. I have always taken very good care of my patients, and I know that they count on me to see them through delivery. I realize that the current situation is my fault, but I sincerely feel that I am letting them down. If the hospital were to allow me say six months to care for my current load of patients, I would immediately announce my retirement from Hospital work (effective, March 1, 2017) and put an immediate halt to accepting new obstetrics patients. In the interim, I would vow to never again do anything to artificially induce labour without the patient's consent.

If you sense that there might be such a possibility, for the sake of my patients and maybe in recognition of the good I have done over the years in spite of my mistakes, please let me know how I might proceed. If, on the other hand, you feel the Hospital's decision is final and absolute, I would appreciate confirmation to that effect.

21. By letter dated August 22, 2016, a copy of which is attached at Tab 15 [to the Agreed Statement of Facts], Dr. Shuen resigned his privileges at North York General Hospital effective immediately.
22. The College conducted interviews with physicians and nurses at NYGH. All of those interviewed confirmed that they were unaware of Dr. Shuen's practice of using misoprostol for office based inductions.
23. The College retained the services of Dr. Jon Barrett to review Dr. Shuen's practice. Based on a review of seven hospital and corresponding office charts, as well as an interview with Dr. Shuen. Dr. Barrett opined that Dr. Shuen fell below the standard of care in his practice of obstetrics by inserting an induction agent into patients who had no indication for induction, in an outpatient setting, without their knowledge or

consent. A copy of Dr. Barrett's report dated June 7, 2017 is attached at Tab 16 [to the Agreed Statement of Facts].

24. Dr. Barrett provided an addendum report dated July 19, 2017, a copy of which is attached at Tab 17 [to the Agreed Statement of Facts].
25. Dr. Barrett provided a further addendum report, dated July 28, 2017, a copy of which is attached at Tab 18 [to the Agreed Statement of Facts].
26. During Dr. Barrett's interview of Dr. Shuen, Dr. Shuen admitted, among other things, that he did not inform patients, discuss the risks, or obtain patients' consent before engaging in office-based inductions, nor did he document this practice or keep records documenting these patients' outcomes. This was despite earlier suggestions by him, which were not true, that nurses at NYGH who had been his patients were aware of and had consented to this practice. He admitted to engaging in this practice for many years.
27. Dr. Shuen's practice was contrary to NYGH practice and policies, and to the SOGC Guidelines for Induction of Labour (2013 and updated in 2015), attached at Tab 19 [to the Agreed Statement of Facts].

Dr. Shuen's prior inappropriate conduct at NYGH

28. In September 2012, Dr. Brown spoke with Dr. Shuen about exceeding his cap on deliveries, as set out in Dr. Brown's note, attached at Tab 20 [to the Agreed Statement of Facts]. Dr. Shuen apologized, citing financial pressure from his divorce.
29. In January 2013, Dr. Brown spoke to Dr. Shuen about his inappropriate and intimidating behaviour with patients and staff, as set out in Dr. Brown's note, attached at Tab 21 [to the Agreed Statement of Facts]. He noted that Dr. Shuen

showed “very little insight.”

Prescribing Concerns

30. Information was obtained from the Shoppers Drug Mart Pharmacy located in Dr. Shuen’s office building regarding medications ordered by Dr. Shuen for “office use.” A copy of the Patient Medical History from Shoppers Drug Mart is attached at Tab 22 [to the Agreed Statement of Facts].
31. By letter dated May 15, 2017, attached at Tab 23 [to the Agreed Statement of Facts], Dr. Shuen confirmed that he prescribed medications “for office use” that were in fact for himself and his wife. These included sedative-hypnosis for sleep, anti-anxiety medications, antibiotics, medication for erectile dysfunction, cholesterol medication, hormone therapy, anti-depressants, dermatological cream, acne medication, mouth sore medication, thyroid medication, vaccines, and medication for stomach acid, irritable bowel syndrome, constipation, and rectal pain.
32. This prescribing was contrary to the College Policy on Physician Treatment of Self, Family Members, or Others Close to Them, a copy of which is attached at Tab 24 [to the Agreed Statement of Facts].

ADMISSION

33. Dr. Shuen admits the facts specified above, and admits that, based on these facts, he engaged in professional misconduct, in that:
 - (a) under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991 (“O. Reg. 856/93”), he has failed to maintain the standard of practice of the profession; and
 - (b) under paragraph 1(1)33 of O. Reg. 856/93, he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the

circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

34. Dr. Shuen also admits that he is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act*, 1991, as related to Dr. Barrett's report dated June 7, 2017.

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Shuen's admission and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession, and in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The Committee found that Dr. Shuen is incompetent.

SUBMISSIONS ON PENALTY

The College seeks the following order:

1. That the Registrar revoke Dr. Shuen's certificate of registration immediately;
2. That Dr. Shuen appear before the Committee to be reprimanded;
3. That Dr. Shuen pay costs to the College for four days of hearing at the current tariff rate (\$10, 180 per day).

Dr. Shuen seeks the following order:

1. That Dr. Shuen's certificate of registration be suspended for 12 months;
2. That Dr. Shuen's practice be permanently restricted to office based gynecology and gynecological oncology;

3. That Dr. Shuen, upon his return to practice, engage a clinical supervisor, acceptable to the College, with whom he will meet monthly to review charts to ensure that Dr. Shuen properly obtains and documents patients' consent. The clinical supervisor is to make regular reports to the College;
4. That Dr. Shuen undergoes an assessment of his practice six months after completion of supervision;
5. That prior to the end of his suspension, Dr. Shuen successfully complete one-on-one educational courses in ethics and consent acceptable to the College;
6. That Dr. Shuen appear before the Committee to be reprimanded.

THE LAW

Subsection 51(2) of the Code sets out the powers of the Discipline Committee following a finding of professional misconduct. It states:

51(2) If a panel finds a member has committed an act of professional misconduct, it may make an order doing any one or more of the following:

1. Directing the Registrar to revoke the member's certificate of registration.
2. Directing the Registrar to suspend the member's certificate of registration for a specified period of time.
3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time.
4. Requiring the member to appear before the panel to be reprimanded.
5. Requiring the member to pay a fine of not more than \$35,000 to the Minister of Finance.

Section 52 (2) of the Code states:

52(2) If a panel finds a member is incompetent, it may make an order doing any one or more of the following:

1. Directing the Registrar to revoke the member's certificate of registration.
2. Directing the Registrar to suspend the member's certificate of registration.
3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified period of time or indefinite period of time.

Accordingly, the Committee has jurisdiction to order a penalty that it determines appropriate in this case and that is in accordance with sections 51(2) and 52(2) of the Code.

EVIDENCE ON PENALTY

The Committee received documentary evidence which included Dr. Shuen's Curriculum Vitae, various documents relating to the retention of Dr. Barrett as an expert, a transcribed interview of Dr. Shuen with the College, patient medical records, decision and reasons for Dr. Shuen's past cautions from the then Complaints Committee (2009) and the Inquiries, Complaints and Reports Committee ("the ICRC") (2014), Dr. Shuen's workload charts, Dr. Shuen's Physician Practice Questionnaire, articles, guidelines and policies.

The Committee also heard the evidence of three witnesses (Dr. Barrett, Dr. Shuen, and Dr. Luk). A summary of their testimony follows.

Dr. Barrett

Dr. Barrett was accepted by the Committee to give expert opinion evidence in the field of obstetrics with a sub-specialty in high risk pregnancy. Dr. Barrett prepared expert reports for the College, dated June 7, 2017, July 19, 2017 and July 28, 2017; these reports are attached to the Agreed Statement of Facts (Exhibit 2, Tabs 16, 17 and 18). Dr. Barrett reviewed the material in respect of Dr. Shuen provided to him by the College and carried out an interview with Dr. Shuen.

Dr. Barrett testified that Dr. Shuen failed to maintain the standard of practice in his care of two patients (Patient A and Patient B) by placing a drug (misoprostol) in the patient's vagina to induce labour. Dr. Shuen did this without clinical justification, without the consent of these patients and without monitoring. Dr. Barrett testified that Dr. Shuen lacked knowledge, skill and judgment and that this lack of knowledge skill and judgment is extreme. Dr. Barrett also testified this resulted in harm or injury or likely harm or injury to patients.

Dr. Barrett testified that misoprostol was initially designed to treat gastritis and that a side effect was a softening of the cervix and stimulation of the uterus. He testified that misoprostol causes powerful uterine contractions. At the height of a contraction, there is no blood flow to the baby and hypoxic damage may occur. As a consequence, careful monitoring must take place. Risks to the mother include precipitous labour and emergency caesarian section. Dr. Barrett testified, as far as he is aware, misoprostol is used for induction of labour in Ontario in cases of fetal death or abortion. This is the case at North York General Hospital (NYGH) and Sunnybrook Health Sciences Centre (SHSC).

Misoprostol is provided in 200mcg tablets and has to be broken in quarters making the dose used by Dr. Shuen imprecise.

Dr. Barrett testified that spontaneous delivery is best when the cervix is ripe, soft and open. According to the guidelines of the Society of Obstetricians and Gynecologists of Canada (SOGC), there should be a compelling and convincing reason to induce labour. There should be a discussion with the patient regarding the risks and benefits of induction and the consequences of allowing the pregnancy to continue. Informed consent must be obtained and documented. Dr. Barrett testified that induction of labour can be offered to patients once pregnancy goes over 41 weeks and at 42 weeks, the risks and benefits should be discussed with the patient. It is Dr. Barrett's view that to induce labour without patient consent would be "almost an assault."

Dr. Barrett testified that labour can often be stimulated by artificial rupture of the membranes. Induction is usually achieved with the use of intravenous Oxytocin or prostoglandin pessaries or gels. These methods are safer than the use of misoprostol. Use of misoprostol to induce labour in the presence of ruptured membranes is contraindicated as there is a higher risk of uterine hyperstimulation. According to the SOGC Guidelines for Induction published in September 2013, misoprostol can be used safely for induction when the membranes are intact and there is in-patient monitoring (see Exhibit 2, Tab 19).

Dr. Barrett testified that when a high number of women present in labour at the hospital at the same time, resources can be overwhelmed. Dr. Shuen did not seem to understand that he was putting not only his own patients at risk, but stressing the system putting other patients at risk. Other planned inductions may have to be delayed as a result of such stress on the system.

Patient A

Dr. Barrett testified that this patient was seen by Dr. Shuen in his office in August 2015, one day after her expected date of confinement (EDC). She was G2P1 and 2 cm dilated. Dr. Shuen swept her membranes which was acceptable. There was no indication for induction. Use of misoprostol was not discussed with the patient, not documented and no consent was obtained. She delivered later that day. A white powdery substance, later

identified as misoprostol, was found in the patient's vagina. This was potentially dangerous to the patient and her baby.

It was Dr. Barrett's opinion that the lack of judgment exhibited by Dr. Shuen when he placed misoprostol in Patient A's vagina to induce her labour was extreme. He concluded that Dr. Shuen failed to maintain the standard of practice and exhibited a lack of knowledge, skill and judgment.

Patient C

Dr. Barrett testified that this patient was seen in June 2016 in Dr. Shuen's office. This was her first baby (expected date of confinement (EDC) same date as June 2016 appointment). She delivered the next day after what was described by the nurse as a precipitous labour. Misoprostol was found in the patient's vagina by the nurse. There was no indication for induction, which was without the patient's knowledge or consent. There was no documentation of use of misoprostol in the patient's record. The rapid labour exposed the mother to the risk of a serious vaginal tear as well as the risks previously mentioned to mother and baby.

Dr. Barrett testified that Dr. Shuen failed to maintain the standard of practice and exhibited a lack of knowledge, skill and judgment in his care of Patient C.

Dr. Barrett testified that Dr. Shuen exposed both Patient A and Patient C to harm unnecessarily and placed stress on the hospital staff exposing other patients to risk of harm when staff had to defer their care.

Additional Patients

Dr. Barrett testified that he reviewed the charts of five additional patients who arrived at the hospital in a cluster on May 21, 2016.

Patient D

Dr. Barrett testified that Patient D saw Dr. Shuen in his office and then experienced a rapid first stage of labour and hyperstimulation noted on the fetal monitor. This suggests that misoprostol was used. Dr. Shuen acknowledged he might have used misoprostol. Dr. Barrett testified that the use of misoprostol was particularly dangerous as the cervix was already dilated to 4 cm and it would have been much safer just to rupture the membranes. There was no clinical indication for induction.

Patient B

Dr. Barrett testified that this patient was seen in Dr. Shuen's office in the morning with spontaneous rupture of the membranes or a suspicion of membrane rupture. Later that day, she came back to the hospital and the cervix dilated from 3cm to 9 cm in one hour. During labour, she had evidence of hyperstimulation and the baby had bradycardia. A caesarean section had to be performed. If misoprostol was used, rupture of membranes made it dangerous.

Dr. Barret testified the remaining three patients did not exhibit hyper-stimulation and there were no adverse effects. Use of misoprostol in these three patients was not proven. Dr. Barrett testified that this does not mean it was not used. If misoprostol was used, it would constitute a failure to maintain the standard of practice.

Dr. Shuen's Interview with Dr. Barrett on April 3, 2017

Dr. Barrett testified that Dr. Shuen told him that he had used misoprostol for many years and that he used a prostoglandin to induce patients even before misoprostol was available. Misoprostol was a less expensive drug.

Dr. Barrett testified that the clustering of Dr. Shuen's patients on weekends, in his view, could not occur spontaneously. Dr. Shuen told Dr. Barrett that while he could not recall

using misoprostol in Patient B after her membranes were ruptured, he had done so in the past, but rarely.

Dr. Barrett testified that Dr. Shuen told him he used misoprostol to short-cut a congested system at the hospital for booking inductions. Dr. Barrett testified that Dr. Shuen told him it was common knowledge among the nurses that he used misoprostol. Dr. Shuen denied using misoprostol for financial reasons. Dr. Barrett testified there is a financial reward for a physician attending the delivery of a baby. Even though there was a soft call system at NYGH which allowed obstetricians to deliver their own patients if they wished, Dr. Barrett was of the view that Dr. Shuen manipulated the delivery of his patients to when he was on call.

Dr. Barrett testified that Dr. Shuen minimized the risk to his patients by saying he used a small dose of misoprostol and does not see much hyperstimulation. Despite being warned by his department chief, and knowing the drug, Dr. Shuen said “most come out fine.” Dr. Shuen also told Dr. Barrett that his practice was safe and better than his colleagues’. Dr. Barrett testified that Dr. Shuen could not know about the safety of his use of misoprostol as he did not document use or follow patients for outcomes. Dr. Barrett testified that Dr. Shuen lacked insight into the harm or potential harm of his practice.

Dr. Barrett testified that he had a concern regarding Dr. Shuen’s obtaining consent, which could apply beyond induction. Dr. Barrett agreed that he did not review any charts of Dr. Shuen’s gynecological patients and the antenatal care documented on the obstetrical charts was fine.

The Committee finds Dr. Barrett to be a credible and reliable witness. His evidence was fair and given in a straightforward and candid manner.

Dr. Shuen

Dr. Shuen described his office practice schedule prior to August 2016. He testified that he would see follow up obstetrical patients on Saturday morning starting at 9:00 a.m. until he was finished.

Dr. Shuen testified that he knew office (out-patient) induction was against hospital policy and SOGC Guidelines. He neither asked, nor told patients (Patient A, Patient C) that he was going to use misoprostol and he intentionally did not document the use of misoprostol on their records. There was no indication for induction.

Dr. Shuen testified he knew his use of misoprostol was wrong and he did not want anyone to know he was using it. He admitted in his testimony that he denied these patients their reproductive rights and autonomy to decide for themselves. He admitted he did this for many years, even before misoprostol was available. Dr. Shuen admitted that by the use of such drug he exposed his patients to hyperstimulation which he erroneously thought he could manage by using a small dose.

Dr. Shuen acknowledged he was aware of the maternal risk of caesarean section, hemorrhage, infection, vaginal and perineal tears, difficult recovery and risk to subsequent pregnancies. He also acknowledged he was aware of the risk to the baby of fetal hypoxia, which could result in a compromised baby and fetal death. Dr. Shuen testified his actions could have stressed the nursing staff with overload and compromised the care of other patients.

Dr. Shuen testified he lied to Dr. Barrett when he said he used misoprostol to get around the hospital process. He told Dr. Barrett there were no adverse consequences. This was not correct. In the absence of documented use, he could not know. He agreed he lied to Dr. Barrett when he told him that nurses knew what he was doing and some asked for it.

Dr. Shuen testified he lied to his obstetrical chief on more than one occasion, until his use of misoprostol was proven. He testified he was concerned about losing his privileges if found out. Dr. Shuen attributed his repeated denials to arrogance and thinking he was indispensable. Dr. Shuen admitted he used misoprotol for his own convenience and he said, "I thought I could get away with it." (see Volume 2, page 76)

Dr. Shuen testified that he has reflected over the last months and now admits he was selfish and did not place patients' interests first. He admitted he betrayed their trust and feels ashamed.

Dr. Shuen described in detail his gynaecological practice (colposcopy, biopsy, contraception, post-menopausal bleeding etc.). Dr. Shuen testified that he wants to be able to continue to practise, as he believes he has skills which are of value.

When interviewed by Dr. Brown in August of 2016, Dr. Shuen voiced that he had always taken good care of patients. Dr. Shuen agreed that by this statement, he showed little insight. In 2017, at the interview with Dr. Barrett, Dr. Shuen estimated the number of patients affected at 2-3 per month of a total of 50 deliveries.

Dr. Shuen agreed that he had been cautioned twice by the College about obtaining informed consent and that he had not learned from these cautions. Dr. Shuen agreed that he breached the College Policy, Treating Self and Family Members. He was aware of this Policy. He kept no record of his personal or family use of the medications listed for office use.

Dr. Shuen admitted in cross examination that, in part, he put patients at risk for financial gain. He agreed that finances were a factor in 2012 when he exceeded his cap on deliveries. Dr. Shuen admitted even at that time, he was inducing and delivering with financial gain as an objective.

The Committee accepted Dr. Shuen's evidence as credible. He gave blanket admissions. He appeared remorseful. However, the Committee did not find his evidence reliable,

given his repeated untruthfulness and admitted acts of self-interest to the detriment of his patients.

Dr. Luk

Dr. Luk testified that he is a general obstetrician gynecologist now transitioning into retirement.

Dr. Luk testified he has known Dr. Shuen since the mid 1980's and has referred patients to him for management of malignant conditions and colposcopy. Dr. Luk testified that he acted as a locum for Dr. Shuen in the short term after August 2017 when Dr. Shuen's staff privileges were suspended. He described the typical patients in Dr. Shuen's practice.

Dr. Luk agreed that induction of labour without consent is a serious matter and that informed consent must be obtained prior to colposcopy, biopsy, and other procedures. Dr. Luk was questioned about the documentation of consent in Dr. Shuen's gynecological charts. Dr. Luk testified he believed consent discussions had occurred and cited as an example a notation on a chart that Dr. Shuen had explained some material risks. But he was not aware of the nature of any consent discussion or whether they occurred.

The Committee accepts Dr. Luk as a credible witness and his evidence reliable. He was fair and his evidence overall was unbiased.

PENALTY AND REASONS FOR PENALTY

Decision

The Committee has determined that revocation of Dr. Shuen's certificate of registration and a reprimand is the appropriate penalty in this matter. The Committee also orders costs to be paid to the College by Dr. Shuen, in the amount of \$40,720.00.

Reasons for Decision

The Committee is aware of the accepted principles that guide the determination of an appropriate penalty. First and foremost is that the penalty must protect the public. The penalty should also provide both specific deterrence to the member and general deterrence to the profession. In addition, the penalty is to reflect the profession's disapproval of the misconduct and must maintain public confidence in the College's ability to regulate the profession in the public interest. Where appropriate, the penalty provides for the potential for rehabilitation of the physician.

The Committee sets out its analysis by first examining the nature of Dr. Shuen's misconduct. This includes the Committee's view of his misconduct and the impact on patients, the profession and the public. The Committee then turns to other factors considered in rendering a fair, just and reasonable penalty.

Nature of the Misconduct

Dr. Shuen admitted before this Committee to having engaged in very serious and unprofessional behaviour. He induced labour with the use of misoprostol in an office setting with the full knowledge that this was a potent drug and could harm both the mother and the baby.

He induced labour without any clinical justification. He did this with many patients over more than a decade. He did not discuss what he was about to do with his patients or obtain their consent. He did not document his use of misoprostol in the patients' charts.

Dr. Shuen's failure to document resulted in omission of important information from the medical record. He did not monitor his patients after inserting misoprostol in their vaginas. He used misoprostol for induction when contraindicated, in the case of patients with ruptured membranes. He did not follow the guidelines for induction of labour of the SOGC or of NYGH.

Dr. Shuen's pattern of practice had been a concern to his department head. When confronted, Dr. Shuen lied repeatedly over a number of years. It was only when the hospital had proof of the use of misoprostol in Dr. Shuen's patients, that he admitted its use. Dr. Shuen lied again to Dr. Barrett, as late as April 2017, when asked why he had done such a thing. Dr. Shuen proffered a number of reasons, including a crowded induction process at the hospital and patient discomfort. In his testimony, he admitted acting for his own convenience, and for financial gain, and being untruthful in his response to Dr. Barrett.

Dr. Shuen initially denied any financial incentive even when it was obvious to Dr. Barrett. Dr. Shuen finally admitted in his testimony before the Committee that he had acted in part for financial gain. That his finances were an important factor is supported by past behaviour in 2012, when Dr. Shuen was called before his department head and admitted to being motivated by a financial incentive in exceeding the cap in his deliveries.

The Committee finds Dr. Shuen's actions to be egregious, highly offensive and intolerable. His actions in placing patients at potential harm, his untruthfulness, and his placement of self-interest above his patient's best interest, are contrary to the fundamental values of the medical profession. The Committee shares Dr. Barrett's view that the misconduct of Dr. Shuen described above is extreme.

The impact of Dr. Shuen's behaviour on obstetrical patients who are particularly vulnerable when close to delivery cannot be minimized. No woman should ever have to question being treated surreptitiously and without consent. This is incompatible with the ethical practice of modern medicine. Dr. Shuen broke an inviolable trust with his patients. He denied them a fundamental patient right, the right to choose.

Dr. Shuen's acts of misconduct, which extended over at least a decade, impact seriously on the reputation of the medical profession. The public has great trust in the medical

profession. In turn, the profession commits to act with honesty and integrity and in the best interest of patients. Dr. Shuen honoured none of these commitments.

Further, Dr. Shuen's misconduct had a detrimental effect on the function of NYGH, his host hospital. His actions resulted in potential problems, by overwhelming available resources, stressing nursing staff and potentially harming other patients whose management and care would have to be deferred. His disregard of the advice and direction of his department chief and actions, which contravened hospital policy, undermined the ability of the hospital to function properly. This cannot help but diminish the public's faith not only in physicians but in hospitals as well.

In the Committee's view, Dr. Shuen's behaviour is nothing short of appalling. Most disturbing is intentionally placing patients at risk of harm for reasons of convenience and financial gain. His dishonesty, disregard of patients' rights and failure to consider the impact of his actions on the healthcare system are additional important factors. It is clear to the Committee that Dr. Shuen's admitted misconduct is of a degree that he cannot be trusted with the care of obstetrical patients.

Other Factors

The Committee accepts that Dr. Shuen holds specialist qualifications in gynecology and gynecological oncology and the Committee accepts that Dr. Shuen is technically capable of doing an office based practice. The question is whether, and under what circumstances, he should be permitted to do so.

The Committee considered and weighed a number of factors to determine whether revocation of Dr. Shuen's certificate of registration is necessary, or if another penalty, as suggested by his counsel, was appropriate. These factors are set out below.

(a) Dishonesty

Dr. Shuen has a lengthy history of repeatedly lying or not being fully truthful. Examples before the Committee include the following:

- In 2013, Dr. Shuen lied outright to Dr. Adrian Brown, then Chief of Obstetrics and Gynecology. Dr. Brown informed Dr. Shuen that a white powder which looked like misoprostol was found in one of Dr. Shuen's patient's vagina. Dr. Shuen denied any knowledge as to how it could have got there;
- In August 2015, nursing staff reported finding a white powdery material in the vagina of another Dr. Shuen's patient. Dr. Shuen denied ever placing any medication in the patient's vagina. Dr. Shuen further lied when he stated he had never done this before. Dr. Brown recorded that Dr. Shuen was aware of the seriousness and implications of such an action which could result in revocation of privileges and potential "battery;"
- On August 18, 2016, Dr. Shuen met with Dr. Brown, Dr. Lloyd Smith (acting chair M.A.C.) and Ms MacRitchie (VP Medical). Dr. Brown indicated that a similar case had arisen in June 2016 with another patient of Dr. Shuen's. Dr. Shuen denied misconduct. Even when faced with the chemical analysis, which demonstrated misoprostol, he denied using it, saying he did not know anything about this or ever using misoprostol in the office. It was only when faced with actions that effectively ended his practice at NYGH, did he recant and admit that he had used misoprostol for many years.
- On April 3, 2017, at an interview with Dr. Barrett, Dr. Shuen was not truthful when he told Dr. Barrett that he induced patients to bypass hospital bureaucracy. He was also not truthful when he told Dr. Barrett that nurses at the hospital knew about this practice, and that some nurses at the hospital asked him to induce them as patients.

In the Committee's view, Dr. Shuen lied intentionally and repeatedly over a number of years to cover up a practice, which would have serious personal consequences. The Committee has serious concern about whether he could be relied on in the future to tell the truth.

(b) Consent

Dr. Shuen admits he did not tell patients he was about to induce them by using misoprostol and he did not obtain their consent.

Dr. Shuen has a history with the College dating back to 2009 with respect to a failure to obtain informed consent. At that time, he was cautioned for failing to obtain informed consent for an episiotomy in a patient during the course of her delivery. In the Decision and Reasons of the Complaints Committee, reference is made to the College Policy Statement #4-05, entitled "Consent to Medical Treatment." This Policy summarizes obligations faced by physicians under the 1996 *Health Care Consent Act* and sets out College guidelines with a view to helping physicians comply with the legislation. In 2009, Dr. Shuen, acknowledged that "To just cut without discussing it with the patient" is totally unacceptable and fails to maintain the standard of practice (see Exhibit 14, page 23).

In 2014, the ICRC issued a written caution to Dr. Shuen following investigation of a complaint from a patient related to a vulvectomy Dr. Shuen had performed. The ICRC noted very little detail in Dr. Shuen's notes with respect to obtaining informed consent, in particular, discussing treatment alternatives and documentation of the consent discussion.

The cautions in 2009 and 2014 ensured that Dr. Shuen was aware of his obligation to always obtain the required informed consent before undertaking any procedure and to document it appropriately. The Committee is left with no doubt that Dr. Shuen was fully aware of his obligation with respect to obtaining informed consent from his patients when he induced labour with misoprostol. It is more troubling that he continued with this

practice contemporaneously with the College's efforts to ensure compliance with his professional obligations.

Dr. Luk and Dr. Barrett agree that informed consent would be required for the types of gynecological procedures that Dr. Shuen proposes to carry out in any future practice. After reviewing some of Dr. Shuen's gynecological charts, Dr. Luk testified he believed Dr. Shuen did obtain informed consent. Dr. Luk explained in his evidence that he based his opinion on the word "explained" which he saw on the chart. He admitted fairly that he did not know if consent was obtained. The Committee drew little comfort from the chart that Dr. Shuen fulfilled or would fulfill his professional obligations.

The Committee is not reassured that Dr. Shuen will obtain and document the required consent in any proposed gynecological practice, given his history of intentional disregard of his professional obligations.

(c) Disregard of Advice

Dr. Shuen had received advice from the College in the form of cautions on two occasions, starting as far back as 2009 and has acted contrary to that advice in respect of his handling of consent issues.

Dr. Shuen understood in 2013 when Dr. Adrian Brown, Chief of Obstetrics and Gynecology at NYGH, called him in and showed him a fragment, which looked vaguely like misoprostol found in his patient's vagina, that this would be considered a serious incident. In 2015, Dr. Brown recorded that Dr. Shuen knows that if he has used misoprostol in his office, especially without the patient's knowledge, that revocation of his privileges would follow and potentially would be "battery" if the patient did not know. Dr. Shuen informed Dr. Barrett during the April 3, 2017 interview that in 2015 after Dr. Brown spoke to him, he stopped doing it for a while, and then he started again.

As a member of the Department of Obstetrics and Gynecology at NYGH, Dr. Shuen would have been aware of the policy regarding the use of Misoprostol for Induction of Intra-Uterine Fetal Demise. He would also be aware of the hospital policy on Induction of Labour. He knowingly and intentionally used misoprostol in a manner not sanctioned by the hospital. He induced many of his patients without indication or clinical justification. In doing so, he did not follow hospital guidelines or accepted policies of the SOGC on the Induction of Labour which clearly state that:

“The reason for induction must be convincing, compelling, consented to and documented.”(see Exhibit 2, Tab 19, page s3)

In the face of the above, the Committee is not reassured that Dr. Shuen is teachable or can be effectively supervised. He has demonstrated that he is unable to translate knowledge into practice when contrary to his personal interest. His errors in judgment are so egregious that the Committee does not believe that supervision and ethics instruction will suffice to achieve the protection, to which the public is entitled.

(d) Lack of Insight

Counsel for Dr. Shuen submits that Dr. Shuen’s testimony demonstrates he has gained insight into his professional misconduct. The Committee does not agree. Admission of misconduct and remorse do not equate to insight. Without doubt, Dr. Shuen has experienced a profound change in his personal circumstances, reflected on his arrogance and has gained some understanding of the impact of his misconduct. The Committee is not persuaded, however, that Dr. Shuen has dealt in any meaningful way with his profound breach in medical ethics. Dr. Shuen’s evidence has not demonstrated to the Committee that he has an interest in remediation in this area, as he has had ample time since his interim suspension to obtain remedial assistance.

The Committee notes that in his August 21, 2016 email to Dr. Brown, Dr. Shuen expresses sincere remorse, acknowledges responsibility and indicates that he can see the

seriousness of his mistakes. Nonetheless, Dr. Shuen goes on to state in that same communication, “I have always taken very good care of my patients.” In his interview with Dr. Barrett in April 2017, Dr. Shuen had not reflected sufficiently to understand his true motives.

In 2017, Dr. Shuen minimized the impact of his misconduct when he said to Dr. Barrett of his patients, “they do labour very well” and “that to my knowledge I have not compromised one baby.” (see Exhibit 7, page 22). He has not followed the patients to know this.

In the 2017 interview with Dr. Barrett, Dr. Shuen estimated that he used misoprostol two or three times a month. However, a review of his deliveries shows that 46% of Dr. Shuen’s patients delivered on the weekend. Dr. Barrett expressed skepticism that clustering of women in precipitous labour could happen spontaneously. The nurses’ comments support that clusters or groups of Dr. Shuen’s patients arrive in triage on Saturdays after seeing him in the office, and that many are primips, who deliver very quickly. Dr. Shuen estimated that he did 50 deliveries per month. It is reasonable to conclude that more than two or three patients a month received misoprostol. This is a further example of minimization.

Lastly, Dr. Shuen states that his real reason for wanting to remain in practice is that he has skills which are useful. Dr. Shuen did not acknowledge being motivated by the personal benefits in remaining a part of a respected profession or the financial benefits. The Committee has little confidence in his expression of insight.

Dr. Shuen’s breach in medical ethics extends beyond his care of patients. He knew the College policy in respect to the treatment of self and family. Despite this, he used office drugs for personal reasons and failed to document their use. This illustrates further Dr. Shuen’s pattern of taking the path of convenience and self-interest over what he knew to be ethical professional behaviour.

It is the Committee's view that, notwithstanding that Dr. Shuen now professes to have gained insight, the evidence as cited above suggests that his insight remains superficial, and he cannot be trusted to act in the best interest of patients.

The Committee accepts (a) - (d) above as aggravating factors.

Mitigating Factors

Mitigating factors include Dr. Shuen's admission and cooperation, which have shortened what would have been a lengthy hearing. The Committee also accepts as a mitigating factor that this is the first time Dr. Shuen has appeared before the Discipline Committee.

Case Law

The Committee is aware that while it is not bound by prior decisions, it should have regard to penalties imposed in similar cases. Both parties submitted cases in support of their respective penalty proposals.

In *CPSO v. Yazdanfar* 2011 CarswellOnt 14166, the misconduct found, as with Dr. Shuen's, was of a very serious nature. The Committee ordered a 24-month suspension and imposed strict terms, conditions and limitations imposed on her certificate of registration to achieve protection of the public. Dishonesty did not play a role in this case, which is a significant distinguishing feature. Dr. Shuen's misconduct is characterized by pervasive dishonesty with his patients, the hospital, and the College in covering up his misconduct. This needs to be reflected in the penalty.

In *CPSO v. Wu*, 2013 ONCPSD 22, the member failed to maintain the standard of practice, engaged in disgraceful, dishonourable or unprofessional conduct and was found to be incompetent, based upon a long list of inadequacies in his medical practice. This included deficiencies in clinical care and a breach of an undertaking with the College in the area of prescribing, supervision and charting. Following a joint submission on

penalty, a six-month suspension of the member's certificate of registration was ordered. In the Committee's view, the findings in this case are not as serious as Dr. Shuen's misconduct and unlike in Dr. Shuen's case, dishonesty was not an issue in Dr. Wu's case.

In *CPSO v. Liberman*, 2012 ONCPSD 12, a case which involved the tragic death of one patient, the Committee made findings of failing to maintain the standard of practice and incompetence and disgraceful, dishonourable and unprofessional conduct related to dishonesty in a self-serving attempt at cover-up. Revocation of Dr. Liberman's certificate of registration was ordered. While the circumstances differ, egregious misconduct and dishonesty are common features with Dr. Shuen's case. The Committee found the Liberman decision helpful in determining the appropriate penalty in this case.

In *CPSO v. Taylor*, 2017 ONCPSD 1, the Committee found disgraceful, dishonourable, or unprofessional conduct related to billing for medical procedures that were not performed and instructing others to create, alter, or otherwise manipulate medical records related to the procedures. The misconduct involved calculated dishonesty and a lack of integrity. Revocation was ordered. Financial incentive and dishonesty are common features in this and Dr. Shuen's case.

The case of *CPSO v. Wilson*, 2003 CarswellOnt 4360 (Div. Ct.) related to Dr. Wilson's role as medical director of an EEG testing facility. Tragically, a number of patients became infected with Hepatitis B, attributed to a lack of supervision and infection prevention and control practices. The Discipline Committee found Dr. Wilson committed an act of professional misconduct and incompetent and ordered revocation. The Divisional Court overturned the revocation and substituted a two-year suspension. The Court commented that the Committee's inference that Dr. Wilson's lack of judgment and insight in his role as medical director applied to his neurology practice was not supported by the evidence. Indeed, there was evidence that Dr. Wilson was an excellent neurologist. The Committee found this case to have little in common with Dr. Shuen's matter and is not support for a lesser penalty.

Conclusion

After considering the submissions of counsel and reviewing all of the circumstances, the Committee has determined that revocation of Dr. Shuen's certificate of registration is the only appropriate penalty in this case that allows the Committee to discharge its duty.

The Committee does not speculate that Dr. Shuen would be unable to maintain the standard of practice in office gynecology or gynecological oncology. Rather, the Committee finds that Dr. Shuen has demonstrated by his actions that he cannot be trusted and is not worthy of the trust invested by the public in the medical profession. . The Committee's view is that his dishonesty and disrespect for patients are relevant to his practice in all areas of medicine. By his egregious behaviour in placing patients at harm, while pursuing his self-interest, confidence in the medical profession is shattered. Dishonesty and failure to respect patients' rights cannot be tolerated. Revocation is necessary to uphold the reputation of the profession and to ensure that the public has confidence that physicians will follow accepted standards of practice and act with honesty and integrity.

The revocation and the public reprimand will further the goal of general deterrence and will hopefully serve to maintain public confidence in the College's ability to regulate the profession in the public interest. A public reprimand delivered directly to Dr. Shuen serves to express the Committee's condemnation of his professional misconduct. Most important, the separation of Dr. Shuen from the medical profession by revocation of his certificate of registration achieves the goal of protection of the public.

Costs

The Committee accepts that the payment of costs by Dr. Shuen to the College is appropriate, on the basis of four days of hearing at the rate of \$10,180.00 per day, for a total of \$40,720.00.

ORDER

Therefore, the Committee orders and directs that:

1. The Registrar revoke Dr. Shuen's certificate of registration, effective immediately.
2. Dr. Shuen is required to appear before the panel to be reprimanded.
3. Dr. Shuen is required to pay to the College costs in the amount of \$40,720.00 within 30 days of the date of this Order.

TEXT of PUBLIC REPRIMAND
Delivered October 23, 2018
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. PAUL KING SHUEN

Dr. Shuen,

It would be an understatement to say how disappointed this Committee is with the totality of your professional misconduct. We speak for the public and the profession in stating that your actions were self-serving, damaging to the public and the profession, and were dishonest and distasteful. What we know about your treatment of the patients in your care, has deeply disturbed the committee. Your care, or better said, lack of proper care, in the unnecessary, furtive, and arguably dangerous procedures you performed on these patients, is and was reprehensible, shameful, and a betrayal of the sense of decency of our profession.

You have denigrated and disregarded the standards of the profession.

Your conduct during the investigation by the hospital, and the College, was, disgraceful, dishonourable and unprofessional. Or put more simply, without ethical basis, devious in method and intent, and filled with lies.

Protection of the public is not just a College objective, but the responsibility of every member of the profession. As well, upholding the College's ability to regulate the profession in the public interest depends on every member of the College keeping protection and service of the public uppermost in mind. You acted as though you were above the law, disregarding the safety, needs and trust of your patients, disregarding the potential consequence to them, for your own convenience and to enrich yourself. I would repeat: In your carelessness, you have truly caused pain and suffering.

You have brought into disrepute ~~to~~ your own name and reputation, and we say once again, we condemn your actions as unfitting for a physician and your removal from the profession is a fitting penalty to protect the public.

This is not an official transcript