

**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. GERALD WAYNE POWELL

PANEL MEMBERS:

**DR. S. BODLEY
MR. P. GIROUX
DR. C. LEVITT
MR. P. PIELSTICKER
DR. J. WATTS**

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS L. CADER

COUNSEL FOR DR. POWELL:

**MR. P. MILLICAN
MR. M. FAASSEN**

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R.W. COSMAN

Hearing Date:	January 10, 2017
Decision Date:	January 10, 2017
Release of Reasons Date:	February 23, 2017

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 January 10, 2017. At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Gerald Wayne Powell 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. Gerald Wayne Powell 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 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. Powell 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*, (“the Code”).

RESPONSE TO THE ALLEGATIONS

Dr. Powell admitted to the first and second allegations 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 an Agreed Statement of Facts and Admissions, which was filed as an exhibit and presented to the Committee:

PART I – FACTS

1. Dr. Powell is a 59 year old psychiatrist practising in Ottawa. Dr. Powell received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (“the College”) on April 30, 1987. He was certified as a specialist in psychiatry by the Royal College of Physicians and Surgeons of Canada in 1989.

THE COLLEGE’S INVESTIGATION

2. In 2009, following a complaint received from a former patient, the College retained an expert to provide an independent opinion with respect to the provision of care by Dr. Powell to this patient. As a result of the concerns raised in this opinion, the Inquiries, Complaints and Reports Committee (ICRC) approved the appointment of investigators under section 75(1)(a) of the Health Professions Procedural Code in order to conduct a broader investigation into Dr. Powell’s psychiatry practice.
3. The College retained Dr. Jon Novick to provide an opinion with respect to Dr. Powell’s standard of care in this broader practice review. Dr. Novick reviewed 25 of Dr. Powell’s patient charts and was also provided with his OHIP billings for the 25 patient charts under review and his daily diary of patient appointments. In October 2014, after reviewing the materials provided, Dr. Novick conducted an interview with Dr. Powell.

Standard of Practice

4. In his report, dated January 4, 2015, Dr. Novick identified three main areas of concern with respect to Dr. Powell’s care and treatment of patients. These included:

- (i) Dr. Powell's failure to maintain an appropriate psychotherapeutic frame in 19 of the 25 charts;
- (ii) Lapses in his documentation, such as omitting start and stop times in 11 of the 25 charts and failing to document the monitoring (by himself or a family doctor) of metabolic side effects from atypical antipsychotic medications in 8 of the 25 charts; and
- (iii) Dr. Powell's inadequate knowledge regarding the monitoring of atypical antipsychotic medications in at least 1 of the 25 charts.

A copy of Dr. Novick's report, dated January 4, 2015, is appended to the Agreed Statement of Facts and Admissions at Tab 1.

5. Dr. Novick opined, in part, about Dr. Powell's failure to recognize and maintain the psychotherapeutic frame of the physician-patient relationship, as follows:

My review revealed that Dr. Powell failed to maintain an appropriate frame with respect to time for most of the patients included in the review because most sessions lasted longer, sometimes significantly longer, than scheduled... In addition, our discussion revealed that Dr. Powell's justification for extending sessions instead of scheduling longer sessions in advance was based on a lack of knowledge and misunderstanding about psychodynamic principles as related to the frame. He indicated that scheduling a patient for a longer session would be treating them as "special." In fact, the opposite is true: extending sessions in the manner in which Dr. Powell practices is more likely to gratify a patient's sense of being special because they are repeatedly "gifted" with extra time. Dr. Powell's system of scheduling also reveals poor judgment when it comes to deciding how and when to start and stop sessions.

...

Appropriately managing no shows and cancellations is also part of maintaining the frame. As I learned from the interview, Dr. Powell told patients they would be held financially responsible for missing appointments and late cancellations, yet he did not hold them to that expectation. At one

point he told me that when he did collect payment, he returned it because he felt bad about charging the patient. I believe this represents what is called a counter-transference enactment. Rather than working with albeit difficult and uncomfortable transference material, the issue was avoided, modelling an approach that did not reinforce responsible behaviour and dismissed problematic behaviour.

6. Dr. Novick provided an addendum to his report, dated April 9, 2015. In addition to the materials previously relied upon, Dr. Novick cites a number of articles and books in his addendum, including an article provided by Dr. Powell. After considering these materials, Dr. Novick amended his finding with respect to Dr. Powell's lack of skill with reference to the frame regarding one patient. However, he noted two additional concerns with respect to the documentation of important clinical changes/situations and a lack of judgment in all of the 19 patient charts in which Dr. Powell failed to maintain an appropriate psychotherapeutic frame. In addition to these revisions, Dr. Novick withdrew his concern regarding Dr. Powell's lack of knowledge of monitoring lipid levels with respect to one patient. The remainder of the opinions reached in his initial report were maintained. Dr. Novick's addendum, dated April 9, 2015, is attached at Tab 2 to the Agreed Statement of Facts and Admissions.
7. Dr. Powell retained a psychiatrist, Dr. Richard Guscott, to provide an opinion with respect to Dr. Powell's standard of care on the 25 charts that were reviewed by Dr. Novick. That report is attached at Tab 3 to the Agreed Statement of Facts and Admissions. Neither Dr. Powell nor the College relies on this opinion for the purposes of this proceeding.

Ontario Health Insurance Plan (OHIP) Billings

8. In his initial report to the College, and in his addendum, Dr. Novick detailed his concerns with respect to Dr. Powell's OHIP billings. He opined that all 25 charts that he reviewed showed evidence of inappropriate billing and that Dr. Powell's billing practices do not meet the standard of practice of the profession.

9. Dr. Powell's concerning billing practices include:

- Billing one unit for missed appointments;
- Billing one unit for cancelled appointments (including at least one appointment that was cancelled by Dr. Powell);
- Billing one unit for telephone calls to patients and telephone prescription renewals;
- Routinely billing for long sessions. Dr. Powell's average appointment for the patients reviewed is between 80 and 110 minutes; 50 minutes is the generally accepted length for a psychiatric appointment;
- Billing special visit premium codes (A990A and A994A) when appointments were not always eligible for a premium rate. These premiums are available to a psychiatrist when he or she attends the office on an urgent basis, when they were not otherwise scheduled to attend. Dr. Powell claimed these premiums in circumstances that did not meet the required criteria; and
- Double billing for the same block of time. There are several instances where a patient was fit in or had their appointment extended on account of a cancellation and claims were submitted to OHIP for both patients.

PART II - ADMISSION

10. Dr. Powell admits the facts in paragraphs 1 to 9 above and admits that, based on these facts:

- (a) He has failed to maintain the standard of practice in the profession contrary to paragraph 1(1)2 of Ontario Regulation 856/93 ("O. Reg. 856/93") with respect to his record-keeping/documentation, his failure to maintain the appropriate psychotherapeutic frame, his inadequate knowledge regarding the monitoring of atypical antipsychotic medications and his billing practices; and
- (b) 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, contrary to paragraph 1(1)33 of O. Reg. 856/93, with respect to his billing practices.

FINDINGS

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

AGREED STATEMENT OF FACTS ON PENALTY

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

Dr. Powell's Discipline History with the College

1. On February 3, 2014, Dr. Powell made admissions before the Discipline Committee of the College and was found by the Committee to have committed an act of professional misconduct under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, 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. The Discipline Committee's Decision and Reasons for Decision, dated March 4, 2014 are attached at Tab 1 [to the Agreed Statement of Facts on Penalty].

Dr. Powell's Mitigating Actions during the College's Investigation

2. On April 7, 2015, Dr. Powell notified the College that he had made a voluntary repayment to OHIP with respect to his erroneous billings. In response to the College's request for further details, Dr. Powell advised that his repayment to OHIP equalled

\$1,204.50 and represented his erroneous billings of code K197 (individual out-patient psychotherapy) for a two-year period.

3. In April 2015, during the College's investigation, Dr. Powell completed the University of Toronto's Medical Record Keeping course.

PENALTY AND COSTS

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Committee recognizes its obligation to accept a joint submission on penalty, unless it would bring the administration of justice into disrepute or would otherwise be contrary to the public interest. The Committee is also cognizant of the basic principles underlying the appropriateness of penalty orders: public protection; general and specific deterrence; maintenance of the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest; and, rehabilitation of the member.

In coming to a decision, the Committee reviewed the joint submission on penalty, the Agreed Statements of Facts and the Joint Book of Authorities. The Committee also considered aggravating and mitigating factors.

Aggravating Factors

The Seriousness of the Finding

The professional misconduct that Dr. Powell admitted to and was found to have engaged in was serious and troubling to the Committee.

Dr. Powell failed to maintain a frame in the psychotherapeutic relationship and he engaged in inappropriate OHIP billing practices. The facts related to these issues are set out in the Agreed Statement of Facts and Admissions.

First, Dr. Powell engaged in a boundary violation, which was a fundamental aspect of the finding against him in his February 3, 2014 hearing. Dr. Novick, the expert witness for the College in this case, wrote in his second report of April 9, 2015, at page 9, quoting initially Sarah Fels Usher, as follows:

the therapist needs to establish a frame for the therapy, and respect for the alliance, by setting boundaries...to end the session at a planned time. Beginning therapists often feel they are giving their patients something “extra” by going overtime, but it is my experience that patients at best find this confusing in terms of what it means about the therapist’s feelings for them, and at worst find it an inconvenience...

Considering the extensions from the patient’s perspective, one has to ask a few questions: what is the experience of a patient who shows up for a 50 minute session that turns into a 80 or 110 minutes session? How is the patient supposed to pace the session without knowing if it will end on time or not? When in the midst of a session does Dr. Powell decide that the session will continue beyond the 50 minutes? When do they know a session will be extended by 30 to 60 minutes? What if the next patient does in fact show? Is the extra time then taken back? How is a patient supposed to schedule the rest of his or her day not knowing if a session will end on time, or an hour late? And how does a patient feel when he or she receives what is essentially a gift of more of Dr. Powell’s time, or doesn’t receive it when it has been so frequent and expected?

As noted below under prior discipline history, Dr. Powell has attended courses on boundary issues and on ethics issues following the 2014 hearing. The Committee would have hoped that in completing these courses, Dr. Powell had a reinforced understanding of the importance of professional boundaries. The Committee expects that going forward Dr. Powell will routinely apply a frame for his therapy, thereby avoiding any misunderstanding by his patients that he has feelings for them and is blurring or crossing a boundary.

Second, the Committee considered the nature and extent of the OHIP billing irregularities as especially egregious, as they violate the public trust and tarnish the reputation of the profession.

Dr. Novick noted over 100 instances of billing irregularities when Dr. Powell's financial self-interest took precedence over OHIP requirements.

The joint submission on penalty for the findings in the current hearing includes: a four month suspension of Dr. Powell's certificate of registration; terms, conditions and limitations on his certificate of registration, such as the retention of a clinical supervisor for 12 months at his own expense, monitoring of OHIP billings by the clinical supervisor and the College, informing the College about his practice locations, unannounced inspections of his office by the College; payment of a fine to the Minister of Finance in the amount of \$20,000; and, a reprimand.

The Committee determined that the proposed sanctions are proportionate to the seriousness of the findings. The four month suspension and the reprimand strongly signal the profession's disapproval of Dr. Powell's misconduct. The significant fine of \$20,000.00 acts as a specific deterrent to Dr. Powell, who was acting in his personal financial self-interest in violation of OHIP billing requirements, and is a general deterrent to the profession. The ongoing monitoring of Dr. Powell's OHIP billings will protect the public from further misconduct of this nature and maintain public confidence in the College's ability to govern in the public interest.

Dr. Powell's Discipline History

On February 3, 2014, in a prior case, the Discipline Committee found Dr. Powell to have engaged in conduct that would be regarded by members as disgraceful, dishonourable or unprofessional. Dr. Powell admitted, and the Committee found, that he entered into intimate sexual relationships with two patients too soon after the termination of each of their long term psychotherapeutic relationships with him. The 2014 penalty order included the suspension of Dr. Powell's certificate of registration for nine months, imposition of terms, conditions and limitations that required remedial education on boundary issues and ethics, a reprimand and costs.

Mitigating Factors

The Committee considered certain mitigating factors in considering whether to accept the joint submission on penalty. The Committee took into account that Dr. Powell has admitted his professional misconduct, has cooperated with the College in avoiding a prolonged and contested

hearing, has spared witnesses from having to appear and testify before the panel, and has given up his right to contest the allegations.

Case Law

The Committee was provided with a Brief of Authorities containing Discipline Committee findings and penalties in a range of cases that were similar to, but not the same as, Dr. Powell's case. The Committee understands that these cases were not binding on it, but inform the principle that like cases should be treated alike.

Wojcicki vs. the College of Physicians and Surgeons (2016) - In this case, Dr. Wojcicki, an internal medicine specialist, admitted and the Committee found that he failed to maintain the standard of practice of the profession in his care of 25 patients, and that he engaged in disgraceful, dishonourable or unprofessional conduct in respect of his OHIP billings. He was also found to be incompetent. The Committee found that he inappropriately billed OHIP for services for which there was no documentation. Dr. Wojcicki's penalty included a two month suspension, a reprimand, educational courses, and office and hospital practice clinical supervision, followed by a reassessment. He was also ordered to pay costs.

Otto vs. the College of Physicians and Surgeons (2015) - Dr. Otto, a general practitioner, admitted and the Committee found that he failed to maintain the standard of practice of the profession and that he engaged in disgraceful, dishonourable or unprofessional conduct. Dr. Otto's patient charts did not support the conditions reported in Special Dietary Allowance (SDA) forms and he did not conduct investigations of children to complete their forms, rather he relied only on parental information. His penalty included a two month suspension, a reprimand, education in ethics, a requirement to have a monitor approve his SDA forms, unannounced inspections of his practice and patient records, monitoring of his OHIP billings, and a fine of \$10,000 to the Minister of Finance. He was also required to pay costs.

Shin vs. College of Physicians and Surgeons (2015) – The Committee found that Dr. Shin committed an act of professional misconduct in that he was found guilty of an offence under the Criminal Code relevant to his suitability to practice, and in that he engaged in disgraceful, dishonourable or unprofessional conduct. Dr. Shin is an ophthalmologist who had billed OHIP

fraudulently for uninsured eye examinations, for fitting contact lenses when his staff did the fittings and for services not rendered. The penalty order included a five month suspension, the requirement to complete an education program in ethics, and a review of his patient charts and OHIP billings every three months by a practice monitor who reported to the College. Dr. Shin was also required to pay costs.

Shomair vs. College of Physicians and Surgeons (2013) - Dr. Shomair admitted and the Committee found that he failed to maintain the standard of practice of the profession in his care and treatment of multiple patients and in his recordkeeping. The joint submission, which was accepted, included a reprimand, 12 months of clinical supervision and a requirement to abide by the supervisor's recommendations, and after six months of supervision, a reassessment of his clinical practice by the College. Dr. Shomair was required to complete education in recordkeeping and two courses in pharmacology. He was subjected to clinical supervision for 12 months and a reassessment of his clinical practice thereafter. He was also ordered to pay costs.

Makerewich vs. College of Physicians and Surgeons (2013) - Dr. Makerevich, an otolaryngologist and sleep medicine doctor, admitted and the Committee found that he had been found guilty of an offence relevant to his suitability to practice related to receiving payment for insured services that he was not entitled to receive, contrary to the *Health Insurance Act*, and that he engaged in disgraceful dishonourable or unprofessional conduct. The Committee ordered a two month suspension, a reprimand, and completion of College facilitated instruction in ethics at his own expense. The Committee also ordered that he pay costs.

Smith vs. College of Physicians and Surgeons (2008) - Dr. Smith admitted and the Committee found that he was found guilty of an offence relevant to his suitability to practice and that he engaged in disgraceful, dishonourable or unprofessional conduct. He committed OHIP fraud and was found guilty under the Criminal Code. He was ordered by the Court to pay \$75,554.35 to OHIP as restitution. Dr. Smith's certificate of registration was suspended for five months, subject to reduction of one month on completion of the medical ethics and informed consent course. It was also ordered that his billing be monitored by a licensed physician at Dr. Smith's expense for two years, with regular reporting to the College. The Committee also ordered him to pay costs.

DECISION ON PENALTY

The Committee accepted that the penalty proposed in the joint submission on penalty is appropriate in the circumstances of this case and met the requirement of serving the public interest.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of January 10, 2017. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Powell to attend before the panel to be reprimanded.
3. The Registrar suspend Dr. Powell's certificate of registration for four (4) months, to commence at 11:59 p.m. on January 10, 2017.
4. The Registrar impose the following as a term, condition and limitation on Dr. Powell's certificate of registration:
 - (a) Prior to resuming practice after the period of suspension of his certificate of registration, Dr. Powell shall retain a College-approved clinical supervisor, who will sign an undertaking in the form attached hereto as Schedule "A" (the "Clinical Supervisor"). For a period of twelve (12) months, Dr. Powell may practice only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management, and continuing education. The period of Clinical Supervision will commence on the expiry of the period of suspension, or on the date that the Clinical Supervisor is approved, if one is not approved during the period of suspension;

- (b) If, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Powell shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Schedule “A”. If Dr. Powell fails to retain a Clinical Supervisor on the terms set out above within thirty (30) days of receiving notification that his former Clinical Supervisor is unable or unwilling to continue in that role, he shall cease practicing medicine until such time as he has obtained a Clinical Supervisor acceptable to the College. If Dr. Powell is required to cease practice as a result of this paragraph, this will constitute a term, condition and limitation on his certificate of registration and such term, condition and limitation shall be included on the public register;
- (c) Upon completion of the twelve (12) month period of Clinical Supervision, as described above, within approximately six (6) months, Dr. Powell shall undergo a re-assessment of his practice by a College-appointed assessor (the “Assessor”). This re-assessment by the Assessor will include a review of Dr. Powell’s office charts and an interview with Dr. Powell. Dr. Powell shall abide by all recommendations made by the College-appointed Assessor. The Assessor shall report the results of this re-assessment to the College;
- (d) Dr. Powell shall inform the College of each and every location where he practices, in any jurisdiction (his “Practice Location(s)”) within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location;
- (e) Dr. Powell shall consent to the sharing of information between the Clinical Supervisor, Assessor and the College as any of them deem necessary or desirable in order to fulfill their respective obligations;
- (f) Dr. Powell shall consent to the monitoring of his OHIP billings and cooperate with inspections of his practice and patient charts by the Clinical Supervisor and College representatives for the purpose of monitoring and enforcing his compliance with this term of the Order. Monitoring this term shall include making

enquiries of the Ministry of Health and Long-Term Care regarding Dr. Powell's billings;

- (g) Dr. Powell shall co-operate with unannounced inspections of his office practice and patient charts by the College for the purpose of monitoring and enforcing his compliance with the terms of this Order and shall provide his irrevocable consent to the College to make appropriate enquiries of any person or institution who may have relevant information for the purposes of monitoring and enforcing his compliance with the terms of this Order; and
 - (h) Dr. Powell shall be responsible for any and all costs associated with implementing the terms of this Order.
5. Dr. Powell shall, within three (3) months, pay a fine to the Minister of Finance in the amount of \$20,000.00, and Dr. Powell shall provide proof of this payment to the Registrar of the College.
6. Dr. Powell pay to the College its costs of this proceeding in the amount of \$5,000 within thirty (30) days from the date of this Order.

At the conclusion of the hearing, Dr. Powell waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND
Delivered January 10, 2017
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
AND
Dr. Gerald Wayne Powell

Dr. Powell, you stand before the Committee that has accepted your admission that you have failed to maintain the standard of practice of the profession and engaged in conduct that is clearly disgraceful, dishonourable and unprofessional.

You must understand the level of abhorrence your behaviour engenders among your colleagues and the public.

The inappropriate, self-interested and dishonest billing of OHIP is particularly egregious as it violates the public trust and tarnishes the reputation of the entire profession.

That you have appeared before this panel and admitted to other allegations which betray the public trust makes your behaviour even more distasteful.

Improving your knowledge, education and patient care are insufficient.

You have now been before this Committee on two occasions – both times have involved boundary violations: one sexual boundaries; and now, perhaps less serious but still important, personal boundaries. You must reflect very carefully and completely in the coming year how you are going to ensure that you never appear before this Committee again.