NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Daniel Charles Sweet this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names or any information that could disclose the identity of the patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

> Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:
>
> > Every person who contravenes an order made under … section 45… is guilty of an offence and on conviction is liable,
> >
> > > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> > >
> > > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Sweet, 2017 ONCPSD 40

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. DANIEL CHARLES SWEET

PANEL MEMBERS: **DR. P. TADROS (Chair)**
MAJOR A.H. KHALIFA
DR. P. GARFINKEL
MS G. SPARROW
DR. J. RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS J. AMEY

COUNSEL FOR DR. SWEET:

MS L. STEWART

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date: July 14, 2017
Decision Date: July 14, 2017
Release of Written Reasons: September 11, 2017

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 14, 2017. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Daniel Charles Sweet 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 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 the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Sweet 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. Sweet admitted to allegations 1 and 2 in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession and that 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. Counsel for the College withdrew the allegation of incompetence.

THE FACTS

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

1. Dr. Daniel Charles Sweet ("Dr. Sweet") is 63-year-old family physician who, at all material times, practised in Ottawa, Ontario. Dr. Sweet received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College') in June 1982. He was certified by the Royal College of Physicians and Surgeons of Canada as a specialist in Anesthesiology on June 7, 1989.
2. Dr. Sweet transitioned from Anesthesiology to family medicine in 1994.

Background

3. On August 6, 2002, the Discipline Committee of the College ordered the Registrar to impose terms, limitations and conditions on Dr. Sweet's certificate of registration, including, *inter alia*, that Dr. Sweet be restricted from prescribing any controlled substances as defined by the *Controlled Drugs and Substances Act, 1996* (the "August 2002 Discipline Committee Order"). A copy of the Decision and Reasons for Decision of the Discipline Committee, dated August 6, 2002 is attached at Tab 1 [to the Agreed Statement of Facts and Admissions].
4. On October 5, 2006, Dr. Sweet entered into an Undertaking with the College whereby he agreed to cease to practise addiction medicine, chronic pain medicine and psychotherapy (the "October 2006 Undertaking"). A copy of the October 2006 Undertaking is attached at Tab 2 [to the Agreed Statement of Facts and Admissions].

Disgraceful, dishonourable and unprofessional conduct: Breaches of the August 2002 Discipline Committee Order

5. Dr. Sweet prescribed controlled substances on three occasions in breach of the August 2002 Discipline Committee Order, as follows:

a) October 17, 2014: Prescription of Androgel to Patient B (a copy of this prescription is attached at Tab 3 [to the Agreed Statement of Facts and Admissions]);

b) January 3, 2015: Renewal of a prescription of Clonazepam to Patient C (a copy of this renewal is attached at Tab 4 [to the Agreed Statement of Facts and Admissions]); and

c) December 14, 2016: Prescription of a hormone replacement therapy containing Testosterone to Patient E (a copy of the relevant information in respect to this prescription is attached at Tab 5 [to the Agreed Statement of Facts and Admissions]).

6. Dr. Sweet admits that by prescribing of controlled substances on the three occasions above in breach of the August 2002 Discipline Committee Order he committed an act of professional misconduct under paragraph 1(1)(33) of O. Reg. 856/93, in that he 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.

Disgraceful, dishonourable and unprofessional conduct: Prescribing Botox to Patient E

7. Dr. Sweet was Patient E's family physician. In or around 2013, the College commenced an investigation into whether Patient E, who is not a regulated health professional, was, among other things, performing rhinoplasties and injecting Botox at a clinic in her home.

8. In the course of its investigation of Patient E in 2014, the College interviewed Dr. Sweet. In that interview Dr. Sweet advised the investigator, among other things, that:

- Patient E had been his patient since approximately 2010;
- Approximately one or two years prior, Patient E had tried to "lure" him into her cosmetic work;
- Patient E had informed him that she was performing face lifts and injections;
- Patient E had inquired whether he could order local anaesthetics for her. Dr. Sweet advised that these are obtained through a prescription and he declined to order them;
- He had never purchased Botox or injected Botox in his entire career.

9. On March 6, 2014, the College obtained an interim injunction Order, followed by a final injunction Order on May 22, 2014, in the Ontario Superior Court of Justice, whereby Patient E was ordered to permanently refrain from performing all controlled acts and other acts relating to the practice of medicine, including administering a substance by injection. A copy of the Original Superior Court of Justice Orders dated March 6, 2014 and May 22, 2014 are attached at Tab 6 [to the Agreed Statement of Facts and Admissions]. The College did not advise Dr. Sweet of these Orders.

10. In the course of a College investigation in 2016, into whether Patient E was in breach of these Orders, a College investigator contacted a pharmacy in Ottawa and learned that Dr. Sweet had prescribed Botox to Patient E. On November 10, 2016, College investigators attended upon Dr. Sweet. Dr. Sweet advised the investigators, among other things, that:

    - He recalled the investigators from their previous visit at his office two years prior in relation to Patient E and her esthetic business;
    - He had since taken a Botox training course to treat migraine headaches;
    - He prescribed Botox to Patient E in April 2016 on the assumption that she needed it for an injection to be performed by another physician for treatment of her chronic pain. He did not confirm with the other physician the reason for the prescription and never followed up with Patient E regarding the injection by the other physician;
    - He prescribed Botox to Patient E again in September 2016. Patient E was to return to him for the injection in October 2016, but she did not show up. He was unsuccessful in following up with Patient E to determine why she did not attend for her appointment;
    - It did not occur to him that Patient E might be diverting the Botox given the small amount he prescribed.

11. A copy of Dr. Sweet's prescriptions of Botox to Patient E is attached at Tab 7 [to the Agreed Statement of Facts and Admissions].

12. Dr. Sweet admits that by prescribing of Botox to Patient E he committed an act of professional misconduct under paragraph 1(1)(33) of O. Reg. 856/93, in that he 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.

Disgraceful, dishonourable and unprofessional conduct: Care and treatment of Patient D

13. On February 17, 2015, a community social worker at a homeless shelter contacted the College with regard to Dr. Sweet's provision of drug samples to a client. A College Investigator spoke to the social worker on February 25, 2015 to obtain more information. The social worker disclosed that the client, who was a former addict, had received free samples of Ralivia (also known as Tramadol) from Dr. Sweet "for pain management".
14. The College accordingly commenced an investigation into whether Dr. Sweet had engaged in an act of professional misconduct, including whether he was in violation of his October 2006 Undertaking to cease practising addiction and chronic pain medicine, and/or had failed to maintain the standard of practice of the profession, and/or was incompetent.
15. The College retained Dr. Brent Wolfrom ("Dr. Wolfrom"), a specialist in family medicine, to provide an opinion on Dr. Sweet's compliance with the terms of the October 2006 Undertaking not to practise addiction medicine or chronic pain management and on Dr. Sweet's care and treatment of his patients. Dr. Wolfrom reviewed twenty-five patient charts and interviewed Dr. Sweet.
16. Dr. Wolfrom concluded that Dr. Sweet engaged in the practice of chronic pain management and in the practice of addiction management in respect of one of the patients, Patient D. In particular, he commented as follows:

> Between September 2012 and October 2014, the time at which a referral to a rheumatologist was finally initiated, [Patient D] visited Dr. Sweet 21 times. Of these appointments, 15 involved some level of assessment or treatment of [Patient D's] chronic pain, and on at least two occasions tramadol prescriptions were provided outside of a clinic visit. It is difficult to ascertain if additional tramadol prescriptions were provided due to a lack of clear documentation. In any event there was a greater than two-year period during which time the majority of [Patient D's] clinic visits involved the treatment of [Patient D's] pain and during which time Dr. Sweet failed to adequately attempt to transfer [Patient D] to another physician for the treatment of [Patient D's] pain symptoms. It is my

> opinion that a reasonable physician would consider Dr. Sweet's care in this case to embody that of chronic pain management…
>
> It is also my opinion that Dr. Sweet engaged in the practice of addiction medicine in his prescribing of clonidine and tramadol [to Patient D]. Dr. Sweet clearly stated at the time of the interview… that he was aware of the opioid receptor agonist properties of tramadol. It can reasonably be concluded that Dr. Sweet's intent in prescribing clonidine and tramadol was to ease the withdrawal effects [from opioids that Patient D] was experiencing, both through the a2-adrenergic agonist activity of clonidine, and the opioid receptor agonist properties of tramadol. Thus Dr. Sweet was effectively utilizing tramadol to provide opioid substitution therapy… [Tramadol's] use in this case was for the treatment of addiction.

17. Dr. Sweet retained Dr. John E. Saar ("Dr. Saar"), also a specialist in family medicine, to review the same patient charts as Dr. Wolfrom. Dr. Saar did not provide an opinion whether Dr. Sweet engaged in the practice of chronic pain management and in the practice of addiction management in respect of Patient D.
18. Dr. Sweet admits that he engaged in the practice of addiction medicine and/or chronic pain medicine in his care and treatment of Patient D in breach of his October 2006 Undertaking and that by doing so he committed an act of professional misconduct under paragraph 1(1)(33) of O. Reg. 856/93, in that he 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.

Failure to maintain the standard of practice of the profession: Patient charts reviewed by Dr. Wolfrom and Dr. Saar

19. In his review of twenty-five patient charts, Dr. Wolfrom concluded that Dr. Sweet failed to maintain the standard of practice of the profession in respect of fifteen patients.
20. Dr. Saar agreed that Dr. Sweet failed to meet the standard of practice of the profession in respect of Dr. Sweet's care and treatment of Patient F. Patient F was the client in respect of whose care the community social worker had contacted the College in February 2015.

21. Dr. Sweet admits that he committed an act of professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O.Reg. 856/93"), in that he failed to maintain the standard of practice of the profession in his care and treatment of Patient F.

Failure to maintain the standard of practice of the profession: Patient charts reviewed by Dr. Mielke and Dr. Saar

22. As a result of a prior College process, Dr. Sweet entered into an Undertaking with the College dated August 16, 2013 (the "August 2013 Undertaking"). The August 2013 Undertaking provided that Dr. Sweet was to undergo a period of clinical supervision for 6 months, followed by a reassessment. A copy of the August 2013 Undertaking is attached at Tab 8 [to the Agreed Statement of Facts and Admissions].
23. The College retained Dr. Cornelia Mielke ("Dr. Mielke"), a family physician, to conduct the reassessment of Dr. Sweet's practice. Dr. Mielke reviewed a total of twenty-five patient charts and interviewed Dr. Sweet.
24. In her review of twenty-five patient charts, Dr. Mielke concluded that Dr. Sweet failed to maintain the standard of practice of the profession in respect of fifteen patients, including as follows:

    a) With respect to Patient G [chart #2], in that Dr. Sweet failed to document a patient encounter at which an injection was administered and at which he prescribed a medication.
    b) With respect to Patient H [chart #4], in that he did not provide adequate preventative care and failed to adequately work up or manage the patient's diagnosis of reflex sympathetic dystrophy.
    c) With respect to Patient I [chart #10], in that he failed to document that he discussed the risks and side effects of prescribing Imovane, a sedative, as a sleep aid to this 90-year-old patient with poor mobility requiring the use of a cane and a history of pelvic fracture due to fall.
    d) With respect to Patient J [chart #11], in that his charting and documentation had inconsistencies, including two different chart notes for the same clinical encounter.

e) With respect to Patient K [chart #15], in that his charting and documentation was inconsistent and where he prescribed Myrbetriq for enuresis to this 9-year-old patient at a time when Myrbetriq was not approved for use in children.

f) With respect to Patient L [chart #16], in that this pediatric patient's immunizations were incomplete or incompletely documented.

g) With respect to Patient M [chart #19], in that he failed to investigate and rule out a possible G.I. source for this patient's anemia, in circumstances where the patient may have had a hysterectomy.

25. Dr. Sweet retained Dr. Saar to review the same patient charts as were reviewed by Dr. Mielke. Dr. Saar agreed with Dr. Mielke that Dr. Sweet failed to maintain the standard of practice of the profession with respect to Patients I [chart #10], R.R. [chart #15] and M [chart #19].

26. In addition, Dr. Saar found that Dr. Sweet may have failed to maintain the standard of practice of the profession in respect of Patient N [chart #5], in that Dr. Sweet prescribed a year-long course of Wellbutrin, an anti-depressant, to this patient ten days after she had been assessed in the Emergency Room for depression and without a clinical encounter at the time of the prescription. Dr. Saar also found that Dr. Sweet may have failed to maintain the standard of practice of the profession in respect of Patient O [chart #21], in that this pediatric patient's immunizations were incomplete or incompletely documented.

27. Dr. Sweet admits that he committed an act of professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O.Reg. 856/93"), in that he failed to maintain the standard of practice of the profession in his care and treatment of nine patients, specifically Patients G [chart #2], H [chart #4], N [chart #5], I [chart #10], J [chart #11], K [chart #15], L [chart #16], M [chart #19] and O [chart #21].

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admissions. Having regard to these facts, the Committee accepted Dr. Sweet's admissions 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.

FACTS ON PENALTY

The following facts were set out in an Agreed Statement of Facts Regarding Penalty, which was filed as an exhibit and presented to the Committee.

Undertaking to the College

1. Dr. Daniel Charles Sweet ("Dr. Sweet") entered into an Undertaking to the College on July 12, 2017, by which he has agreed, among other things, that, effective July 12, 2017, he has resigned his membership with the College of Physicians and Surgeons of Ontario ("the College" and has agreed never to re-apply for membership in Ontario or in any other jurisdiction. The Undertaking is attached at Tab 1 [to the Agreed Statement of Facts Regarding Penalty].

Interim Orders

2. On May 10, 2016, following the referral of allegations to the Discipline Committee, the Inquiries, Complaints and Reports Committee (the "ICRC") directed the Registrar to impose terms, conditions and limitations on the certificate of registration of Dr. Sweet pursuant to s. 37 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Original Section 37 Order").
3. The Original Section 37 Order provided that, in addition to the restrictions on Dr. Sweet's certificate of registration set out in the August 2002 Discipline Committee Order and the October 2006 Undertaking, Dr. Sweet shall not prescribe Monitored Substances, shall modify his EMR to prevent him from prescribing all Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and Monitored Drugs, and shall post signs at all of his practice locations indicating that he must not prescribe Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and Monitored Drugs.

4. On August 9, 2016, pursuant to a request from Dr. Sweet accompanied by additional information, the ICRC issued a second Order pursuant to s. 37 of the HPPC (the "Second Section 37 Order"). The Second Section 37 Order contained the same terms as the Original Section 37 order, with the exception that it provided that Dr. Sweet shall modify his EMR to prevent him from prescribing all Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances and Monitored Drugs when this feature becomes available on his EMR.
5. On January 26, 2017, following the referral to the Discipline Committee of additional allegations, the ICRC directed the Registrar to suspend Dr. Sweet's certificate of registration. A copy of the Order dated January 26, 2017 is attached at Tab 2 [to the Agreed Statement of Facts Regarding Penalty].

Prior Discipline History

6. On August 6, 2002, the Discipline Committee found that Dr. Sweet was incompetent after receiving an Agreed Statement of Facts outlining that Dr. Sweet prescribed non-methadone opioids to patients as maintenance therapy. The Discipline Committee ordered the Registrar to impose terms, limitations and conditions on Dr. Sweet's certificate of registration, including, *inter alia*, that Dr. Sweet be restricted from prescribing controlled substances. A copy of the Decision and Reasons for Decision of the Discipline Committee dated August 6, 2002 is attached at Tab 1 to the Agreed Statement of Facts and Admissions.
7. On June 3, 2004, the Discipline Committee found that Dr. Sweet had committed an act of professional misconduct after receiving an Agreed Statement of Facts in which Dr. Sweet admitted that he had written a total of six (6) prescriptions for three (3) patients in 2002 and 2003 in breach of the August 2002 Discipline Committee Order that he not prescribe narcotics and controlled substances. The Discipline Committee ordered that Dr. Sweet's certificate of registration be suspended for <u>three (3) months</u> and that he complete the Ethics course. A copy of the Decision and Reasons for Decision of the Discipline Committee dated June 3, 2004 is attached at Tab 3 [to the Agreed Statement of Facts Regarding Penalty].
8. On April 29, 2008, the Discipline Committee found that Dr. Sweet had committed an act of professional misconduct after receiving an Agreed Statement of Facts in which Dr. Sweet

admitted he committed acts relevant to the practice of medicine that, having regard to all the circumstances, would be reasonably be regarded by members as disgraceful, dishonourable or unprofessional based on evidence that, contrary to the Order of the Discipline Committee, there was no sign in the waiting area of the Clinic where he was practising, informing patients of the restrictions on Dr. Sweet's prescribing privileges. Signs were eventually posted in Dr. Sweet's office locations in early May 2007, ten weeks after receiving notice from the College. The Discipline Committee ordered that Dr. Sweet's certificate of registration be suspended for two (2) months. A copy of the Decision and Reasons for Decision of the Discipline Committee dated June 30, 2008 is attached at Tab 4 [to the Agreed Statement of Facts Regarding Penalty].

9. On February 22, 2012, the Discipline Committee found that Dr. Sweet had committed an act of professional misconduct after receiving an Agreed Statement of Facts in which Dr. Sweet admitted that he had written two (2) prescriptions in 2010 and 2011 in breach of the August 2002 Discipline Committee Order that he not prescribe narcotics and controlled substances. The Discipline Committee ordered that Dr. Sweet's certificate of registration be suspended for four (4) months. A copy of the Decision and Reasons for Decision of the Discipline Committee dated March 7, 2012 is attached at Tab 5 [to the Agreed Statement of Facts Regarding Penalty].

Prior remediation of Dr. Sweet's family medicine practice

10. Dr. Sweet completed the Medical Record-Keeping course in 2006 and again in 2009.
11. As a result of a patient complaint, a supervisor was imposed on Dr. Sweet for 6 months in 2011. A reassessment of Dr. Sweet's family practice in 2012 found a lack of appropriate documentation and that Dr. Sweet did not appear to be familiar with many of the principles of primary care.

Additional Facts

12. Dr. Sweet cooperated with the investigations detailed in the Agreed Statement of Facts and Admissions.
13. In the course of the investigations, Dr. Sweet submitted letters of support from several colleagues who reported that based on their knowledge and experience with Dr. Sweet he did not lack judgment and did not pose a risk of harm to patients.

14. After the referral of allegations to the Discipline Committee, the College received correspondence from some of Dr. Sweet's patients who expressed their support of Dr. Sweet and appreciation of his medical care.

PENALTY AND COSTS ORDER AND REASONS

The College and Dr. Sweet jointly submitted that a reprimand and costs would be an appropriate order in this case.

The Committee considered that protection of the public from further misconduct by this physician is of the utmost importance in determining the appropriate penalty. The penalty must provide specific and general deterrence and communicate the profession's disapproval of the misconduct. It is also vital to maintain the public's confidence in the College's ability to regulate the profession in the public interest.

Dr. Sweet entered into an Undertaking with the College that resulted in his immediate resignation from the College on July 12, 2017, two days before this hearing. In this Undertaking, he agreed never to apply or re-apply for a certificate of registration to practice medicine in Ontario or in any other jurisdiction. This Undertaking will serve to protect the public from any further misconduct by Dr. Sweet. It will also serve to maintain public confidence in the integrity and reputation of the medical profession, and in the College's ability to effectively govern the profession in the public interest. The public must trust that the College governs the profession to ensure that physician maintain the standards of practice of the profession and that no physician misuses his position of trust and authority to take advantage of vulnerable patients.

The Committee finds that behaviour such as Dr. Sweet's brings into disrepute the reputation of the profession as a whole. Removal of Dr. Sweet from the practice of medicine conveys to both the public and the profession that a physician cannot maintain the privilege of remaining a member of the profession, where he engages in professional misconduct as Dr. Sweet has been found to have done by the Discipline Committee.

Dr. Sweet's disregard for standards in the continued prescribing of opiates and other controlled substances

The Committee expresses its abhorrence of Dr. Sweet's repetitive misconduct that resulted in multiple appearances before the Discipline Committee. In each instance, he cooperated with the College investigation, acknowledged his practice deficiencies and signed an agreed statement of facts; each time this resulted in various penalties and significant efforts by the College to rehabilitate Dr. Sweet. However, it is unfortunate that Dr. Sweet did not improve his practice behaviour despite repeated appearances before the Discipline Committee over a period of 15 years.

In August 2002, Dr. Sweet first appeared before the Discipline Committee after College investigators examined his practice in June 2000. An expert (Dr. Maureen Pennington) found serious concerns in his regular practice of providing non-methadone opiates as a form of "harm reduction" maintenance therapy. Dr. Sweet's practice deficiencies included: not taking into account patients' reported use versus actual use of opiates; not assessing tolerance in new patients; not considering the risk of overdose; and, few efforts to monitor pharmacy visits or patients' potential for diversion of drugs. Dr. Pennington found that Dr. Sweet's office and charts were in disarray and that Dr. Sweet exposed his patients to significant risks of harm.

The Discipline Committee found in August 2002 that Dr. Sweet was incompetent. Following the parties' joint submission on penalty, the Committee ordered that Dr. Sweet be restricted from prescribing any controlled substances and that he display a sign in his office, notifying patients of this restriction on his prescribing.

In spite of an interim restriction on his practice imposed by the Executive Committee on July 10, 2001, he prescribed Tylenol #3 to a patient on July 17, 2002, and he wrote two prescriptions for clonazepam for another patient. One year later, he wrote two prescriptions for clonazepam for a third patient. In June 2004, the Committee found that Dr. Sweet committed an act of professional misconduct, imposed a three-month suspension of his certificate of registration and ordered him

to take an ethics course. The terms, conditions, and limitations imposed by prior order on his certificate of registration were ordered to remain in full force and effect.

In October 2006, Dr. Sweet signed an Undertaking acknowledging that "I may be incompetent in my Psychotherapy Practice, Addiction Medicine Practice and Chronic Pain Management practice." At that time, he agreed to transition to a general family medicine practice and no longer perform psychotherapy, addiction medicine or pain management. He also agreed to a clinical practice monitor and to have this monitor review patient charts weekly with Dr. Sweet. He was to have his practice assessed at the end of 2006 and again, at the end of 2007. Following a Discipline Committee hearing in April 2008 pertaining to his failure to post a sign in the waiting area of the Clinic where he was practising informing patients of the restrictions on his prescribing privileges, the Committee imposed a further two-month suspension of his certificate of registration, and a reprimand.

Another Discipline Committee hearing was held in February 2012, after a pharmacist reported to the College that Dr. Sweet had prescribed a controlled substance to a patient in June 2010 and to another patient in November 2010. With regard to the first patient, Dr. Sweet reported feeling "pressured" to prescribe. With regard to another patient, he wrongly accepted the patient's opinion that the drug was not a controlled substance. Both excuses are unacceptable and did not justify Dr. Sweet to prescribe in contravention of the Committee's order in effect.

Following the hearing, wherein the Committee was presented with an agreed statement of facts and joint submission on penalty, the Committee ordered a further four-month suspension of Dr. Sweet's certificate of registration and a reprimand. The Committee noted their great concern regarding Dr. Sweet's repeated appearances before the Discipline Committee and said that "any further breach of a College order could result in a harsher penalty in the future."

In May and August 2016, the ICRC referred to the Discipline Committee further allegations against Dr. Sweet and in January 2017, the ICRC made an interim order directing the Registrar to suspend Dr. Sweet's certificate of registration. The behaviours that led to this action included: prescribing Androgel to Patient B (October 2014), clonazepam to Patient C (January 2015), and

testosterone to Patient E (December 2016). Dr. Sweet acknowledged that he provided free samples of an analgesic narcotic to a homeless man in a shelter, Patient F, a former addict, as a form of pain management (February 2015). In these various cases, Dr. Sweet prescribed controlled medications in breach of a Discipline Committee order.

An external expert, Dr. Wolfrom, concluded that Dr. Sweet was practising pain management and also opined that by prescribing clonidine and tramadol to patient D, he was practising addiction medicine between September 2012 and October 2014. He concluded that Dr. Sweet failed to maintain the standard of practice of the profession in respect to fifteen patients whose charts he reviewed.

After Dr. Sweet transitioned to a general family practice in 2006 and 2007, he did not provide appropriate care to a number of patients. As a result of a patient's complaint, a supervisor was imposed on Dr. Sweet's practice for six months in 2011. In 2012, his family practice was reassessed. It was found that he did not appear to be familiar with many of the principles of primary care, and his documentation was inadequate, despite taking medical records courses in 2006, and again in 2009.

Dr. Sweet entered into an Undertaking with the College in August 2013, which involved a six-month period of clinical supervision followed by a reassessment. The reassessment by Dr. Mielke revealed significant failings by Dr. Sweet to maintain the standard of practice of the profession in fifteen of twenty-five patient charts reviewed.

The deficiencies found included: inadequate workup of a patient's anemia, incomplete immunization (or not documented), inadequate workup and management of a patient with anemia and another with reflex sympathetic dystrophy. He inappropriately prescribed medication to a child. His documentation was poor – failing to note when an injection was administered or a medicine prescribed, for example.

Ungovernability

The Committee finds that by his conduct, Dr. Sweet displayed a disregard for the College and its role in regulating members of the profession. In his text "A Complete Guide to the *Regulated Health Professions Act*" (2017), Richard Steinecke reviewed the concept of "ungovernability". This concept originates with the legal profession. It includes a pattern of conduct that demonstrates that the member is unprepared to recognize his or her professional obligations and the regulator's role. It does not just relate to the serious nature of a prior disciplinary record; rather, it occurs when the member's present attitude to his or her governing body makes it clear that the member is unlikely to cooperate with the College in the future.

The care of Patient E illustrates Dr. Sweet's cavalier attitude to the College and its orders. Patient E was under investigation by the College for performing rhinoplasties and administering Botox to patients without proper qualifications. The College informed Dr. Sweet that his patient was administering Botox to others. In spite of this, he gave her two scripts for Botox – he said it had not occurred to him that Patient E may be diverting the Botox; he did not put her request into the overall context of his clinical encounters with her and there was no follow up.

The Committee noted the extensive efforts at rehabilitation that the College had offered to Dr. Sweet over more than a decade – courses on ethics, record keeping, boundaries and interviewing, and preceptorships and chart reviews. All efforts at remediation failed, as Dr. Sweet continued to fail to maintain the standard of practice of the profession.

The Committee considered that the entire pattern of Dr. Sweet's repeated involvements with the College since 2002 indicate he would not abide by the College's policies or regulations, including the Undertakings signed by him. This disregard of the College makes him ungovernable and on the evidence before the Committee, the most severe penalty of revocation is warranted. Dr. Sweet's immediate and permanent resignation from the practice of medicine made it unnecessary to consider the imposition of an order of revocation, that otherwise would have been imposed.

A physician with the privilege to practise must accept the authority of the College, whose job it is to protect the public. Breaches of undertakings and Committee orders are considered very seriously by the Committee, as they show disregard for the College, put the public at risk, and undermine public confidence in the College's role of governing the profession in the public interest.

Mitigating Factors

The only mitigating factor in this case is Dr. Sweet's cooperation with the College investigation and in admitting the facts and liability. This admission and the joint submission on penalty and costs saved the time and the expense of a lengthy hearing. Most importantly, it spared the witnesses from the need to testify.

Case Law

The Committee recognized that no two cases are identical, but reviewing similar cases may aid in determining the appropriate penalty. The Committee reviewed two earlier Discipline Committee decisions: *CPSO v. Dr. Patel* (2015) and *CPSO v. Dr. Dubins* (2016).

In *CPSO v. Dr. Patel* (2015), Dr. R. Patel was a general practitioner in a solo practice. He had been permitting staff to conduct procedures on patients beyond that which is appropriate for non-physicians. This included: physical examinations and signing for prescription renewals when Dr. Patel was not in the office, and inappropriate OHIP billing. In that case Dr. Patel admitted to the misconduct, but the parties disagreed as to what would be the appropriate penalty order. Dr. Patel had signed two previous undertakings with the College, in 1992 and 1999. It was noted by the Committee that Dr. Patel continued to engage in professional misconduct even after he knew that the hearing pertaining to the allegations of professional misconduct against him was proceeding and while he was under supervision. His certificate of registration was revoked.

CPSO v. Dubins (2016) involved a physician who continued the inappropriate practice of hypnotherapy, despite a previous Complaints Committee caution. Dr. Dubins resigned and agreed never to practise medicine again in Ontario or anywhere else.

Conclusion

The Committee found that Dr. Sweet's behaviour represents professional misconduct of the most egregious kind and, in the absence of the Undertaking, it would have imposed the most severe penalty, a revocation of his certificate of registration. The Committee accepted that Dr. Sweet's July 12, 2017 Undertaking, wherein he undertakes to resign his membership with the College and never to apply or re-apply for membership in Ontario or in any other jurisdiction, is an even more serious result, than an order of revocation. Accepting Dr. Sweet's Undertaking to resign his membership with the College and never to apply or re-apply for membership in Ontario or in any other jurisdiction will ensure better public protection than a revocation of his certificate of registration, as the governing legislation would allow him to re-apply in Ontario and is not binding in other jurisdictions.

Dr. Sweet's Undertaking to resign his membership with the College and never to apply or re-apply for membership in Ontario or in any other jurisdiction will serve as a general deterrent for the profession. It demonstrates to the profession and the public that the disgraceful misconduct exhibited by Dr. Sweet will not be tolerated. Given the Undertaking to resign signed by Dr. Sweet, the Committee is of the view that a reprimand is an appropriate penalty, as jointly submitted. In addition, the Committee finds this an appropriate case in which to order that Dr. Sweet pay costs to the College at the College's tariff for a one day hearing.

ORDER

The Committee stated its finding of professional misconduct in paragraphs 1 and 2 of its written order of July 14, 2017. In that order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Sweet attend before the panel to be reprimanded.

4. Dr. Sweet pay to the College costs in the amount of $5,500.00, within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Sweet waived his right to an appeal under subsection 70(1) of the Code. Dr. Sweet was not present at the hearing. The Committee decided to administer the reprimand on a date that Dr. Sweet would be available.

TEXT of PUBLIC REPRIMAND
Delivered August 25, 2017
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
Dr. DANIEL CHARLES SWEET

It is truly a travesty that you have not accepted your Governing body's attempts to rehabilitate you on at least five different occasions.

Your behaviour is so egregious that if you had not resigned, surely, this Committee will have revoked your certificate of registration, on the basis of the materials before us.

Your repeated misconduct is so indefensible that we wonder where your moral compass and principles have disappeared to.

You have displayed to us that you are not governable and not willing to learn from your mistakes. We have no other choice but to pass this judgement and accept the fact you will never practice medicine again.