

**SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee  
(the Committee)**  
(Information is available about the complaints process [here](#) and about the Committee [here](#))

**Dr. Paul Maxwell Irwin (CPSO# 57194)  
General Surgery  
(the Respondent)**

## **INTRODUCTION**

On May 30, 2018, by Order of the Discipline Committee, the Respondent's licence was restricted to providing small surgical procedures requiring local anesthesia and surgical consultations. At the same time, his licence was suspended for five months from May 30 to October 30, 2018.

The College received information raising concerns that the Respondent was prescribing a large amount of narcotics and other controlled substances, and may have been prescribing while his licence was suspended. Concerns were also raised that when the Respondent resumed his practice, he was seeing walk-in patients (providing primary care), which is contrary to the restrictions on his licence.

Subsequently, the Committee approved the Registrar's appointment of investigators to review the Respondent's practice.

## **COMMITTEE'S DECISION**

A Surgical Panel of the Committee first considered this matter on May 21, 2021 and issued its decision. The Surgical Panel of the Committee considered this matter again at its meeting of January 22, 2022 and revised its decision due to a factual error. The Committee required the Respondent to appear before the Committee to be cautioned with respect to working outside the terms, conditions and limitations on his certificate to practice, as imposed as part of the May 2018 Discipline Order, in particular, by practicing primary care; and with respect to failing to follow the guidelines for opioids for chronic non-cancer pain, and inappropriate antibiotic prescribing and management of Crohn's disease.

The Committee also accepted an undertaking from the Respondent.

## **COMMITTEE'S ANALYSIS**

As part of this investigation, the Registrar appointed three independent Assessors to review a number of the Respondent's patient charts, interview the Respondent, and submit written reports to the Committee.

### *Practising while Licence Suspended*

The information before the Committee did not indicate that the Respondent practised while his licence was suspended by order of the Discipline Committee. The Committee was satisfied that prescriptions filled during this time were renewals. However, it was concerned that the Respondent issued opioid prescriptions with multiple renewals prior to his suspension without ensuring subsequent assessments of patients (e.g. to evaluate the medications efficacy, aberrant behavior etc.), which is contrary to the Canadian Guidelines for Opioids for Chronic Non-Cancer Pain.

### *Failure to abide by the terms, conditions and limitations on his licence to practice*

The report from Assessor #2 indicated that the Respondent provided care to three patients outside the restrictions on his licence to practice, as the care was neither a surgical consultation or a small surgical procedure. The Committee agreed with Assessor #2's conclusion about these three patients.

Chronic pain management is its own speciality, as is primary and palliative care. None of these areas of practice fall within the Respondent's practice restrictions or within the scope of a general surgeon. If a physician wishes to practice out of scope, they must report this to the College, and must participate in an individualized College review process to demonstrate their competence in the area in which they intend to practise. The Respondent did not request such a change of scope.

### *Prescribing*

Assessor #2 concluded the Respondent failed to maintain the standard and lacked knowledge in his prescribing antibiotics and in the management of Crohn's disease, and by failing to take pain histories when prescribing narcotics. Assessor #2 found that there was potential harm to the patient; and stated that if the Respondent's narcotics prescribing was lax in general, this could expose his other patients to harm.

Assessor #3 concluded that the Respondent failed to meet the standard of care and showed a lack of knowledge and judgement in 11 of 11 charts reviewed. In many regards, the Respondent failed to follow the Canadian guideline for non-cancer chronic pain management with respect to prescribing long term opioids.

The Committee agreed with Assessor #2 and Assessor #3 that the Respondent did not meet the standard in his prescribing, and noted deficiencies in the Respondent's

prescribing of opioids, his adherence to the guidelines for opioids for chronic non-cancer pain, and in his antibiotic prescribing and management of Crohn's disease.

In addition to cautioning the Respondent as noted above, the Committee agreed to accept an undertaking from the Respondent in which he has agreed not to prescribe or administer Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, and Monitored Drugs.