NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Edward James Smith, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under … section 45 … 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. Smith, 2019 ONCPSD 49

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. EDWARD JAMES SMITH

PANEL MEMBERS:

MR. P. PIELSTICKER
DR. W. McCREADY
DR. I. ACKERMAN
MR. J. LANGS
DR. E. SAMSON

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. E. WIDNER

COUNSEL FOR DR. SMITH:

MR. J. MACDONALD

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. McALEER

Hearing Date:	**July 12, 2019**
Decision Date (liability):	**July 12, 2019**
Decision Date (penalty):	**October 4, 2019**
Release of Reasons Date:	**October 4, 2019**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on July 12, 2019. Prior to hearing submissions on penalty, the Committee stated its finding that Dr. Edward James Smith committed an act of professional misconduct and reserved its decision on penalty.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Edward James Smith committed an act of professional misconduct:

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

It was also alleged that Dr. Smith 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 ALLEGATIONS

Dr. Smith admitted the first and second allegations in the Notice of Hearing. Counsel for the College withdrew the allegation of incompetence in the Notice of Hearing.

THE FACTS

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

1. Dr. Edward James Smith ("Dr. Smith") is a 63-year-old physician practicing medicine in Ottawa, Ontario.

2. Dr. Smith received his medical degree at the University of Ottawa in 1981. He received his certificate of registration authorizing independent practice in Ontario in 1982.

OVERVIEW OF THE CASE

3. Nerve blocks performed for the treatment or management of chronic pain must be performed in an Out-of-Hospital Premises ("OHP") that is approved by the College's Out-of-Hospital Premises Inspection Program ("OHPIP"). All OHPs are subject to the OHPIP, to relevant legislation and to Program Standards.

4. Between 2012 and May 2017, Dr. Smith provided nerve blocks to patients for the treatment or management of chronic pain in a clinic that was not an approved OHP.

5. In 2011, Dr. Smith wrote to the College stating that he did not fall within the College's OHPIP and that he did not perform procedures than can only be performed in an OHP. As a result, his clinic was never inspected or approved by the OHPIP, as required by legislation. Contrary to the information he provided to the College, Dr. Smith continued to provide nerve blocks that can only be provided in an approved OHP until May 2017, when an unannounced inspection by the College determined that he was in fact providing OHP procedures in an unapproved clinic.

OUT OF HOSPITAL PREMISES INSPECTION PROGRAM ("OHPIP")

6. On April 9, 2010, an amendment to Regulation 114/94 under the *Medicine Act* adding Part

XI, Inspection of Premises where Certain Procedures are Performed came into effect. The amendment applied to two groups of physicians:

- Those who are already performing procedures in an out-of-hospital premises at the time the Regulation came into effect on April 9, 2010; and
- Those who intend to perform procedures in the future.

7. Following the amendment referred to above, the Out-of-Hospital Premises Inspection Program (OHPIP) was created and was charged with identifying premises where the specified procedures were already being performed so that an inspection could be arranged to ensure compliance with the Regulation and Program Standards. A two-year grace period was put in effect so that physicians who had previously been performing procedures now captured by the amendment had time to be inspected and approved, as set out in the Standards:

   "In April 2010, Regulation 114/94 provided a 60-day window for all CPSO members performing or assisting in procedures in Out-of-Hospital Premises (OHPs) to notify the College. By June 2012, all premises that existed prior to June 2010 had their inspection-assessment completed. New premises or relocating premises continue to be inspected within 180 days of notification."

8. The OHPIP, administered by the College, applies to all settings or premises outside a hospital ("OHP premises") that perform procedures involving the use of anesthesia or sedation as defined in O. Reg. 114/94, made under the *Medicine Act*, 1991, ("the Regulation"), attached at Tab A to the Agreed Statement of Facts on Liability**.** Part XI of the Regulation sets out the definition of "procedure" for the purposes of the OHPIP.

9. Mandatory standards for OHP premises are set out in Program Standards ("the Standards"), authorized under the Regulation and attached at Tab B to the Agreed Statement of Facts on Liability**.** The Medical Director of an OHP is responsible for the duties outlined in the Standards, including notification to the College of plans to open a new OHP.

10. As set out in the Standards, Level 2 procedures include procedures performed using intravenous (IV) sedation, regional anesthesia and tumescent anesthesia. A majority of nerve blocks used in interventional pain management are categorized as Level 2 procedures that can be performed only in an OHP setting or a hospital. If a premises performs any Level 1 or 2 procedures, it must be approved as an OHP by OHPIP. Any premises that performs both Level 1 and Level 2 procedures must be approved as a Level 2 OHP. Attached at Tab C to the Agreed Statement of Facts on Liability is the College document titled, "Applying the Out-of-Hospital Inspection Program (OHPIP) Standards in Interventional Pain Premises."

11. The OHPIP is overseen by the College's Premises Inspection Committee ("PIC") and by Program Staff

12. The OHP program is based on trust and relies on self-reporting from Medical Directors and physicians. As mandated in the Standards, a Medical Director is required to notify the program before opening an OHP so that the premises can be inspected. In order to ensure patient safety and quality of care, strict adherence is required to the detailed requirements set out in the Standards. PIC must approve the premises following an inspection before any patient procedures can be performed.

13. As set out in Standards 2.1.2 and 2.2.1, any member planning to operate an OHP must notify the College and the premises must be inspected and assessed prior to receiving approval and providing services to patients.

DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

14. Dr. Smith had been performing nerve blocks for the treatment or management of chronic pain in his family practice in Ottawa prior to the amendment to Regulation 114/94, described above.

15. Once the OHP program came into effect, Ontario physicians were informed of the requirement to notify the program if their activities fell within the amendments described above. By letter dated July 27, 2010, attached at Tab D to the Agreed Statement of Facts on Liability, Dr. Smith wrote to the College and listed the procedures that he performed as part of his chronic pain practice. Based on Dr. Smith's letter, it was determined by OHP Program staff that he fell within the ambit of the program and that an inspection was required.

16. After being notified that an inspection was required, Dr. Smith telephoned OHP Program staff on May 9, 2011, and advised them that he is "only doing joint steroid injections with local" and that he would be writing a letter to "get off the OHP list". Attached at Tab E to the Agreed Statement of Facts on Liability, is a copy of the memorandum of the telephone call between Dr. Smith and the OHP Program staff on May 9, 2011.

17. By letter dated May 10, 2011, Dr. Smith wrote to the College indicating that his practice did not fall within the program and that no inspection was required. After receiving his letter, the program reimbursed Dr. Smith the amount of $2,225, which was the annual fee for the program at that time. Attached at Tab F to the Agreed Statement of Facts on Liability is a copy of Dr. Smith's letter and the reimbursement forms initiated by the College. Based on the information provided by Dr. Smith, his office was not inspected and was not approved as an OHP at any time.

18. In May 2016, the College received anonymous information that Dr. Smith was renting space to another physician, Dr. Mathieu Bélanger, who was performing Level 2 interventional pain management procedures in Dr. Smith's clinic. This was subsequently verified through an inspection conducted by the OHP Program.

19. On October 31, 2016, in the course of a College investigation into Dr. Bélanger's practice, Dr. Bélanger informed the College that Dr. Smith was performing Level 2 procedures despite not being approved by the College.

20. On May 31, 2017, as a result of the information received from Dr. Bélanger, College investigators and the OHP program conducted an unannounced inspection of Dr. Smith's clinic. The unannounced inspection confirmed that Dr. Smith was performing both Level 1 and Level 2 OHP procedures. During the unannounced inspection, Dr. Smith stated he would "shut himself down." Attached at Tab G to the Agreed Statement of Facts on Liability is a letter dated June 1, 2017, from Dr. Smith to Ms. Pedersen, confirming that he will cease performing Level 2 procedures.

21. The unannounced inspection revealed multiple deficiencies, as set out in the Assessment report dated June 1, 2017 and attached at Tab H to the Agreed Statement of Facts on Liability. The location did not meet requirements for an OHP as set out in the Standards. Dr. Smith's clinic did not have the required equipment, did not meet general physical standards including electrical issues, did not meet medication standards, did not have policy and procedural manuals and did not meet staffing requirements. Following its review of the Assessment report, PIC wrote to Dr. Smith advising him that he was not permitted to provide any OHP procedures. Attached at Tab I to the Agreed Statement of Facts on Liability is a PIC decision letter dated June 2, 2017, to Dr. Smith. In a further letter dated June 5, 2017, from PIC to Dr. Smith, attached at Tab J to the Agreed Statement of Facts on Liability**,** the status of "fail" was confirmed. A "fail" status indicates that the premise is not permitted to perform any OHP procedures.

22. On February 6, 2018, in the context of the College's investigation, the Inquires, Complaints and Reports Committee made an Order under section 25.4 of the Code, attached at Tab K to the Agreed Statement of Facts on Liability**,** that Dr. Smith is not permitted to perform any procedures that can only be performed in an OHP.

FAILURE TO MAINTAIN STANDARD OF PRACTICE

23. As part of its investigation, the College obtained a report from Dr. Joseph Doran dated September 6, 2017, attached at Tab L to the Agreed Statement of Facts on Liability. Dr. Doran's *curriculum vitae* is attached at Tab M to the Agreed Statement of Facts on Liability. Dr. Doran is an anesthesiologist with both a hospital practice and a clinic practice in pain management. Dr.

Doran has worked as a College assessor in the past and has acted as an expert advisor in anesthesia and chronic pain for the Canadian Medical Protective Association.

24. Dr. Doran's report outlines the risks to patients in providing OHP procedures in an unapproved setting. In Dr. Doran's opinion, providing OHP procedures in a non-OHP setting is a failure to maintain the standard of practice. Based on his review of the OHP assessment summary (Tab H to the Agreed Statement of Facts on Liability), Dr. Doran opined that Dr. Smith failed to meet the standard of practice in multiple instances, as set out at pages 3 to 6 of his report.

25. In addition, Dr. Doran reviewed eleven (11) patient charts that had been obtained as part of the College's investigation. In Dr. Doran's opinion, Dr. Smith failed to maintain the standard of practice and displayed a lack of knowledge and judgment. Dr. Doran's conclusions on Dr. Smith's failure to maintain the standard of practice are, in part, as follows:

> Dr. Smith did not meet the standard of practice of the profession in several instances:
>
> 1. He performed procedures (occipital nerve blocks and paravertebral nerve blocks) which must be done in a Level 2 OHP in his office without having previously passing an OHP Assessment-Inspection. When his office was inspected on May 31, 2017, he failed to meet the required standards in operating a Level 2 OHP confirming an unsafe practice environment to perform interventional procedures.
> 2. There was no consent on the chart.
> 3. Vital signs were not obtained before and after the procedure.
> 4. A second registered health professional was not available to assist.
> 5. There was no intraoperative monitoring of the patient, which must include pulse oximetry and blood pressure.
> 6. There was no documentation of vital signs, consent obtained or the results of the procedure, which are required elements of the chart.
> 7. He did not have ACLS certification while performing these procedures.

8. There was a lack of essential resuscitation equipment and medication.

26. On the issue of lack of knowledge, Dr. Doran's opinion was as follows:

> Dr. Smith showed a potential lack of knowledge in that he appeared to not appreciate the potential complications associated with the procedure study performed. He performed procedures, which have the potential for significant possibly immediate complications without adequate monitoring, equipment for resuscitation or having appropriate qualifications in ACLS [Advanced Cardiac Life Support]. As an interview of Dr. Smith was not part of my investigation, I am unable to comment further on this.

27. On the issue of lack of judgment, Dr. Doran's opinion was as follows:

> Dr. Smith clearly displayed a lack of judgment:
>
> i) Performing high-risk procedures in a non-OHP setting without adequate staffing, equipment, policy and procedures, consent and monitoring.
> ii) Performing high-risk procedures without adequate means or expertise to treat potential, life-threatening complications.
> iii) Dr. Smith knew or [ought] to have known that the procedures he was performing where [sic] to be done in an OHP. He had written a letter dated May 10, 2011 stating that he was not performing procedures that were required in an OHP setting and therefore did not need to be inspected. Clearly in reviewing his patient charts and his OHIP billings he was continuing to do these procedures.

28. Based on data obtained from OHIP, the College investigator prepared an analysis for the years 2011 to 2017 showing the amounts billed for nerve block procedures in the context of Dr. Smith's total OHIP claims by year. The College investigator's memo, dated November 5, 2017, is attached at Tab N to the Agreed Statement of Facts on Liability.

ADMISSION

29. Dr. Smith admits the facts specified above, and admits that, based on these facts, he engaged in professional misconduct:

(a) He 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; and

(b) He has failed to maintain the standard of practice of the profession.

FINDINGS

The Committee accepted as correct the facts set out in the Agreed Statement of Facts on Liability. Having regard to these facts, the Committee accepted Dr. Smith's admission and, on July 12, 2019, found that he committed an act of professional misconduct, 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, including by misleading the College regarding the procedures he was performing and by not meeting the requirements for an OHP, including that he: did not have the required equipment; did not meet general physical standards including electrical issues; did not meet medication standards; did not have policy and procedural manuals and did not meet staffing requirements. Also on July 12, 2019, the Committee found that Dr. Smith committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession, including performing high-risk procedures in a non-OHP setting without adequate staffing, failing to do pre and post procedure vital signs and intraoperative monitoring and document vital signs and consent, failing to have ACLS certification and lacking essential resuscitation equipment and medication.

SUBMISSIONS ON PENALTY

The College submitted that an appropriate penalty and costs order consisted of:

1) A seven-month suspension;
2) The imposition of terms, conditions and limitations on Dr. Smith's certificate of registration requiring that he comply with College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practice, Take Extended Leave of Absence or Close their Practice Due to Relocation" and that he will successfully complete the PROBE course in ethics and professionalism at his own expense, within six months of the date of the Order;
3) A reprimand; and
4) Costs payable to the College in the amount of $10,370.00 within thirty days of the order.

Counsel for Dr. Smith agreed with the requirement for a reprimand and the amount of costs proposed by the College. However, counsel for Dr. Smith submitted that a two-month suspension with a delayed imposition was appropriate, and that the imposition of terms, conditions and limitations on Dr. Smith's certificate of registration requiring him to comply with Policy #2-07 and the ethics course was unnecessary.

Both College counsel and counsel for Dr. Smith made submissions in support of the penalty each proposed based on the following cases:

- *College of Physicians and Surgeons of Ontario v. Bray*, June 18, 2019 (summary from the College's public register)
- *Ontario (College of Physicians and Surgeon of Ontario) v. Bélanger*, 2018 ONCPSD 18
- *Ontario (College of Physicians and Surgeons of Ontario) v. Kesarwani*, 2018 ONCPSD 7

These cases are discussed below.

PENALTY AND REASONS FOR PENALTY

The Committee considered the following principles in deciding on an appropriate penalty.

- public protection;
- specific deterrence of the member;
- general deterrence of the profession;
- maintaining the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest;
- rehabilitation; and
- proportionality.

The Committee should also consider aggravating and mitigating factors.

Aggravating Factors

Dr. Smith was dishonest in his communications with the College. In his letter to the College dated July 27, 2010, he stated that he was doing paravertebral blocks. Based on Dr. Smith's letter, OHP Program staff determined that he fell within the ambit of the program and that an inspection was required. After being notified that an inspection was required, however, Dr. Smith telephoned OHP Program staff on May 9, 2011, and advised them that he was "only doing joint steroid injections with local" and that he would be writing a letter to "get off the OHP list". In his subsequent letter of May 10, 2011, he failed to advise that he was continuing to provide paravertebral blocks, despite providing details with respect to the type of procedures that he did perform (i.e., trigger point injections) and those that he did not perform (i.e., epidurals, ganglion blocks, femoral or sciatic nerve blocks, intravenous sedation or any types of operations). Paravertebral blocks are classified as regional anesthesia in the OHPIP standards manual and as such, are classified as Level 2 procedures.

The Committee did not accept Dr. Smith's counsel's submission that Dr. Smith made a simple mistake by not including the fact that he was conducting paravertebral blocks in his May 10, 2011 letter. In relation to the letter of May 10, 2011, the expert opined that Dr. Smith clearly displayed a "lack of judgment" in that Dr. Smith knew or ought to have known that the procedures he was performing were to be done in an OHP. The Committee finds Dr. Smith's

communications with the College went beyond a “lack of judgment” and was deceitful. The Committee considered this an aggravating factor.

Dr. Smith also rented space to another physician, Dr. Bélanger, who was performing Level 2 interventional pain management procedures in Dr. Smith’s clinic.

The expert outlined in his opinion that Dr. Smith was performing both cervical and lumbar paravertebral blocks. The expert listed a significant number of potential complications associated with these procedures. The expert opined and the Committee found that Dr. Smith failed to maintain the standard of practice of the profession in multiple respects: performing procedures in his office that are required to be performed in an OHP and failing to meet standards for a Level 2 OHP confirming an unsafe practice environment to perform interventional procedures; no consent; no pre and post procedure vital signs; no second registered health professional to assist; no intraoperative monitoring of the patient; lack of required elements in the chart; no ACLS certificate while performing these procedures; and a lack of essential resuscitation equipment and medication.

The expert also opined that Dr. Smith showed a potential lack of knowledge in that he appeared not to appreciate the potential complications associated with the procedure study performed. He further opined that Dr. Smith clearly displayed a lack of judgment in performing high-risk procedures in a non-OHP setting without adequate staffing, equipment, policy and procedures, consent and monitoring and without adequate means or expertise to treat potential, life-threatening complications and in not acknowledging he was doing these procedures in his May 10, 2011 letter to the College.

The Committee considered that Dr. Smith stopped performing these procedures only after an inspection by the College and that he had been doing these procedures for six years, to be an aggravating factor.

The Committee concludes that Dr. Smith put patients at risk by failing to maintain the standard of practice of the profession in his performance of these high-risk procedures and that this was an

aggravating factor. The fact that no patient harm was reported was fortunate. However, that no actual harm occurred did not reassure the Committee, given the risk of harm to patients over a six-year period, and it was not persuaded that this was a mitigating factor.

Mitigating Factors

Dr. Smith's cooperation with the College in its investigation, his admission to the misconduct and the fact that he has no prior discipline history with the College were considered mitigating factors.

Case Law

The Committee is not bound by prior decisions of this Committee. Each case must be decided on its own facts. However, the Committee recognizes that generally, cases that are similar in nature should result in a similar penalty.

In *CPSO v. Bray*, eleven patients were administered a medication, propofol, without an anesthesiologist present, contrary to regulation. The case proceeded on an agreed statement of facts and admission to disgraceful, dishonourable or unprofessional conduct and failure to maintain the standard of practice of the profession. The Committee accepted a joint proposal on penalty and ordered a four-month suspension and a reprimand. The Committee also ordered that Dr. Bray pay costs in the amount of $6,000. In this panel's view, the misconduct in *Bray* was less serious than the misconduct in Dr. Smith's case, taking into account the aggravating and mitigating factors. In *Bray*, there does not appear to have been any active attempt to deceive the College, although it does appear that Dr. Bray was not forthcoming with respect to his use of propofol. The expert opinion in *Bray* also found that there was no increased risk of harm or injury to the patients.

In *CPSO v. Bélanger*, the physician carried out Level 2 procedures in an unlicensed facility [Dr. Smith's facility] for a period of approximately three months. The case proceeded on an agreed statement of facts and Dr. Bélanger admitted to disgraceful, dishonourable or unprofessional conduct. The Committee accepted the parties' joint submission on penalty and ordered a five-

month suspension, a reprimand and the requirement to complete an ethics course, along with an order to pay costs. Comparing the short duration of Dr. Bélanger's behavior (which only lasted three months) to six years of such behavior by Dr. Smith, the Committee finds Dr. Smith's misconduct to be more serious. Further, in Dr. Smith's case, the Committee made the additional finding of failing to maintain the standard of practice of the profession in multiple respects and that Dr. Smith's conduct resulted in a risk of harm to his patients.

In *CPSO v. Kesarwani*, Dr. Kesarwani moved his practice location and performed OHP procedures at the new location, without having the premises inspected. Further, Dr. Kesarwani deceived the College in his dealings with them. The case proceeded on an agreed statement of facts and admission to disgraceful. dishonourable or unprofessional conduct. The Committee accepted the joint proposal on penalty and ordered a three-month suspension, a reprimand and a requirement to complete an ethics course. It also ordered that Dr. Kesarwani pay costs. The Committee's view is that Dr. Smith's misconduct – his deceptive behavior and the length of time he performed procedures in his uninspected and unlicensed office – to be more egregious than the behavior of Dr. Kesarwani. Further, as indicated previously, the Committee has made an additional finding of failing to maintain the standard of practice in Dr. Smith's case.

The expert opinion regarding Dr. Smith clearly indicated the potential for patient harm by Dr. Smith's manner of practice. The Committee views the risk of harm to patients as more serious than was apparent in any of the three prior cases considered.

Length of Suspension

Having considered the circumstances and the nature of the misconduct, the aggravating and mitigating factors and the range of suspension in prior cases, the Committee concludes that a seven-month suspension is appropriate in this case.

The College's regulation of the profession, in the interest of the public, relies on the honesty of members of the profession in their dealings with the College as their regulatory body. Members have both the privilege of professional regulation and the attendant responsibility to report their

activities in a forthright fashion, as much of their activities are carried out in the privacy of their offices. The penalty must denunciate Dr. Smith's dishonest behavior and emphasize the importance of honest self-reporting to him and to the profession in general.

Professional expectations, standards of practice and OHP program standards are in place to ensure patient safety. The College is mandated by its governing legislation to uphold the ethics and standards of the profession and to administer the regulatory structure that governs OHPs. Its ability to do so in the public interest requires the confidence of the public. In the Committee's view, a seven-month suspension demonstrates that such misconduct is taken seriously and adequately sanctioned.

The Committee considered Dr. Smith's request for a delay in implementing any suspension and notes that it would be unusual to grant such a request, absent supporting circumstances. The Committee is not persuaded that a delayed implementation of the suspension is appropriate in this case. Dr. Smith has been aware that a period of suspension would be ordered, although the duration was in dispute. Also, the Committee's decision on penalty has been under reserve for a period of time. The Committee concludes that Dr. Smith has had adequate time to prepare for a period of suspension.

Rehabilitation

Dr. Smith's counsel's submission that Dr. Smith had ceased to perform similar procedures and would not be acting as a medical director of an OHP was considered. The fact that Dr. Smith not only performed Level 2 procedures in his office, but also facilitated another physician's doing so, led the Committee to conclude that Dr. Smith did not fully grasp the ethical issues involved. The Committee concludes that the imposition of the requirement to take an ethics course is appropriate in the circumstances.

The Committee also notes that any physician absent from practice for more than three months must comply with policy #2-07, "Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to

Relocation." The Committee concludes it is appropriate to impose the requirement that Dr. Smith comply with this policy, given Dr. Smith's failure to comply with professional expectations and standards of practice of the profession in the circumstances of this case.

Summary

The Committee concludes that the behavior of Dr. Smith was deceitful, his failure to abide by program standards occurred over a lengthy period and had the potential to cause patient harm. The regulator relies on truthful reporting by its members in order to protect the public. The public has the right to know that they are receiving safe care, which meets the requisite standards.

ORDER

Therefore, the Committee ordered and directed that:

1. The Registrar suspend Dr. Smith's certificate of registration for a period of seven months, to commence on the date of this order;

2. Dr. Smith shall appear before the Committee to be reprimanded;

3. The Registrar to place the following terms, conditions and limitations on Dr. Smith's certificate of registration:

    (i) Dr. Smith shall comply with College Policy #2-07 "Practice Management Considerations for Physicians Who Cease to Practice, Take an Extended Leave of Absence or Close Their Practice Due to Relocation".

    (ii) Dr. Smith will successfully complete the PROBE course in ethics and professionalism at his own expense, within 6 months of the date of this Order, or any alternative course in ethics and

professionalism approved by the College. Dr. Smith will agree to abide by any recommendations of the PROBE program and provide proof of completion to the College.

4. Dr. Smith pay to the College costs in the amount of $10,370.00 within 30 days of the date of this Order.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Edward James Smith

The Tribunal delivered the following Reprimand
by videoconference on Tuesday, December 21, 2021.

*****NOT AN OFFICIAL TRANSCRIPT*****

Dr. Smith:

Your behaviour in this matter was deceitful and dishonest. You advised the College that you were not performing nerve block procedures so that you would not be subject to an OHP inspection, but you continued to administer nerve block procedures fully knowing your practice should have been subject to an inspection. Additionally, you engaged the services of another physician to undertake the same procedures.

You have shown a complete disregard for your profession by breaching the College's regulations and program standards. Public protection and public confidence in the medical profession are absolutely critical.

In addition to your deceitful conduct in misrepresenting the nature of your practice, once your practice was inspected you were found to be below the standard of practice.

You put patients at risk by providing OHP procedures in an unapproved setting. Further, there were many other deficits in your practice as outlined in our decision.

Not only have you put your patients at risk of harm, but you have also maligned the entire medical profession by your callous disregard for the relevant regulations, program standards and patient safety.

We trust that the mandated PROBE ethics course will enlighten you as to the seriousness of your deliberate action in making false representations to your regulator. A seven-month suspension is a severe penalty and expresses this Committee's displeasure. It goes without saying this Committee does not wish to see you before it again.