OPSDT Ontario Physicians and Surgeons Discipline Tribunal TDMCO Tribunal de discipline des médecins et chirurgiens de l'Ontario

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Pardis,* 2022 ONPSDT 8
Date: February 17, 2022
Tribunal File No.: 20-006

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Bijan Pardis

FINDING AND PENALTY REASONS

Heard: November 17 and December 6, 2021, by videoconference

Panel:

Mr. Raj Anand (chair)
Dr. Glen Bandiera
Mr. Jose Cordeiro
Dr. Melinda Davie
Ms. Linda Robbins

Appearances:

Ms. Morgana Kellythorne, for the College
Mr. Andrew Matheson, Ms. Keary Grace, Ms. Kara Smith and Ms. Emilie Bruneau, for Dr. Pardis

RESTRICTION ON PUBLICATION

The Tribunal ordered, under ss. 45-47 of the Health Professions Procedural Code, that no one may publish or broadcast the names or any information that would identify patients referred to during the Tribunal hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this order.

INTRODUCTION AND OVERVIEW

[1] Dr. Pardis is a family physician who practises in the Toronto area. He received his certificate of registration from the College of Physicians and Surgeons of Ontario in 1995.

[2] In this application, the College alleged that Dr. Pardis had committed acts of professional misconduct and was incompetent. At the hearing, he admitted most of the allegations, which covered a wide array of conduct over a lengthy time period. This included:

- incompetence and failing to maintain the standard of practice of the profession in his care of several patients across two investigations;
- failing to maintain the standard of practice of the profession in maintaining infection prevention standards and other aspects of the administration and management of his addiction treatment clinics;
- engaging in disgraceful, dishonourable or unprofessional conduct at those clinics in areas such as administration and management; hiring, compensation, supervision and professionalism of clinic staff; infection prevention and control; patient privacy and confidentiality; the relationship with an adjoining pharmacy; and maintenance of boundaries with patients, staff and service providers;
- engaging in disgraceful, dishonourable or unprofessional conduct in failing to comply with provisions of an undertaking he gave regarding the termination of his family practice that led to the disposition of a prior discipline case against him in 2017;
- engaging in professional misconduct by having a conflict of interest because of the relationship between one of his clinics and the adjoining pharmacy and failing to notify patients of his ownership interest in the pharmacy.

[3] Dr. Pardis and the College were able to agree on the facts with respect to both liability and penalty and they provided a separate agreed statement of facts on each of these issues. Dr. Pardis admitted the above allegations and after a recess the panel accepted and made findings based on his admissions and moved to a consideration of penalty and costs.

[4] The parties agreed that our order should include a reprimand and that Dr. Pardis should pay costs of $10,370.

[5] They disagreed on the substance of the penalty we should impose. The College asked for revocation of his certificate of registration, while Dr. Pardis proposed a one-year suspension, together with a detailed list of terms and conditions he would have to comply with on his return to the practice of addiction medicine. Both parties submitted written and oral argument.

[6] In our view, revocation is the appropriate disposition.

[7] These are our reasons for decision on both finding and penalty.

FINDINGS

[8] The ASF on liability revealed that Dr. Pardis had committed acts of professional misconduct and was incompetent in several different and serious ways, over a lengthy time period. We set out the agreed facts in some detail, because the evidence on findings is extensive, and it is also relevant to our decision on penalty that follows later in these reasons.

1. Multiple breaches of his undertaking to the College

[9] On March 8, 2017, the Tribunal found that Dr. Pardis had committed acts of professional misconduct because he had failed to maintain the standard of practice of the profession. In its reasons for decision, *College of Physicians and Surgeons of Ontario v. Pardis*, 2017 ONCPSD 18, the Tribunal noted that since February 2013, Dr. Pardis had been required to complete a specified education and remediation program that was directed at his family practice. Despite some improvements, a 2015 review revealed numerous significant concerns, and on the day of the hearing, Dr. Pardis entered into a detailed undertaking that the Tribunal relied on in deciding the matter.

[10] Dr. Pardis undertook not to engage in the practice of family medicine. He agreed to provide written notification to each current patient at their next appointment and to each new or returning patient in the future, that:

- he could not act as their family physician or provide any family medicine services to them;
- he advised them to have a family physician;
- he was asking them for the family physician's contact information; and
- it was desirable for him to be able to communicate with the patient's family physician in order to provide health care and to ensure that the family physician was aware of their treatment and received relevant information.

[11] Dr. Pardis also undertook:

- to maintain a copy of the written notification provided to and signed by the patient, and any contact information that Dr. Pardis or his staff received regarding the patient's family physician;
- to maintain a record of any limitation that a patient placed on their consent to Dr. Pardis's communication with their family physician;
- to make a note that he informed the patient that it was desirable that family physicians be made aware of all treatments the patient was receiving;
- to provide these family physicians any reasonably necessary information about their patients, including test results; and
- to post a specific notice in a clearly visible and secure location in each of his waiting rooms, advising the reader of his practice restriction and to post a certified translation in any language in which he provided services. The wording and form of the notice was stipulated as an appendix to the undertaking and was simple and straightforward. The text stated in bold and large font:

  IMPORTANT NOTICE

  Dr. Pardis must not practise family medicine or provide any family medicine services.

  And then in smaller font:

Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

[12] We found that Dr. Pardis engaged in disgraceful, dishonourable or unprofessional conduct by failing to comply with many conditions in his March 8, 2017 undertaking to the College that were aimed at maintaining patient safety.

[13] On seven different dates between February 2018 and September 2019, College staff visited one or more of Dr. Pardis's four office locations. They found haphazard compliance with the signage requirements. For example, on some occasions, and in some locations, signs were posted, but not with the required form or content. While the specific sign that Dr. Pardis agreed to had the heading "important notice" in capital letters and in a box, this was missing at times. While the form he undertook to post made clear that Dr. Pardis "must not practise family medicine," staff found a sign that simply related that "Dr. Pardis does not practise family medicine." There was no signage at all in several locations when staff attended.

[14] When College staff asked for confirmation that Dr. Pardis's posted signage in Farsi was a certified translation, the response was that it was not; instead, the signage had been prepared by an office manager described as being fluent in Farsi. When Dr. Pardis's counsel provided a certified translation of the Farsi translation that was posted, the wording did not match the wording he had undertaken to use.

[15] In 2019, College staff also examined Dr. Pardis's records alongside Ontario Health Insurance Plan (OHIP) records for each of his patients from March 8, 2017 onward. This review showed that in almost every case, Dr. Pardis failed to notify his patients, until several appointments had passed, of the limitations on his practice that he had undertaken to provide at the "next appointment." In many cases, his records showed that he did not provide this advice for several months. In most instances, the required communication with patients' family physicians took even longer, and again many appointments took place in the meantime.

[16] Also in 2019, the College retained Dr. Neal Belluzzo, who practises family medicine with a specialty in addiction medicine, to provide an expert opinion on a number of specific questions, based on his review of 20 patient charts.

[17] Some of these questions related to Dr. Pardis's compliance with his March 8, 2017 undertaking. Dr. Belluzzo stated in his final report that in 11 of the 20 cases, Dr.

Pardis had consent to provide the patient's family physician with information that was reasonably necessary for the patient's care, but Dr. Pardis failed to provide it. In the remaining cases, the patient either had no family physician, did not consent to information-sharing or was only briefly cared for by Dr. Pardis. Dr. Pardis did not communicate the necessary information in any of the 20 cases, and he breached his undertaking in all 11 cases in which he had consent to do so.

[18] The parties agreed that Dr. Pardis had not complied with the provisions of his undertaking that required Dr. Pardis to post signage using the required wording, post a certified translation and notify patients as required.

2. Charting, assessment, prescribing and treatment regarding Patients A and B

[19] In his initial report, based on the charts he reviewed, Dr. Belluzzo thought Dr. Pardis was providing family medicine services, contrary to his undertaking. Dr. Belluzzo changed his view after Dr. Pardis sent him a response, describing his rationale for the medications he prescribed. Dr. Belluzzo had been largely unable to determine Dr. Pardis's treatment rationale from the charts alone, because "the clinical documentation in the vast majority of charts consist[ed] of a pre-filled template which is "cut and paste" for every clinical encounter," with any added documentation "often brief and incomplete," without "accompanying documentation justifying the reasons for its use."

[20] In his final report, Dr. Belluzzo stated his conclusions regarding issues that went beyond Dr. Pardis's non-compliance with his undertaking.

[21] Dr. Belluzzo concluded that Dr. Pardis was incompetent and failed to maintain the standard of practice in the 20 cases. For example, Dr. Pardis used essentially identical templates for every encounter, his notes lacked sufficient detail and he conducted incomplete assessments. He displayed a lack of knowledge, skill and judgment in the 20 cases. Dr. Pardis's clinical practice, behaviour or conduct, including the prescribing of specific medications for particular patients, had the potential to expose five patients to harm or injury.

[22] Dr. Belluzzo was also asked to provide his opinion on Dr. Pardis's treatment of Patients A and B. Dr. Belluzzo reviewed a wide array of evidence, including videotapes taken by Patient A of certain interactions with three individuals: Patient

B (also a staff member at one of Dr. Pardis's clinics), Dr. Pardis and the pharmacist in an adjoining PharmaDocs pharmacy. We refer to this evidence below.

[23] Dr. Belluzzo concluded that the care provided to Dr. Pardis to Patient A did not meet the standard of practice of the profession. Dr. Belluzzo cited the absence of a clinical note; providing a prescription for a controlled substance, methadone, without any valid patient identification; recording an incomplete history; failing to provide detailed advice regarding options for opiate use disorder; neglecting to discuss dosages of methadone, risks of toxicity or risks of illicit substance use with patients; neglecting to review urine drug screen results with patients; and violating patient confidentiality.

[24] Dr. Belluzzo cited many of the same facts in support of his conclusion that Dr. Pardis's care of Patient A displayed a lack of knowledge, skill and judgment, and he also concluded that Dr. Pardis's clinical practice, behaviour or conduct exposed or was likely to expose Patient A to harm or injury.

[25] Regarding Patient B, Dr. Belluzzo again concluded that Dr. Pardis's care did not meet the standard of practice of the profession. There were no notes corresponding to their 32 clinical encounters, and Dr. Pardis provided an initial dose of methadone that was greater than what was permitted for a high-risk patient at initiation. For similar reasons, Dr. Belluzzo stated that Dr. Pardis also displayed a lack of knowledge, skill and judgment.

[26] Dr. Belluzzo stated that Dr. Pardis exposed Patient B to harm or injury. Dr. Pardis entrusted Patient B (the staff member) to store and dispense take-home methadone doses for himself and others. This was captured on videotape on two occasions, when Patient B was seen providing Patient A with a labelled bottle from the fridge behind the reception desk in one of Dr. Pardis's clinics. In Dr. Belluzzo's opinion, this practice would also expose Patient A and other methadone patients to harm or injury.

[27] Based on Dr. Belluzzo's reports and the parties' agreed facts, we found that Dr. Pardis was incompetent and failed to maintain the standard of practice of the profession in his care of Patients A and B. He exposed or was likely to expose both patients to harm or injury.

3. Infection prevention and control in Dr. Pardis's addiction treatment clinics

[28] Here as well, the evidence before us was obtained from unannounced visits, video footage and Dr. Belluzzo's expert reports.

[29] On November 3, 2017, investigators from the College and the Ontario College of Pharmacists attended together at Dr. Pardis's Church Street and Etobicoke clinic locations, both of which had adjoining pharmacies.

[30] At the Church Street location, no physician was on site. In addition to the pharmacist, the receptionist Mr. S was present, and several other persons were resting or sleeping on the floor in the entry area, in front of the pharmacy and doctor's office. Under the staff sink there was a bag with syringes and other equipment including tourniquets, which Mr. S said a patient must have put there.

[31] Mr. S described himself as a janitor and a receptionist who had been with the clinic for 15 months, having begun as a volunteer. He took urine samples, conducted urine testing, recorded the results for physician review and obtained and verified information from new patients, including their last dose of methadone. According to Mr. S, he sometimes asked patients to help him take out the garbage or sweep the clinic. He kept used urine drug sample test strips in the kitchen in a big box. Dr. Pardis went to the clinic twice a week.

[32] At the Etobicoke location, the investigators found expired medications. Gloves and full urine bottles from drug screening were discarded into a plastic garbage bag. The investigators were told that used urine dip strips were retained, to be shown to Dr. Pardis later. (According to Dr. Pardis, the expired medications came from a period when he was practising family medicine.)

[33] While she was at the Etobicoke clinic, a College investigator interviewed Dr. Pardis by telephone about his hiring and training of staff. He told her that for training purposes he provided the methadone booklet that he gives to patients and he has a copy of the College guidelines for methadone in "all of the terminals." These materials, however, were not in the clinic, and staff confirmed at the time that they did not have them.

[34] On November 15, 2017, when investigators returned to the Church Street location to retrieve a security footage recording device, College staff observed breaches of patient privacy and confidentiality.

[35] Patients walked around the clinic and went through the back and front doors. The electronic medical records system was open on the computer behind the reception desk and at times a patient could be seen there while the computer was displaying records. The pharmacist would occasionally come to the desk to look at medical records.

[36] A College investigator also obtained security camera video footage from the Church Street location, covering dates between October 2017 and November 2018. She viewed and summarized a random sampling of the footage.

[37] For example, on October 18, 2017, a patient left a urine sample at an unstaffed reception desk and a few minutes later Mr. S was seen behind the reception desk, testing the sample without gloves, with coffee on the desk. There was no handwashing before or after he handled the specimen. About an hour later, Mr. S was testing a urine sample at the reception desk, without gloves, but with coffee and peanut butter on the same desk.

[38] Various patients and unidentified individuals were seen coming behind the reception desk, touching the computer keyboard and using the phone. Mr. S was seen lying on a treatment table watching videos and sleeping there overnight. He and an unidentified male were seen smoking in the reception area and the unidentified individual was seen sleeping at night behind the reception desk. Mr. S appeared to use drugs, including in the physician treatment room, and appeared to place an item above the overhead ceiling tiles.

[39] The College investigator's inspections on November 3 and 6, 2017 at the Church Street location identified numerous infection prevention and control deficiencies, including stool in the waiting room, no medical grade disinfectants, no paper on the examination table in the physician's office, a staff member with visibly soiled hands and fingernails, no medical gloves, sleeping bags and 20 to 30 large garbage bags on the floor in the clinic entrance and inappropriate disposal of sharps.

[40] At the Etobicoke clinic, also on November 3, 2017, photographs revealed urine screening occurring at the reception desk, a sharps container placed next to kitchen supplies and used urine drug tests located in a cardboard box labelled with patient names. At an unannounced inspection at the same location five days later, the College investigator found that there were no gloves. Staff tested urine at the reception desk and specimens and test cartridges were discarded in a garbage bin at the desk. There were expired vaccines in a fridge also used for storing both food and specimens. A staff member at the clinic later stated that staff sometimes let patients test their own urine.

[41] On November 9, 2017, the investigator provided Dr. Pardis's counsel with details of the infection prevention and control concerns and asked for a response within a week with the corrective steps Dr. Pardis had taken. Despite counsel's reply, the investigator's next visit on November 22 revealed continuing deficiencies. While drinking from a disposable cup, Mr. S was doing urine testing at the reception desk, and there was no separate, sterile area at the desk. He communicated drug screen results within earshot of other patients. Sterile wipes were not used between tests as required. The only additional training or direction that Mr. S could provide was that he had been directed by Dr. Pardis's manager of clinic staff to make sure to clean more.

[42] On December 11, 2017, Dr. Pardis's counsel sent what was described as his new infection prevention and control policies. When a further inspection was performed on February 7, 2018 at three locations (Dr. Pardis had by then sold the fourth, in Scarborough), there were continuing infection prevention and control problems.

[43] For example, in the Markham clinic, there were expired medication supplies, expired blood collection tubes and an expired bottle of alcohol. Urine specimen testing was being done at a desk adjacent to the reception area. Urine specimen bottles were disposed of in a black garbage bag, rather than yellow biomedical waste bags as required. Clinic staff were uncertain of whether the waste management company that emptied the garbage bins was qualified to handle biomedical waste.

[44] At the Mississauga clinic, reception staff and the physician on site were both wearing visibly perforated gloves, and they were not medical grade gloves. There

was no hospital grade disinfectant. When a patient exited one of the bathrooms, which were located behind the reception desk, the staff computer screen was visible. Urine specimens were tested behind the reception desk while patients were present in the waiting area. A sharps container in the physician's treatment room was overfilled.

[45] A small dog that accompanied a couple of patients was off-leash and roamed freely in the treatment room and the waiting area during this and previous appointments. At one point the dog defecated on the floor mats in the waiting area. When another patient complained about the smell, the dog's owner cleaned up the mess and took the dog outside.

[46] At the Etobicoke location, staff wearing medical gloves performed urine tests at the counter adjacent to the reception desk. Specimen containers were disposed of in black garbage bags.

[47] Consistent with Dr. Belluzzo's expert opinion, we found that Dr. Pardis failed to maintain the standard of the profession in infection prevention and control. He displayed a lack of knowledge, skill and judgment in this area, and it exposed or was likely to expose patients to harm or injury.

4. Administration and management of Dr. Pardis's addiction treatment clinics

[48] The evidence we received under this heading came from several sources.

[49] Patient A took video recordings of interactions with Patient B (the staff member) and Dr. Pardis in January 2017 at the Church Street clinic and provided them to a College investigator. We received the recordings together with the investigator's summaries. They show Patient B offering Patient A $20 for every person Patient A brings to the clinic and then talking with him about how to obtain illicit drugs. They discussed kickbacks, and then the staff member told Patient A, "I could grab a point off you but I don't have any cash on me," and the staff member agreed he "still gets high." Dr. Pardis then assessed and provided Patient A with a prescription for methadone, even though Patient A provided no identification and Dr. Pardis appeared to steer Patient A to "my pharmacy."

[50] Twice Patient B provided methadone bottles to Patient A without requiring the doses to be witnessed while he was in the clinic.

[51] The security footage between October 2017 and November 2018 that we summarized earlier was a second source of evidence about Dr. Pardis's unsatisfactory administration and management at the Church Street clinic.

[52] Finally, as we noted earlier, Dr. Belluzzo was given a wide range of evidence that had been collected by the College, which he supplemented with his own inquiries, With this information he formed an opinion about several central issues, including the administration and management of Dr. Pardis's clinics. Dr. Belluzzo pointed out in his final report that as sole physician owner of his clinics, Dr. Pardis was responsible to ensure that his clinic posed no injury or harm to both patients and staff. To properly do so, staffing, training and administration are vital.

[53] Having regard to Dr. Belluzzo's report, we conclude that Dr. Pardis failed to maintain the standard of practice of the profession, engaged in disgraceful, dishonourable or unprofessional conduct and was incompetent in his administration and management of addiction treatment clinics in many respects.

[54] Dr. Pardis did not ensure that his clinics were staffed by properly trained employees. His clinics failed to maintain a policy and procedure manual or records of employee training. Dr. Pardis did not provide adequate urine drug screening, infection control or patient confidentiality training for staff, and he failed to ensure that staff were not engaging in activities that could expose patients to harm or injury. Moreover, he failed to ensure a safe working environment for staff, with physical barriers between the waiting room and the reception area.

[55] As noted, Patient B was working at the clinic while he was a patient of Dr. Pardis. In the next section we consider the boundary violation that resulted from this employment relationship on its own. Apart from this, the evidence shows that while he was interacting with Patient A as clinic staff, Patient B would have just been initiated on methadone. It was poor judgment to employ a patient who was newly initiated on methadone.

[56] In addition, having staff who engaged patients in unprofessional and illegal activities had the potential to expose clinic patients to harm and injury. In particular, Patient B dispensed methadone to Patient A without adequate training. This occurred for example when Patient B dispensed methadone to Patient A on his own

and allowed Patient A to leave the clinic with both bottles unopened. Patient B had one day of training.

[57] Dr. Pardis failed to ensure that staff adequately supervised urine drug screening. He exposed or was likely to expose patients to harm or injury, by creating the risk of inaccurate results. Patient B, for example, had no training in this area.

5. Maintenance of boundaries

[58] Dr. Pardis hired both Patient B and Patient C to work for him while they were patients. Such dual relationships with a physician can create boundary violations. In this case, the College relied on their engagement as Dr. Pardis's staff as well as the circumstances surrounding some of Patient B's duties. The parties jointly submitted that we should find that Dr. Pardis failed to maintain appropriate boundaries, and that this failure constituted disgraceful, dishonourable and unprofessional conduct.

[59] Patient B was hired to work at the Church Street clinic when it opened in 2016. He was paid $20 for registering new patients outside of clinic hours. Patient B viewed the payments as a "recruitment bonus."

[60] Patient B received one day's training from a woman at another clinic owned by Dr. Pardis. His training focused on how to turn on the computer, connect to the physician using telemedicine and print and scan forms.

[61] Dr. Pardis treated Patient B and prescribed methadone for him between September 2016 and November 2017, while Patient B was working at the clinic. It appears that Patient B received paycheques from Parad Inc. This corporation owned the pharmacy adjoining the Church Street clinic, and it was itself owned 49% by Dr. Pardis and 51% by Masoud Amidi, the pharmacist at that location.

[62] As we noted earlier, Patient B should not have been employed in this capacity when he was newly initiated on methadone as Dr. Pardis's patient. Patient B also engaged Patient A in unprofessional and illegal activities, which had the potential for harm and injury to Patient A and others. As an example, Patient B dispensed methadone to Patient A without requiring the doses to be witnessed. The result was that Patient A left with the unopened methadone bottles, and as Dr. Belluzzo stated, we do not know what happened to the methadone.

[63] Dr. Pardis also engaged in boundary violations with respect to Patient C.

[64] Dr. Pardis began treating Patient C in his family practice in 1997, and he continued to be Dr. Pardis's methadone patient two decades later, at the time of the College investigation. About midway through this period, in 2006 or 2007, Dr. Pardis hired Patient C to provide infrastructure for the computer server where patient data was stored. Patient C did not have access to patient information.

[65] Based on this evidence and the parties' joint submission, we found that Dr. Pardis engaged in disgraceful, dishonourable or unprofessional conduct in failing to maintain appropriate boundaries with Patients B and C.

6. Patient privacy and confidentiality

[66] Dr. Pardis failed to ensure the maintenance of patient privacy and confidentiality. Much of the evidence on this point was covered earlier and the College investigator observed it both firsthand and on security footage.

[67] Patients walked through the Church Street clinic and had access to the area behind the reception desk where the office computer was logged on and open to the electronic medical record system.

[68] In 2017, Mr. Amidi, the pharmacist at the adjoining pharmacy, was observed occasionally walking up to the reception desk computer to look at records and he was present for telemedicine services without patient permission.

[69] In 2020, Dr. Pardis provided a "notice to all patients" stating that he was a minority shareholder in an onsite pharmacy and that the pharmacist was a member of the team with access to medical records. His counsel stated that this notice was first posted in relevant locations in approximately 2001 or 2002. Even if this posting were effective, it was not in place when the College investigator attended any of Dr. Pardis's clinic locations, including Church Street.

[70] After performing urine testing at the reception desk, a staff member, Mr. S, communicated the results within earshot of other patients.

[71] We therefore found that Dr. Pardis engaged in disgraceful, dishonourable or unprofessional conduct in failing to protect and maintain patient privacy and confidentiality.

7. Conflict of interest with the pharmacy

[72] Many of the prescriptions issued by Dr. Pardis were filled at the pharmacy adjoining his Church Street practice location. As we noted above, Dr. Pardis had a 49% ownership interest in Parad Inc., which owned the pharmacy, and he had an obvious financial self-interest in sending patients with their prescriptions to the adjoining pharmacy.

[73] Most of the cheques to both Patient B and Mr. S came from Parad Inc., based on an arrangement for the pharmacy to "subsidize" the clinic. Parad Inc. also paid rent, heat and hydro for the space it shared with the clinic. This arrangement resulted in Dr. Pardis receiving a benefit from a supplier of medical goods or services – drugs – to his patients, which Dr. Pardis acknowledged is a conflict of interest. It was a conflict of interest that was not removed by posting a sign about it.

[74] As we stated, Dr. Pardis was seen on the videotape taken by Patient B in circumstances where a prescription needed to be filled. Dr. Pardis did not ensure that Patient B knew he could choose where he would fill the prescription.

PENALTY

[75] This is the one area of disagreement (although obviously a significant one) between the parties. The College submits that Dr. Pardis should be reprimanded and his certificate of registration be revoked.

[76] Dr. Pardis takes the position that revocation would be a "grossly disproportionate" penalty, "very unreasonable in the circumstances." Dr. Pardis's draft order is lengthy, but its most significant terms are these. He would receive a one-year suspension, after which he could resume an addiction medicine practice for one year under detailed clinical supervision. About six months after that, he would have to receive a satisfactory reassessment of his practice. There are many other proposed terms, conditions and limitations, including terms of methadone treatment; record keeping; frequency and nature of meetings, observations and chart reviews with the clinical supervisor(s) and the assessor; coaching and training

on boundaries, ethics, security and privacy; posting of notices regarding his pharmacy ownership; notifications to his patients' family physicians; consent to unannounced inspections; provision of information to the College by Dr. Pardis, his supervisor(s), the assessor, OHIP and other agencies; and payment of all costs to implement the order.

[77] After briefly outlining the parties' submissions, we will move to our analysis and conclusion.

[78] The College stressed the Tribunal's objectives in imposing penalties, which include protection of the public; maintenance of public confidence in the reputation and regulation of the profession; specific and general deterrence; rehabilitation of the member; the seriousness of the misconduct; and any aggravating and mitigating factors in this case.

[79] The College pointed out that this was Dr. Pardis's second discipline finding. We have found that he failed to maintain the standard of practice of the profession, engaged in disgraceful, dishonourable or unprofessional conduct and had a conflict of interest. He was also incompetent in the care of many patients.

[80] The College also noted that in its prior finding, Dr. Pardis's practice deficiencies were described as "longstanding," extending back to 2010, and he was being given "one final chance" to meet the expected standards.

[81] Dr. Pardis did not take issue with the factors that this Tribunal must consider in ruling on an appropriate penalty. He argued, however, that in reaching that decision, we should aim for consistency with prior decisions and should only choose revocation of his certificate of registration if no lesser penalty would adequately achieve the accepted penalty principles.

[82] Dr. Pardis argued that cases involving record-keeping, failure to maintain the standard of practice and disgraceful, dishonourable or unprofessional conduct, the typical penalty is a suspension with terms. He argued that result would be appropriate here, where there is a history of discipline and Inquiries, Complaints and Reports Committee (ICRC) involvement, together with mitigating factors that include the subsequent steps he has taken that support a potential for rehabilitation. In these circumstances, the protection of the public does not

necessitate revocation, where a long suspension with closely tailored terms and conditions is adequate to minimize the risk that remains.

ANALYSIS

[83] Subsection 51(2) of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c. 18 (the Code) empowers the Tribunal to make one or more of these orders upon a finding of professional misconduct:

> Orders
>
> 51(2) If a panel finds a member has committed an act of professional misconduct, it may make an order doing any one or more of the following:
>
> 1. Directing the Registrar to revoke the member's certificate of registration.
> 2. Directing the Registrar to suspend the member's certificate of registration for a specified period of time.
> 3. Directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time.
> 4. Requiring the member to appear before the panel to be reprimanded.
> 5. Requiring the member to pay a fine of not more than $35,000 to the Minister of Finance.
>
> 5.1 If the act of professional misconduct was the sexual abuse of a patient, requiring the member to reimburse the College for funding provided for that patient under the program required under section 85.7.
>
> 5.2 If the panel makes an order under paragraph 5.1, requiring the member to post security acceptable to the College to guarantee the payment of any amounts the member may be required to reimburse under the order under paragraph 5.1. 1991, c. 18, Sched. 2, s. 51(2); 1993, c. 37, s. 14(2).

[84] Section 52 of the Code lists the Tribunal's powers when it makes a finding of incompetence. These include revocation, suspension or the imposition of terms, conditions and limitations, as well as the authority to specify requirements to remove a suspension or terms, conditions and limitations that are imposed.

[85] As this Tribunal stated in *College of Physicians and Surgeons of Ontario v. Minnes,* 2015 ONCPSD 3 at pp. 4-5, aff'd *College of Physicians and Surgeons of Ontario v. Minnes*, 2016 ONSC 1186 (Div. Ct.) at para. 10:

> The principles relevant to the imposition of penalty in disciplinary proceedings are well-established. The protection of the public is the paramount consideration. Others include: maintenance of public confidence in the reputation and integrity of the profession and in the principle of effective self-governance; general deterrence as it applies to the membership as a whole; specific deterrence as it applies to this particular member; and, the potential for rehabilitation of the member. The weighing of these principles, in light of the specific facts and circumstances of the case, is the task to be undertaken by the [Tribunal] in arriving at its decision regarding penalty. Aggravating and mitigating factors, if any, pertaining to the events in question, will be considered. Proportionality is an important element to be considered by the [Tribunal]. The most severe penalties should be imposed for the most serious transgressions.

[86] A penalty decision involves "a highly individualized exercise that goes beyond a purely mathematical calculation. It involves a variety of factors that are difficult to define with precision": *R. v. Lacasse*, 2015 SCC 64, at p. 1091. In addition to the individual circumstances of "the offence" and "the offender," we must consider similar cases that have been put forward by both parties, in order to discern the proper range of penalties and to accord fairness and proportionality. At the same time, as the *Minnes* panel stated at pp. 4-5:

> Each case is…unique. While a review of similar decisions can often disclose some commonality between the facts of the case under consideration and previous factual situations, there will be differences reflecting the individual circumstances of the cases. The challenge for the [Tribunal] is to carefully consider all of the facts and circumstances of the case and, by weighing the accepted principles of penalty in a fashion that takes into account the unique features of the case, to arrive at a fair and just decision.

[87] As noted in *Minnes,* our penalty disposition must endeavour to maintain the reputation of the profession and public confidence in its regulation, in addition to the individual interests of the member before us. The English Court of Appeal captured this principle long ago in a solicitor's case, *Bolton v. Law Society*, [1993] EWCA Civ 32, at para. 15:

> Because orders made by the tribunal are not primarily punitive, it follows that considerations which would ordinarily weight in

> mitigation of punishment have less effect on the exercise of this jurisdiction than on the ordinary run of sentences imposed in criminal cases. It often happens that a solicitor appearing before the tribunal can adduce a wealth of glowing tributes from his professional brethren. He can often show that for him and his family the consequences of striking off or suspension would be little short of tragic. Often he will say, convincingly, that he has learned his lesson and will not offend again. On applying for restoration after striking off, all these points may be made, and the former solicitor may also be able to point to real efforts made to re-establish himself and redeem his reputation. All these matters are relevant and should be considered. But none of them touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness…The reputation of the profession is more important than the fortunes of any individual member. Membership of a profession brings many benefits, but that is part of the price.

Nature and gravity of the misconduct and incompetence

[88] On the uncontested facts, Dr. Pardis engaged in several different types and examples of serious misconduct and incompetence over an extended time period. In our reasons on finding, we summarized more than 600 pages of evidence, together with several videotapes, that comprise the ASF on finding.

[89] That summary showed that Dr. Pardis failed to meet the standard of his profession, engaged in disgraceful, dishonourable and unprofessional conduct and was incompetent in numerous and multifaceted ways, including:

- multiple breaches (involving signage, translation, notification and communication with both patients and family physicians) of the straightforward undertaking he gave on March 8, 2017 that a previous Tribunal panel took into account in deciding to impose only a reprimand and terms, conditions and limitations on his certificate of registration;

- multiple instances of failing to maintain the standard of the profession, and of incompetence, in his care of patients, including “copy and paste” charts, incomplete assessments and dangerous prescribing practices, all of which had the potential to expose patients to harm or injury;

- repeatedly failing to maintain the standard of practice of the profession, engaging in disgraceful, dishonourable or unprofessional conduct and being

incompetent in something as basic as infection prevention and control at his clinics – including urine screening at the reception desk, garbage bags in the entrance way, the absence of medical gloves or proper disinfectants and inappropriate sharps disposal – which again exposed or was likely to expose patients to harm or injury;

- failing to maintain the standard of practice of the profession, engaging in disgraceful, dishonourable or unprofessional conduct and being incompetent in matters again as basic as the administration and management of his addiction treatment clinics, involving inadequate training and inappropriate assignment of staff who interacted with patients, slept at the clinic, offered compensation and deals to patients, used drugs at the clinic and allowed patients to roam unconstrained through sensitive areas of the clinic;

- failing to maintain appropriate boundaries, by treating and prescribing methadone to Patient C, who worked in IT at the clinic, and to Patient B, who also worked at the clinic and dispensed unwitnessed methadone doses to Patient A;

- failing to ensure patient privacy, again over a lengthy time span, by allowing both patients and the pharmacist from the adjoining pharmacy access to confidential health information and failing to notify patients that the pharmacist was being given access to confidential records; and

- engaging in a conflict of interest and disgraceful, dishonourable or unprofessional conduct in his relationship with the adjoining Church Street pharmacy by intermingling their finances and failing to ensure that patients were aware of their choice of pharmacy.

[90] The public does not expect to find such a combination and extent of egregious failures from a professional who has been given the privilege of practising his profession. This is especially so when most of these failures occurred over an extended period, despite the ongoing communications, reviews and inspections that Dr. Pardis was undergoing.

Dr. Pardis's prior interactions with the College

[91] The history of Dr. Pardis's interactions with his regulator shows that while he has been before this Tribunal only once before, in 2017, he has known about the College's concerns with his practice for about 10 years, which is about 40% of the time he has been in practice.

[92] In its decision of February 6, 2013, the ICRC noted the following: extensive deficiencies in Dr. Pardis's medical records, deficiencies of care, practice management issues, serious problems with documentation and Dr. Pardis's remedial actions, including his undertaking to the Methadone Committee not to use methadone for chronic pain, ceasing primary care for chronic pain patients and taking a medical record-keeping course.

[93] The ICRC issued a written caution to Dr. Pardis about his record-keeping and his practice management, believing "that the physician would benefit from some written direction as to how to conduct himself or herself in the future." The ICRC also required Dr. Pardis to complete a specified continuing education or remediation program, including record-keeping, safe opioid prescribing and office management. It also ordered Dr. Pardis to attend education sessions with a preceptor in these areas, and to undergo a reassessment about 18 months after the completion of the preceptorship, consisting of a review of 15 to 20 patient records and an interview with the assessor.

[94] Also on February 6, 2013 the ICRC considered the report of an investigation that resulted from a complaint in April and October 2010 about Dr. Pardis's clinical and administrative conduct. After reviewing information from the patients and Dr. Pardis, as well as medical records, an interview with Dr. Pardis and an independent opinion, the ICRC again reached conclusions about deficient documentation and management of chronic pain, as well as other issues. The ICRC issued a written caution to Dr. Pardis that he should not treat methadone patients for chronic pain or for other medical problems, he should improve his practice management and his record-keeping. In addition, he should have complied with the College policy on ending the physician-patient relationship.

[95] On January 15, 2015, the ICRC considered a complaint by another physician about access to files after he relocated his methadone practice from Dr. Pardis's clinics.

The ICRC issued advice to Dr. Pardis that if another physician asks for records and the patient has not provided consent, he must ask for that consent, and not hold the records hostage in a way that could compromise patient care. He also received a caution not to treat methadone patients for chronic pain or for other medical problems, to ensure better practice management.

[96] On June 7, 2017, the ICRC considered an investigation into another complaint regarding Dr. Pardis's treatment of a patient's relative. The ICRC again received an independent opinion as well as information from several other sources, including Dr. Pardis. The ICRC agreed with the independent opinion that Dr. Pardis did not meet the standard of practice in his care of a patient, and expressed concerns about his prescribing practices, a boundary violation in receiving gifts from a patient and allowing her to direct her own care. It also noted that despite his completion of a course on medical record keeping in order to remedy deficiencies, there were ongoing difficulties with his records.

[97] The ICRC ordered Dr. Pardis to complete a course on boundaries and to review the College Practice Guide and policy on maintaining appropriate boundaries. The ICRC cautioned him about his record-keeping and his prescribing of benzodiazepines and psychoactive drugs.

[98] The first disciplinary finding against Dr. Pardis was made on May 2, 2017. In its decision and reasons, the Tribunal noted the following.

[99] Regarding Dr. Pardis's family practice, Dr. Evan Llewellyn, the preceptor appointed pursuant to the ICRC's February 6, 2013 decision, delivered three reports. He identified many concerns with Dr. Pardis's practice, including a need for better documentation of his patient encounters and patient profiles. Despite improvement in his record keeping during the preceptorship, Dr. Pardis's charts indicated some eight cases in which Dr. Pardis failed to investigate conditions that could be due to an underlying malignancy. When asked, Dr. Pardis advised the College through counsel of follow-up steps he had taken following Dr. Llewellyn's review of their care.

[100] The reassessment of Dr. Pardis's practice under the terms of the February 6, 2013 ICRC order was to take place 18 months after the completion of Dr. Llewellyn's preceptorship. The reassessment did not occur. Instead, as a result of the concerns

raised by Dr. Llewellyn, the College commenced an investigation under s. 75(1)(a) of the Code and the Registrar appointed investigators.

[101] The College retained Dr. Robert Bernstein to review Dr. Pardis's family practice, and he interviewed Dr. Pardis and reviewed 25 of his patient charts.

[102] Dr. Bernstein stated that Dr. Pardis provided care with cultural sensitivity and he demonstrated knowledge of the circumstances of the lives of his patients, most of whom were Iranian immigrants.

[103] Dr. Bernstein, however, stated that Dr. Pardis failed to meet the standard of practice in several aspects. These included: poor record-keeping, in 80% of the charts Dr. Bernstein reviewed; lack of preventive care, in the majority of cases; lack of a coordinated approach to chronic disease management, appropriate knowledge and weighing of risks; over-testing and over-screening; over-prescription of antibiotics for viral illnesses and poor coordination with consultants on medication management.

[104] Apart from a "more immediate risk of harm" in four cases, Dr. Bernstein concluded that Dr. Pardis's care was "substandard" and represented a potential risk of harm.

[105] Regarding Dr. Pardis's methadone practice, as a result of concerns of the College's Methadone Committee, Dr. Pardis undertook on November 9, 2010 to practise methadone treatment under the guidance of a clinical supervisor and subject to reassessment by a College-appointed assessor. In January 2012, the ICRC approved the appointment of investigators to examine Dr. Pardis's practice, and the ICRC retained a medical inspector to review charts and interview Dr. Pardis.

[106] The assessor, Dr. Melissa Snider-Adler, reviewed 25 patient charts and issued a final report on February 8, 2015. She found that Dr. Pardis failed to meet the standard of practice of the profession in several respects, including the prescribing of medications without an awareness of potential side effects or the need for monitoring. Dr. Pardis's medical record keeping was so deficient that she could not determine in 22 of the cases whether his care met the standard of practice of the profession. Among other things, he used an electronic medical record template in which he wrote "yes" or "no." While some detail was added, the prescribed

medications, and conversations with patients including follow-ups were not adequately documented.

[107] In response to these concerns, Dr. Pardis informed the College that he had made changes to his practice in several areas: limiting his prescribing of medications to those related to methadone treatment and its side effects, improving his counselling about side effects and risks, documenting patient counselling and upgrading his electronic medical record keeping system.

[108] Based on these admitted facts, the Tribunal found that Dr. Pardis committed professional misconduct because he failed to maintain the standard of practice of the profession.

[109] The parties made a joint submission on penalty. The panel reviewed the February 2013 ICRC reports, and noted that since then, his family medicine practice had been under review or investigation or subject to preceptorship. The panel stated in *College of Physicians and Surgeons of Ontario v. Pardis*, 2017 ONCPSD 18, at pp. 10-11:

> [Dr. Llewellyn and Dr. Bernstein] pointed to multiple problems in Dr. Pardis' family practice including problems investigating medical conditions, problems in management of patients' medical conditions, record-keeping problems, excessive/unnecessary laboratory investigations, over prescribing of antibiotics, and poor coordination of care with consultants.
>
> With respect to his methadone practice, concerns by the College date back to April 2010…As a result of an investigation…Dr. Pardis entered into an undertaking to practise methadone treatment under the guidance of a clinical supervisor. [Dr. Adler] subsequently assessed Dr. Pardis' methadone practice. In her report dated February 8, 2015, she noted similar charting/record keeping deficiencies as had been seen in review of his family practice, concerns about methadone interactions with other prescribed medications, and adherence to CPSO methadone maintenance treatment program standards and clinical guideline. Note was made that a lack of documentation to support his clinical decision making made it difficult to determine if Dr. Pardis was adhering to methadone treatment guidelines. [Emphasis added]

[110] The Tribunal cited as an aggravating factor that the deficiencies in both family and methadone practices are "long-standing, going back to at least 2013 and 2010 respectively," despite preceptorship throughout that time. The panel was "quite

troubled" by the "chronicity of Dr. Pardis failing to maintain the standard of practice of the profession and the seeming intransigence to change despite review and preceptorship. Serious consideration was given as to whether this physician was ungovernable or not rehabilitatable:" *Pardis*, at p. 11. [Emphasis added]

[111] Importantly, the panel viewed as a mitigating factor Dr. Pardis's undertaking with respect to the supervision and reassessment of his methadone and the terms by which he confirmed he would not be engaged in family practice. These gave " some comfort and demonstrates some insight on the part of Dr. Pardis." The Tribunal also warned that "maintaining the standard of practice is not something which is optional."

[112] The panel accepted the parties' joint submission and ordered a reprimand, compliance with his undertaking and terms, conditions and limitations that required clinical supervision, followed by a reassessment of Dr. Pardis's methadone practice within about six months and then within a further 12 months.

Significance of Dr. Pardis's history

[113] Several conclusions can be drawn from the chronology since 2010, most of which are aggravating circumstances for purposes of penalty. These conclusions relate directly to the duration, repetition and gravity of Dr. Pardis's conduct that we consider under separate headings, but in the particular circumstances of this case, they have additional aggravating impact.

[114] First, while Dr. Pardis has only been the subject of discipline on one occasion, he has exhibited very similar deficiencies in his practice for a very long time.

[115] Second, the College and its ICRC have attempted to work constructively with Dr. Pardis in every way possible, but he has been resistant to change and improvement. It is not necessary to determine whether this "seeming intransigence" is intentional, reckless, uncaring or unavoidable. We have little evidence on this point, and the parties did not directly address the question of intent. From the standpoint of public protection and the reputation of the profession, and in the absence of any evidence of personal circumstances that would mitigate this conduct, the duration and gravity of Dr. Pardis's very similar deficiencies constitute serious aggravating factors.

[116]Third, another aggravating factor is the flagrant and repeated breaches of a simple undertaking that forms an important aspect of the misconduct in this case.

[117]Fourth, that undertaking evidently represented an important factor in the parties' joint submission, as well as an important "comfort" to the 2017 panel that Dr. Pardis had insight into his obligations and was determined to do something about the longstanding deficiencies. The panel's understanding in turn led to its decision not to impose a suspension, and to give Dr. Pardis a further opportunity to demonstrate that he would correct the longstanding breaches that had forced the College to intervene on so many occasions.

Repetition and duration of Dr. Pardis's conduct in this case

[118]As noted, the history points to concerns about the repetition and duration of the misconduct and incompetence in the allegations before us, which is an important aggravating factor in itself.

[119]The evidence on finding shows that even restricted to the allegations in the notice of hearing, the misconduct and incompetence extended over a considerable time. A non-exhaustive list includes issues of administration and management of Dr. Pardis's clinics, which spanned at least 2016 to 2018 and were revealed in part by many contemporaneous video recordings and inspections during those years. Infection prevention and control violations were found most prominently in late 2017 and early 2018. Boundaries concerns with Patient C went back more than a decade, and with Patient B for much of 2016 and 2017. Conflict of interest matters relating to the pharmacy company were outstanding for several years and notifications to patients were insufficient even as late as 2020.

[120]Breaches of Dr. Pardis's undertaking could only take place after March 2017, when he executed it, but during the following two-and-a-half years, there were many breaches of the signage, patient notification and physician communication requirements.

[121]Dr. Pardis sought to minimize the breaches of his undertaking in several ways, describing them as "his failure to comply strictly with some of the requirements." First, Dr. Pardis argued that he did not practise family medicine after signing his undertaking not to do so. Second, his signage in his practice locations was "not

precisely as stipulated." Third, he provided his office manager's translation in Farsi rather than a certified translation. Fourth, Dr. Pardis "did not always advise the patients at their next appointment" that he could not practise family medicine. Fifth, he failed to provide his patients' family physicians with information that was reasonably necessary to their care, but many patients had no family physician, did not consent to the communication or were only briefly cared for by Dr. Pardis.

[122] The first point is true, but partial compliance does not excuse the many violations of other aspects of Dr. Pardis's undertaking. The remaining points simply downplay and re-characterize findings that we made above in accordance with Dr. Pardis's own admissions. His submissions do not excuse or minimize the obvious, ongoing and egregious non-compliance that Dr. Pardis displayed toward a simple set of obligations that he accepted with the assistance of counsel.

[123] Dr. Pardis's submissions with respect to the gravity of his misconduct and incompetence follow a similar pattern. He argues that his admission to failing to maintain the standard of practice of the profession is based on the findings of Dr. Belluzzo and the majority of Dr. Belluzzo's comments on the 20 charts he reviewed related to medical record-keeping. Even if that were important, given the long history of concerns expressed and corrective measures taken with respect to documentation, the submission is simply not correct.

[124] Dr. Belluzzo did opine that Dr. Pardis failed to maintain the standard of practice in the 20 cases. Record-keeping in the form of templates was one problem. Incomplete assessments, failure to address an unexpected drug screen or to screen for amphetamine, and many other instances were cited.

[125] Dr. Belluzzo also concluded that Dr. Pardis displayed a lack of knowledge, skill and judgment in the same 20 cases. Dr. Pardis submits that "this is not a finding that [he] is unfit to continue to practi[s]e." In his written penalty submissions, he does not address the litany of examples that Dr. Belluzzo cites in support of his conclusion.

[126] Because of the lengthy history that we outlined above, the duration and repetition of the misconduct and incompetence in this case is particularly serious. These were not isolated incidents or occasional lapses in judgment. Again, while Dr. Pardis received formal discipline only once, the 2017 Tribunal cited the history back to

2010, and noted the efforts of both the College and Dr. Pardis to fix the longstanding problems. Even in 2017, the Tribunal had doubts about whether this was going to happen and whether Dr. Pardis could be rehabilitated.

[127] Faced with that warning, it is most striking that Dr. Pardis engaged in a litany of ongoing violations of his straightforward obligations under his undertaking. This aspect of the case raises serious issues of integrity. But many aspects of the record-keeping and patient care concerns that we found were evident in his practice before, during and after the investigations, preceptorship, supervision and the 2017 hearing. The administration and infection control issues were not close to acceptable and these and other aspects of Dr. Pardis's incompetence and misconduct placed patients at risk of harm.

[128] Dr. Pardis participated in a time-consuming and difficult back and forth with the College over most of the last decade. The fact that this process did not result in any improvement in Dr. Pardis's conduct is inexplicable to us and indeed distressing from a public protection standpoint. This feature of Dr. Pardis's conduct also forms part of the aggravating impact of the historical record that must be reflected in the severity of the penalty in order to maintain confidence in the reputation and regulation of the profession.

[129] The duration and repetition of misconduct and evidence of incompetence also casts doubt on the promises and assurances of future rehabilitation that are inherent in the penalty proposal he puts forward.

[130] Before leaving the history, we want to address two points that Dr. Pardis made through counsel several times during his penalty submissions.

Admission, remorse and acceptance of responsibility

[131] This is evidently a mitigating factor in Dr. Pardis's favour. He entered into two ASFs, as noted, encompassing a lengthy and extensive history that would have required a lengthy hearing and many witnesses for the College to put forward its case. Through his admissions, Dr. Pardis expressed remorse, and his cooperation and acceptance of responsibility saved time and expense for both the College and the Tribunal.

Rehabilitation and remediation

[132]Dr. Pardis argues that he has demonstrated “commitment and success in meeting standards. Dr. Pardis has made sustained improvements when practising under his clinical supervisor, Dr. David Marsh, up until May 2017.”

[133]Dr. Pardis submits that the panel should give significant weight to Dr. Marsh’s input and its apparent contrast with Dr. Belluzzo’s reports. The ICRC made an interim order on April 12, 2016 that required Dr. Pardis, pending resolution of the allegations that were pending against him, to practise under the guidance of a clinical supervisor acceptable to the College in respect of his family medicine practice.

[134]Three days later, however, Dr. Pardis advised the College that he did not expect to be able to find a clinical supervisor for his family practice, and therefore he would cease practising family medicine as of that date. He has in fact not practised family medicine since.

[135]Dr. Pardis also entered into an interim undertaking dated April 28, 2016 regarding his methadone practice, under which he agreed to practise under the guidance of a clinical supervisor acceptable to the College.

[136]Dr. Marsh was Dr. Pardis’s clinical supervisor from May 2016 to March 2017, pending the 2017 hearing. Dr. Marsh provided six clinical supervision reports during that period. Dr. Pardis then practised under Dr. Marsh’s clinical supervision for three months under the terms of the Tribunal’s 2017 order, and during that period Dr. Marsh provided three additional reports covering March through May 2017.

[137]As we noted earlier, this was the second time Dr. Pardis undertook to submit to clinical supervision. He had given a similar undertaking to the Methadone Committee in 2010, and in its 2017 decision, the Tribunal found that he had failed to maintain the standard of practice in his addiction treatment practice. In effect, the 2017 decision arose out of Dr. Pardis’s unsuccessful remediation and several ICRC dispositions in which he was reminded of the need to improve his clinical practice, practice management and record-keeping.

[138]Nevertheless, Dr. Pardis stresses that Dr. Marsh’s nine reports over 2016-2017 were positive. Each month Dr. Marsh met with Dr. Pardis, either in person or online,

and reviewed a number of Dr. Pardis's charts. Dr. Marsh expressed similar views in each of his reports. In the final one, for example, Dr. Marsh stated that Dr. Pardis showed "willingness and motivation to make changes in his clinical practice. He has made substantial improvements and I believe he is committed to continuing to improve." In Dr. Marsh's view, Dr. Pardis "is a knowledgeable physician in the area of opioid agonist treatment and I have not seen any evidence that his practice places his patients at risk of harm."

[139] While Dr. Marsh's reports suggest that Dr. Pardis improved, their importance as indicators of rehabilitation is diminished by two major factors.

[140] First, they capture the information available to Dr. Marsh during a specific time frame. We have evidence about Dr. Pardis's addiction practice both before and after that period. It shows that the wide-ranging problems preceded Dr. Marsh's review, they were longstanding, and they remained outstanding many months after Dr. Marsh completed his work.

[141] Second, the evidence that led to our findings, covering a period well beyond Dr. Marsh's observations, is much more direct and comprehensive. As we described above, it includes on-site inspections, video surveillance, videotapes taken by a patient, conversations and interviews with Dr. Pardis and many others, as well as chart reviews and a meticulous examination of Dr. Pardis's practice by Dr. Belluzzo.

[142] Even if we accept that Dr. Marsh's reports demonstrate some evidence of improvement, it was short-lived. Moreover, the reports are largely inconsistent with the evidence about the period immediately afterwards, and they do not purport to cover a host of serious issues – breach of undertaking, signage, conflicts of interest, the operation of the clinics, sanitation, boundaries, to name a few - that resulted in our findings.

[143] Dr. Pardis also stressed that the 2017 Tribunal order stated that Dr. Pardis's methadone practice would be reassessed about six months after the period of his clinical supervision with Dr. Marsh, and once again 12 months after the completion of the first reassessment, by an assessor selected by the College.

[144] The College did not conduct those reassessments, and Dr. Pardis argued that there is no specific evidence about why that occurred.

[145]Dr. Pardis argues that these reassessments would have occurred toward the end of 2017 and the end of 2018, respectively, and Dr. Pardis would have had "an opportunity to further demonstrate to the College what he had shown through his work with Dr. Marsh." He also submits that if deficiencies had been noted in the reassessments, he would have had an opportunity to remedy them. In short, the Tribunal should not fault Dr. Pardis for failures that could have been obviated if he had benefited from these additional rehabilitative processes.

[146]On the issue of why the reassessments did not occur, the evidence indicates the following. In December 2017, as a result of information gathered in one of the files relating to Dr. Pardis, the College's Quality Management Division notified the Office of Controlled Substances of Health Canada that it would no longer support Dr. Pardis receiving the exemption under the *Controlled Drugs and Substances Act* that allowed him to prescribe methadone.

[147]The withdrawal of Dr. Pardis's methadone exemption by Health Canada was effective January 10, 2018, but the federal regime changed about four months later, and the requirement of an exemption was removed. On July 5, 2018, the ICRC made an interim order that restricted Dr. Pardis's ability to prescribe methadone unless he obtained a practice monitor. He did not, so Dr. Pardis has been restricted from prescribing methadone pending this hearing.

[148]With this limitation in place, the College did not proceed with the reassessments. As we described earlier, Dr. Belluzzo was retained to provide a very detailed and comprehensive examination of Dr. Pardis's practice. His reports showed a wide range of deficiencies over a period that covered the time when the reassessments would have taken place, extending well into 2018.

[149]Dr. Pardis was aware of the investigative procedures, as well as Dr. Belluzzo's retainer, both of which extended over a lengthy period. Yet the reports expose egregious shortcomings that were longstanding and indicative of a complete absence of concern.

[150]The evidence gives us no confidence that further time and attention through reassessments would have made any appreciable difference in the information the College and Dr. Belluzzo gathered that led to this hearing. Dr. Pardis has had many opportunities and has failed to remediate the broad, serious and pervasive

concerns that resulted in findings of misconduct, conflict of interest and incompetence.

[151] In response to the longstanding concerns about Dr. Pardis's office administration, he provided what he described as his new secretary training protocol, some records of training and eight short memoranda to staff during 2019 and 2020.

[152] The first three memoranda are a few sentences each and are addressed to secretaries. They provide some direction about infection control. The last five relate to COVID protocols, including the cancellation of the Christmas party because of COVID, and do not address the issues in this case in any direct or substantive manner.

[153] Dr. Pardis voluntarily took a medical record-keeping course at the University of Toronto for six hours on November 11, 2020 and scored 15 out of 21. In our view, this is not a significant rehabilitative event, given the history of this case.

Tribunal and judicial decisions

[154] Both parties put a number of authorities before us to support their positions. We have reviewed all of them, bearing in mind that penalty determinations are very fact-specific, and they also depend on a variety of factors, which can point in different directions in any individual case. No two cases are identical, and while we are not bound by prior Tribunal decisions, consistency and predictability in our jurisprudence is an important factor to consider. Ultimately, there was little difference in the legal principles put forward by the two sides, which we summarized earlier.

[155] Dr. Pardis argued that a 12-month suspension, together with stringent conditions that he would have to satisfy before and after resuming practice, would satisfy the need for public protection, specific and general deterrence and proportionality, provide an opportunity for rehabilitation and maintain confidence in the integrity and reputation of the profession. He cited several decisions in which similar penalties were ordered, and he also pointed the panel to the recent court decisions in *College of Physicians and Surgeons of Ontario v. Peirovy,* 2018 ONCA 420 and *College of Physicians and Surgeons of Ontario v. Lee*, 2019 ONSC 4294 (Div. Ct.)

to support more general penalty principles, such as the importance of addressing and balancing the well-understood penalty principles and providing consistency.

[156] In *Peirovy*, the Court of Appeal restored the six-month suspension ordered by the Tribunal that had been overturned by the Divisional Court: *College of Physicians and Surgeons of Ontario v. Peirovy*, 2017 ONSC 136. The court described at paras. 67 and 69 a suspension of that length as "serious," and stressed the importance of a fair consideration of mitigating factors, which we have attempted to carry out in these reasons. Dr. Pardis also pointed to "the numerous mitigating factors" cited by the Court of Appeal in Dr. Peirovy's case: the progress that Dr. Peirovy had made in the rehabilitation process, including his embarrassment and shame for his actions (even though he did not admit liability) and the effectiveness of the practice monitor condition.

[157] The court, however, relied on the Tribunal's finding that Dr. Peirovy's behaviour could be corrected, and indeed that it was possible for the member to continue to practise safely. Given the particular combination of mitigating factors and the evidence of the experts, the court regarded the Tribunal's conclusion as within "the range of reasonable outcomes in the circumstances."

[158] It was the court's function in *Peirovy*, given the standard of review, to decide whether the Divisional Court had erred in deciding that the penalty imposed by the Tribunal was manifestly unfit. The Court of Appeal ruled that a six-month suspension was within a reasonable range of penalties on the facts of that case, having regard to the length of suspension and the particular terms that would address the specific nature of his risk to the public.

[159] Our role, on the other hand, is to determine the appropriate penalty in all of the circumstances of this case. For that reason, we described at considerable length the nature, length, breadth, depth and duration of the misconduct and incompetence, as well as the attempts at rehabilitation and the degree of success that Dr. Pardis had achieved. Those facts, alongside the mitigating factors that Dr. Pardis has put forward and the case law that we consider below, cause us to conclude that revocation is necessary.

[160] Dr. Pardis noted that in *Lee*, the Divisional Court faulted the Tribunal for having rejected further supervision by a practice monitor even though it had acknowledged

that it might protect the public. The court also held at para. 101 that the Tribunal "dismissed as not relevant the Appellant's prolonged compliance with restrictions, virtually without incident…" Dr. Pardis's case is the opposite in both respects. We do not accept that further conditions of the types he has put forward will protect the public, and that is precisely because of his prolonged and egregious non-compliance with restrictions that were either agreed to, or ordered, or both.

[161]We do agree, as the Tribunal and the Divisional Court did in *Lee*, that it is important "to maintain the reputation and integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest."

[162]The Divisional Court accepted the Tribunal's conclusion that "revocation would send a clear message to other victims of sexual abuse by physicians that reporting such behaviour is encouraged and will be taken seriously. But the [Tribunal] did not consider whether other penalties would accomplish the same objective." While the nature of Dr. Pardis's conduct is obviously quite different, we accept the broad proposition that the Tribunal should assess whether the penalty objectives can be met with a less onerous penalty than revocation: *Doyle v. Discipline Committee of the College of Physicians and Surgeons of Ontario*, 2019 ONSC 3905.

[163]We also accept the proposition put forward by the court in the next sentence of its reasons: that we should balance all of the factors, rather than focusing only on the nature of the conduct. We have done that in reaching our conclusion that revocation is necessary to address the public interest and the imperative of public protection, having regard to the nature of the conduct, as well as the aggravating and mitigating factors we discussed above, in order to achieve specific and general deterrence as well as maintain public confidence in the regulation and reputation of the profession.

[164]In *Doyle*, at para. 27, the Divisional Court made clear that "the penalty of revocation is not reserved for the "worst of the worst" cases or offenders. It is available when the facts justify the imposition of a revocation in order to protect the public where no lesser punishment will do so."

[165]Having considered the guidance that the courts have provided in these three recent cases, we will briefly review the Tribunal decisions that Dr. Pardis put forward in support of a reprimand, a 12-month suspension, restrictions, monitoring and

reassessments. In his submission, the proper range for professional misconduct that is standards related but also integrity related is a six to 12-month suspension with carefully tailored terms, conditions and limitations.

[166] Dr. Pardis submitted several cases that say that a lengthy suspension (ranging from six months to two years in those cases) is a serious penalty that sends a clear message to the member and to the profession, and it can maintain public confidence in the College's ability to govern the profession in the public interest and in the integrity and the reputation of the profession. In all of these cases, he argued, a reprimand followed, which on its own publicly expresses the Tribunal's abhorrence for the member's actions: *College of Physicians and Surgeons of Ontario v. Yaghini*, 2017 ONCPSD 29; *College of Physicians and Surgeons of Ontario v. Phipps*, 2019 ONCPSD 45; *College of Physicians and Surgeons of Ontario v. McArthur*, 2018 ONCPSD 58.

[167] The principle in those cases, standing on its own, is not contentious, but none of these decisions involved a similar set of facts to this case.

[168] In *College of Physicians and Surgeons of Ontario v. Alexander*, 2018 ONCPSD 60, the Tribunal ordered a six-month suspension, a reprimand, completion of an individualized education plan, clinical supervision by a College-approved supervisor for 12 months, a practice reassessment six months after the clinical supervision period and restrictions on patient numbers and frequency and ongoing monitoring, including unannounced inspections and the delivery of a monthly patient log to the College.

[169] Dr. Alexander's conduct was principally standards related. He had two prior disciplinary findings, although neither was recent and one was quite dated. He had been practising under clinical supervision as a result of an interim undertaking he gave to the ICRC.

[170] Among other differences, Dr. Alexander's penalty resulted from a joint submission. That lessens but does not eliminate its precedential value. The agreed disposition is obviously the product of negotiation and compromise, and the Tribunal is properly hesitant to overturn a joint submission unless it would bring the administration of justice into disrepute or would be unconscionable. Accordingly,

while the disposition may reflect a proper range, it does not have the same precedential weight as a contested decision.

[171] The panel in *Alexander* noted that the parties had submitted four prior penalty decisions. Three involved two to six-month suspensions, while the fourth resulted in revocation, and it was cited before our panel by the College: *Kamermans R.J. (Re)*, 2014 CanLII 99715. While the last case is distinguishable from Dr. Pardis's on the facts, the Tribunal's short summary in *Alexander* of what it took from that case was telling: the member "failed to maintain the standard of practice of the profession and also…was incompetent…An important distinguishing feature…was that [the member] lacked insight into his issues and displayed a rigidity of thinking that made him not amenable to remediation." While that revocation case arose from a contested liability hearing, Dr. Pardis's conduct, without any explanation on his part, is largely reflected in the quoted description from Dr. Alexander's case.

[172] *College of Physicians and Surgeons of Ontario v. Tamari*, 2018 ONCPSD 43 also involved a reprimand, a six-month suspension and terms, conditions and limitations on his certificate. The member's misconduct included breach of a prior Tribunal order, and disgraceful, dishonourable or unprofessional conduct. He had two prior findings of professional misconduct and a lengthy history of cautions from the Complaints Committee.

[173] The Tribunal relied on the following mitigating factors: agreement on facts, joint submission on penalty and several steps taken inside and outside his practice to minimize the risk of recurrence. Dr. Pardis asserted that each of these factors was present in his case.

[174] We do not agree. We have no joint submission on penalty and we have very little in the way of remediation on his part. We have discussed the contrast and the relative weight of Dr. Marsh's and Dr. Belluzzo's reports about Dr. Pardis's practice. While he has taken medical record-keeping courses in the past, they have not been effective in improving his practice. The only course that remains untested in this regard is the one-day session we mentioned earlier.

[175] Dr. Pardis cited the Tribunal's recent decision in *College of Physicians and Surgeons of Ontario v. Vaidyanathan*, 2021 ONCPSD 1, which also involved serious allegations, some of which were similar to Dr. Pardis's case: unprofessional

behaviour in the work environment and multiple failures to meet the standard of practice regarding medical record-keeping and patient assessments in the context of narcotics prescribing and exposure of patients to potential harm. Other allegations were quite different: improper billing of OHIP, self-treatment, unprofessional communications with other healthcare professionals and providing incomplete and inaccurate information to the College.

[176] The Tribunal ordered a 12-month suspension, a reprimand, the completion of an individualized instruction on medical ethics, prohibitions regarding narcotics prescriptions, posting of notices and cooperation with unannounced inspections. However, in addition to the differences in the facts and the allegations, the dispute between the parties on the appropriate suspension was between a six and 12-month suspension. Revocation was not under consideration, none of the authorities provided to the Tribunal supported that penalty and the panel did not address whether revocation would be appropriate in the circumstances.

[177] Two other Tribunal decisions put forward by Dr. Pardis are readily distinguishable. In *College of Physicians and Surgeons of Ontario v. Gill*, 2019 ONCPSD 49, at p. 11, the panel noted that the member's compliance with an addiction recovery program demonstrated his potential for rehabilitation. The gravity of the conduct in *College of Physicians and Surgeons of Ontario v. Gutman*, 2017 ONCPSD 47 was less than in this case.

Conclusion

[178] Dr. Pardis's misconduct and incompetence was extensive, multi-faceted and lengthy. His actions go well beyond isolated incidents; indeed, in many respects, they reflect patterns and repetitions of the same or similar problems.

[179] Dr. Pardis placed many patients at risk of potential harm. He failed to meet the standard of practice of the profession in numerous and longstanding respects. He violated his undertaking to the College, also in numerous respects and over a significant duration, despite the Tribunal having accepted a joint submission in 2017 that spared him a suspension and encouraged him to save his practice and his status by taking the need for rehabilitation and improvement seriously.

[180]Dr. Pardis was integrally involved, alongside his counsel, in virtually every aspect of the College's investigative, disciplinary and remediation actions. The College made him fully aware of the need to improve his practice management, office administration, clinical practice, infection prevention and record-keeping. The College applied many techniques - interim supervision, clinical supervision and others we have described - without success. If anything, the length, breadth and depth of Dr. Pardis's ethical breaches only became more obvious, far-reaching and surprising with the passage of time.

[181]It should not have taken secret videotapes, recordings and unannounced inspections to bring home to Dr. Pardis that deal-making with vulnerable patients, testing urine samples alongside coffee cups at the reception desk and the discovery of dog feces and other unsanitary conditions would be completely unacceptable to the public, to his fellow professionals and to current and potential patients.

[182]Only revocation - not a 12-month absence after the history of recurring misconduct and incompetence - is a proportional response in these circumstances. Only revocation can maintain public confidence in the profession, and assure the public that College processes can provide protection from similar misconduct by Dr. Pardis or others.

[183]Dr. Pardis has had more than enough time and opportunity to fix these egregious problems. In our view, he is past the point of rehabilitation. Specific deterrence can only be achieved by removing his privilege to practise, and is necessary as general deterrence to demonstrate to the profession that lines have to be drawn where integrity, competence, governability and professionalism have been lost.

[184]The aggravating factors, which we have described in these reasons, far outweigh the mitigating circumstances – Dr. Pardis's admissions to the findings we have made, the two ASFs and his cooperation in the Tribunal process. Moreover, his acceptance of responsibility provides the Tribunal with no confidence that the lengthy pattern of his misconduct, particularly over the last several years, will be reversed. From our assessment of the evidence on both finding and penalty, the public interest and patient safety would not be protected at all, and certainly not by the period of oversight that is contemplated by the draft order put forward by Dr.

Pardis. His continued practice is inconsistent in our view with the overriding consideration of maintenance of the integrity of the profession and public confidence in the profession's ability to regulate itself.

[185] In reaching our conclusions we have considered not only the results, but the nature of the deficiencies and other circumstances that the Tribunal has taken into account in other cases. In *College of Physicians and Surgeons of Ontario v. Shum*, 2013 ONCPSD 40, at p. 10, for example, the findings of professional misconduct and incompetence involved the absence of an infection prevention and control program, inadequate office procedures, the use of non-sterile gloves and the lack of hand hygiene. The Tribunal described this as an "egregious case of clinical failing in infection control, urological procedures and management and performance as a family physician." With respect to his family practice, he exposed his patients to risk by failing to provide proper and complete care, "repeatedly failing to maintain clinical standards and failing to exercise proper skill and judgment." His "failings were fundamental and profound."

[186] Like Dr. Shum, Dr. Pardis failed to meet the standard of practice and was incompetent in similar respects. Unlike Dr. Shum, Dr. Pardis engaged in other misconduct and his actions raised issues about his governability.

[187] Dr. Shum's circumstances included mitigating factors that are not present in Dr. Pardis's case: Dr. Shum had no discipline history, and he showed insight and remorse in accepting the proposed penalty. Nevertheless, the Tribunal accepted the parties' joint submission and revoked Dr. Shum's certificate of registration.

[188] *Kamermans* also involved many features that are common to this case: failure to maintain the standard of the profession and incompetence in his area of practice in both documentation and care of several patients, thereby creating a potential risk of harm. Like Dr. Pardis, Dr. Kamermans had a prior discipline finding, and was aware of concerns about his documentation for years, yet he was inattentive, which spoke "to his level of receptivity and motivation to improve." Unlike Dr. Pardis, his failure to improve related only to documentation, and was entirely clinical in nature. Dr. Kamermans, however, did not acknowledge liability, so he gained no credit for remorse and acceptance of responsibility, as Dr. Pardis does.

[189] Dr. Kamermans argued that a reprimand, together with terms, conditions and limitations on his practice, including working with a practice monitor for one year, taking a record keeping course and submitting to a reassessment, was a sufficient penalty. The Tribunal rejected that submission, and we adopt its conclusion on the facts of Dr. Pardis's case: "The profession must recognize that the chances for change are not infinite, and that a member who has repeatedly failed to maintain the standard of practice and is also found to be incompetent cannot continue with unsuccessful education and remediation forever."

[190] In *College of Physicians and Surgeons of Ontario v. Patel*, 2015 ONCPSD 22, the Tribunal found that the physician was incompetent, failed to maintain the standard of practice in his care of 27 patients and engaged in disgraceful, dishonourable and unprofessional misconduct. He had failed to properly manage his practice, supervise his staff or understand his professional responsibilities when he was not present to supervise. While under supervision and facing a disciplinary proceeding, he had failed to comply with his undertaking.

[191] Like Dr. Pardis, the physician proposed a suspension and a period of clinical supervision, followed by a reassessment. An expert in that case opined that Dr. Patel was remediable.

[192] The Tribunal held that the physician's actions provided no confidence in his ability and willingness to take the necessary steps to be rehabilitated. He had been disciplined twice before, although these findings were dated. Having regard to the "cumulative impact of the breadth and pervasiveness of Dr. Patel's clinical misconduct, and its extent, together with his failure to respond to the recommendations of his College-appointed supervisor, [that] provided evidence of ungovernability," the Tribunal ordered the revocation of his certificate of registration. Taking into account the similarities to Dr. Pardis's case, we reach the same conclusion.

[193] *College of Physicians and Surgeons of Ontario v. Prevost*, 2015 ONCPSD 14 is not directly on point, because the physician had already undertaken to resign his membership and not to reapply. The penalty for failure to maintain the standard of practice was therefore only a reprimand, but the panel stated that if he had not made the undertaking, his certificate would "undoubtedly" have been revoked.

[194] The Tribunal's concerns at p. 17 and 19, however, were similar in many respects to ours. There was a "glaring lack of clinical judgment across the entire spectrum of" his practice, "a blatant disregard for the welfare of his patients and for patient safety," a "cavalier attitude towards" patient care, "inadequate, often non-existent medical recordkeeping" and a "failure to communicate with colleagues with respect to transfer of care." The Tribunal pointed out the "sheer volume and repetitive nature of his failings," which were "nothing short of egregious."

[195] *Doyle*, a Divisional Court decision that we mentioned earlier in the context of general penalty principles, upheld a Tribunal decision to revoke the physician's registration and reject a suspension and remediation. While the facts were different, what was common was failings that were "fundamental, pervasive and profound" concerns, Dr. Doyle's discipline history, a persistent lack of insight and failure to apply knowledge, a lack of judgment and practice under supervision that proved to be ineffective.

[196] The Divisional Court rejected the submission that revocation was a disproportionate penalty in light of Dr. Doyle's assurances about his future conduct. The court accepted the Tribunal's reasoning that echoes the circumstances in Dr. Pardis's case: that "the same assurances given some time ago for the same or similar issues have not been borne out." In the meantime, "many more patients have been subjected to unprofessional and/or incompetent treatment:" *Doyle*, at para. 25.

[197] The College referred to other Tribunal cases in which serious and wide-ranging professional misconduct and/or incompetence, accompanied by repeated missed opportunities to remediate, led to revocation.

[198] In *College of Physicians and Surgeons of Ontario v. Wu,* 2020 ONCPSD 1, the Tribunal rejected the physician's proposal, which was similar to Dr. Pardis's in its structure: a 15-month suspension, together with a return to practice that would be conditional on a practice assessment, then supervision, followed by a second practice assessment.

[199] In *College of Physicians and Surgeons of Ontario v. Hanson*, 2020 ONCPSD 22, aff'd *Hanson v. College of Physicians and Surgeons of Ontario*, 2021 ONSC 513, the physician asked for a 12-month suspension, followed by clinical supervision and a practice assessment.

[200] In both, the Tribunal relied on the nature and scope of the misconduct, the extensive history with the College and the failed remediation efforts.

[201] From our analysis it is clear to us that a reprimand together with revocation of Dr. Pardis's certificate of registration is necessary in order to achieve the well-established penalty principles we articulated earlier.

[202] Even the extensive and scheduled process put forward by Dr. Pardis will not adequately protect the public and satisfy the requirement to maintain public confidence and the integrity and reputation of the profession. Dr. Pardis's proposal does not provide sufficient specific or general deterrence. The aggravating circumstances outlined above far outweigh the few mitigating factors – essentially his admission to misconduct and incompetence, and his incomplete and inadequate attempts at remediation – that operate in Dr. Pardis's favour.

[203] Given the totality of circumstances, beginning with the nature, extent, duration and repetitiveness of the professional misconduct and incompetence, together with the consequences of his conduct for patients, members and the public as a whole, further opportunities for remediation are out of the question. The risk of harm and the absence of integrity, governability and professionalism require the Tribunal to impose a penalty that is commensurate with the gravity of the misconduct.

ORDER

[204] For the reasons provided we find Dr. Pardis:

a. incompetent under subsection 52(1) of the Code in that his professional care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted; and

b. committed an act of professional misconduct under:

- paragraph 1(1)2 of O.Reg 856/93 in that he failed to maintain the standard of practice of the profession.

- paragraph 1(1)33 of O.Reg 856/92 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.

- paragraph 1(1)5 of O.Reg 856/93 in having a conflict of interest.

[205]We therefore order and direct:

a. Dr. Pardis to attend before the Tribunal to be reprimanded;

b. The Registrar to revoke Dr. Pardis's certificate of registration effective February 18, 2022 commencing at 12:01 am; and

c. Dr. Pardis to pay the College costs in the amount of $10,370.00 within 30 days of the date of these reasons.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Tribunal File No.: 20-006

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Bijan Pardis

The Tribunal delivered the following Reprimand
by videoconference on Tuesday, May 17, 2022.

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

Dr. Pardis, the panel is astounded at the depth and breadth of your misconduct. It demonstrates your profound and pervasive lack of regard for patient safety, your regulator and the profession.

Your misconduct reflects extremely poorly on you and on the profession. The public deserves a clean, safe environment when they attend a doctor's office. We found the state of your various premises to be truly appalling. There is no excuse for such conditions.

Patients place great trust in their physicians. Your addiction practice consisted of particularly vulnerable patients. You have betrayed their trust with your lackadaisical approach to your undertakings with the College, your various boundary violations and your blatant conflict of interest with the pharmacy. Furthermore your failure to maintain the standard of the practice of the profession with regard to record keeping, patient care and confidentiality as well as office administration and safety policies violated the public trust.

You have been given many opportunities over the last decade to meet the standard of the profession and clearly you did not take your responsibility to your patients, the public or your profession seriously.

We are not persuaded by your assurances that you will improve. Physicians must uphold the basic tenet of the profession to do no harm. To protect the public we have ordered the revocation of your licence to practise as you, Dr. Pardis, are ungovernable.

Your misconduct requires the most serious of sanctions. Such far reaching transgressions displayed a lack of integrity placing your needs ahead of your patients'. Should you wish to apply for reinstatement of your certificate of registration in the future, the onus will be put squarely on you to prove you are worthy of the great privilege to practise medicine in Ontario.