Indexed as: Sweet (Re)

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

IN THE MATTER OF a Hearing directed
by the Executive Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 36(1) of the ***Health Professional 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. R. MACKENZIE (CHAIR)
DR. B. GIBLON
A VANSTONE
R. SANDERS

Hearing Date: August 6, 2002
Decision/Released Date: August 6, 2002

DECISION AND REASON FOR DECISIONS

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on August 6, 2002. At the conclusion of the hearing, the Committee made a finding that Dr. Sweet was incompetent within the meaning of the *Health Professions Procedural Code* (the "Code") and pronounced its order following from that finding. The Committee further indicated that reasons for decision would be delivered subsequently in writing.

ALLEGATIONS

The Notice of Hearing, dated June 6, 2001, (Exhibit 1) alleged that Dr. Sweet committed an act of professional misconduct:

1. under paragraph 1(1)3 of Ontario Regulation 856/93 ("O.Reg. 856/93") made under the Medicine Act, 1991, in that he failed to maintain the standard of practise 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.

It was also alleged that Dr. Sweet was incompetent within the meaning of subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patients of a nature or to an extent that demonstrates that he is unfit to continue practise or that his practice should be restricted.

PLEA

Dr. Sweet by way of plea admitted to the allegation of incompetence, on the basis of an Agreed Statement of Facts entered into evidence at the hearing (Exhibit 2). The College then withdrew the allegations of professional misconduct set out above.

EVIDENCE

The Agreed Statement of Facts, dated August 6, 2002 provided as follows:

1. Dr. Sweet is a 48-year-old general practitioner practicing in Ottawa, Ontario. He is primarily engaged in addiction counseling and group therapy related to addiction issues. He also treats patients with chronic pain and those with dual diagnosis (i.e., drug dependent and Axis I psychiatric diagnosis).

2. In June 2000, investigators were appointed by the College to look into Dr. Sweet's practice, with particular reference to instances in which he offered opioid maintenance and withdrawal to opioid dependent individuals. An expert's report was prepared for the College by Dr. Maureen Pennington, an expert in addiction psychiatry, from the Faculty of Medicine of the University of Western Ontario, a copy of which is Appendix "A" [to the Agreed Statement of Facts].

3. Dr. Sweet does not prescribe methadone and has never held a license from the CPSO for this purpose.

4. On July 10, 2001, the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 37 of the Health Professions Procedural Code, ordered that terms and limitations be placed on Dr. Sweet's Certificate of Registration, as follows:

> "That Dr. Daniel Charles Sweet be restricted from prescribing narcotics, controlled substances and sedative hypnotics, including benzodiazepines."

The interim suspension Notice is attached as Appendix "B" [to the Agreed Statement of Facts].

5. Dr. Sweet, prior to the above noted suspension of his narcotic prescribing privileges, ran as part of his practice what he termed a "Harm Reduction Program" in which he supplied opioid medications to certain opioid dependent individuals. The purpose of Dr. Sweet's program, as he conceived it, was to remove these patients from drug seeking on the streets and to offer addiction counseling with a view to improving the social and medical condition of these individuals.

6. Dr. Sweet has represented to the College of Physicians and Surgeons of Ontario that he acknowledges that prescribing narcotics, other than Methadone, to drug dependent individuals is not a proper standard of care, when methadone programs are accessible, and that he will not do this in the future and he will continue to strictly observe any drug prescribing restrictions on his Certificate of Registration.

DECISION AND REASONS FOR DECISION

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. The panel also had careful regard for and accepted the expert evidence of Dr. Pennington as set out in her report. Dr. Pennington conducted a comprehensive review of multiple

patient records from Dr. Sweet's practice and subsequently interviewed Dr. Sweet in his office. Her conclusions included the following observations:

- "Dr. Sweet did not routinely consider that his patients report of their use of opiods may have been exaggerated in order to make it more likely that he would supply them with drugs. He did not routinely assess tolerance in new patients. He offered few reasons in his charting for the initial doses selected."
- "In my opinion, Dr. Sweet was not appropriately careful about prescribing low intial doses of opiods to patients. He unwisely did not consider the risk of overdose in non-tolerant individuals."
- "Dr. Sweet made few and inconsistent efforts to monitor the frequency of patients' trips to the pharmacies and the amount of drug dispensed. There is no evidence in his charting that Dr. Sweet had a clear understanding of the amount of medication his patients were taking."
- "Dr. Sweet did not seem aware of the need to take appropriate precautions against the misuse or diversion of drug product that he was making available to patients."
- "I note the general disarray of Dr. Sweet's office when the College visited as shown to me in photographs taken on that date. The physical chaos evident in the pictures reflected the organization of the charts internally and the practice generally."

In summary, Dr. Pennington stated:

> "In my opinion, Dr. Sweet made an error in judgment in prescribing non-methadone opioids to patients as maintenance therapy but I believe that he thought that he was acting appropriately in an effort to help some very needy people.

> However, in prescribing these medications, Dr. Sweet ran some risks which may have had serious consequences for his patients and himself. He gave out too much medication to patients who were not clearly tolerant to opioids. He was not careful in his prescribing practice so he had no real control over the supply (quantity) of pills he made available. He did not heed subtle or clear warnings from co-workers, a colleague and patient themselves that he was authorizing opioids incautiously. Indications are that his office was so disorganized at time that important charts were lost.
>
> Because he failed to take reasonable precautions in his records and clinical practice against the misuse of opioids in a dependent population, Dr. Sweet did not meet the standards of practice expected of a practitioner in his situation."

On the basis of the Agreed Statement of Facts, the uncontested expert evidence of Dr. Pennington, and Dr. Sweet's admission to the allegation of incompetence, the panel found Dr. Sweet to be incompetent within the meaning of subsection 52(1) of the Code.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and the member presented a joint submission with respect to penalty and costs.

The panel noted that the College maintained no allegation of professional misconduct and, therefore, different considerations applied to the order than would have been the case if the panel had before it a professional misconduct matter. The question before the panel was the appropriate order to be made upon its finding that Dr. Sweet was incompetent within the meaning of the Code.

The panel took note of the fact that Dr. Sweet cooperated fully with the College in its investigation and did not contest the restrictions on his practice that were imposed in July

2001. His subsequent admission to the allegation of incompetence also obviated the need for a lengthy discipline hearing.

Also, both counsel informed the panel that Dr. Sweet has been referred to the Quality Assurance Committee of the College and has agreed to fully cooperate with the investigation and subsequent steps to be taken by that Committee. The Panel anticipates that the Quality Assurance process will identify the underlying factors in Dr. Sweet's clinical practice that have contributed to his inappropriate prescribing, and initiate remedial action.

The panel concluded that the prescribing restrictions as set out in the jointly proposed order will protect the public while allowing Dr. Sweet to continue in practice to a restricted degree.

FINDING AND ORDER

1. This Committee finds that Dr. Daniel Charles Sweet is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patients of a nature or to an extent that demonstrates that he is unfit to continue practise or that his practice should be restricted;

2. This Committee directs the Registrar to impose the following terms, conditions and limitations on Dr. Sweet's certificate of registration:
    a) that Dr. Daniel Charles Sweet be restricted from prescribing any controlled substances as defined by the *Controlled Drugs and Substances Act*, 1996, being any substance included in Schedules I, II, III, IV and V of that Act, which schedules are attached to this order; and
    b) that Dr. Daniel Charles Sweet display a sign in plain view to patients entering his office waiting room notifying patients that he is restricted from prescribing any controlled substances included in Schedules I, II, III, IV and V of the *Controlled Drugs and Substances Act*, 1996;

3. This Committee orders that the terms conditions and limitations on Dr. Sweet's certificate of registration, as set out in paragraph 2 of this Order, shall remain in full force and effect unless and until they are removed or varied by a subsequent panel of the Discipline Committee on application for that purpose; and,

4. This Committee orders that Dr. Sweet shall pay the College its costs in the amount of $2,500.00 within one month of the date of this order.