Indexed as: Hanson (Re)

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

IN THE MATTER OF a Hearing directed by the Executive Committee and the Complaints Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(2) and Section 36(1) of the **Health Professions Procedural Code**, being Schedule 2 of the ***Regulated Health Professions Act, 1991*** S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PAUL RUSSELL HANSON

PANEL MEMBERS: **DR. P. CHART (CHAIR)**
D. EATON-KENT
DR. M. DAVIE
M. THOMPSON
DR. E. STANTON

Hearing Date: **May 11, 2009**
Decision Release Date: **May 11, 2009**
Release of Written Reasons: **July 14, 2009**

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on May 11, 2009. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Hanson committed acts of professional misconduct:

(1) under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93") in that he has failed to maintain the standard of practice of the profession; and

(2) under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Hanson is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991* ("the Code"), in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue practise or that his practice should be restricted.

RESPONSE TO THE ALLEGATIONS

Dr. Hanson accepted the first and second allegations in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession and that he has engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the

circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the allegation of incompetence.

FACTS AND EVIDENCE

The following Agreed Statement of Facts was filed as an exhibit and presented to the Committee:

Background

1. Dr. Hanson obtained his medical degree at the Academy of Medicine in Cracow (Poland) in 1985. He received his Certification of Registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College") in 1992.

2. Dr. Hanson advises that he completed a four year urology residency program at Dalhousie University in 1993. He does not hold any specialty certifications and is a general practitioner in Windsor.

College investigation into Dr. Hanson's clinical practice

Two Public Complaints

3. On June 27, 2006, the College received a letter of complaint from A.B. with concerns about the treatment and care he had received from Dr. Hanson in 2003.

4. On October 20, 2006, the College received a letter of complaint from C.D. with concerns about the treatment and care her boyfriend, E.F., had received from Dr. Hanson in September 2006.

Registrar's Investigation

5. On May 8, 2007, the Executive Committee of the College approved an appointment of investigators under section 75(a) of the Health Professions Procedural Code after it considered information from the Complaints Committee regarding these two complaints.

6. The College retained the services of a urologist, Dr. G, to review 19 patient charts obtained from Dr. Hanson's office practice, as well as A.B.'s medical chart.

7. Dr. G opined on the 19 patient charts and prepared a report, dated November 15, 2007, and an addendum, dated December 17, 2007. A copy of the reports is attached at Tab 1 [to the Agreed Statement of Facts]. Dr. G opined that Dr. Hanson did not meet the standard of practice of the profession in the treatment provided to the patients in 7 charts. In 3 other charts Dr. G found that the treatment and care provided by Dr. Hanson met the standard of practice except with respect to operative reports. Dr. G raised no concerns about 9 charts.

8. In regard to A.B., Dr. G prepared a report dated February 4, 2008, and an addendum report dated February 11, 2008. A copy of the reports are attached at Tab 2 [to the Agreed Statement of Facts]. Dr. G opined that Dr. Hanson did not meet the standard of practice of the profession in his treatment and care of A.B.

9. In summary, the aspects of care which Dr. G identified as failing to maintain the standard include Dr. Hanson's:

(i) lack of operative records;

(ii) use of Versed and Fentanyl without intravenous access;

(iii) use of intramuscular preparations without intravenous access; and

(iv) decision to proceed with a hydrocelectomy procedure.

Dr. Hanson's response regarding his clinical practice

10. Dr. Hanson voluntarily relinquished his prescribing privileges with respect to narcotics and targeted substances (including benzodiazepines) effective March 19, 2004. Dr. Hanson agreed to terms and conditions on his certificate effective February 22, 2007, that he may not prescribe narcotics or targeted substances (including benzodiazepines). Dr. Hanson is permitted by Health Canada to prescribe controlled drugs, but has voluntarily agreed with the College that the only controlled drug he will prescribe is Androgenic Steroid Replacement.

11. Due to the voluntary agreements restricting Dr. Hanson's prescribing privileges in 2004, the concerns raised by Dr. G regarding his use of Fentanyl and Versed, which

related to care provided to 4 patients in 2002, are no longer relevant to Dr. Hanson's current and future practice.

12. Dr. Hanson retained a urologist, Dr. J, to opine on the same 19 charts reviewed by Dr. G. Dr. J prepared a report, dated September 24, 2008, regarding the patient charts, however, as he was a later treating physician in the 19th case, he did not provide an opinion on that chart. A copy of the report of Dr. J is attached at Tab 3 [to the Agreed Statement of Facts]. Dr. J opined that Dr. Hanson's "notes in some records were somewhat sparse and lacking in detail" but that Dr. Hanson "provided appropriate urologic care to his patients and… [that] his practice did not exceed the scope of a general physician with special urological training".

Admission

13. Dr. Hanson admits that he failed to maintain the standard of practice of the profession in his record-keeping including his operative reports.

The second Registrar's investigation into Dr. Hanson's practice

14. On November 7, 2007, the College received an anonymous letter which expressed concerns regarding a variety of procedures being performed by Dr. Hanson, including penile enhancement procedures, as well as his advertising.

15. On November 27, 2007, the Executive Committee of the College approved an appointment of investigators under section 75(a) of the Health Professions Procedural Code after it considered the information received in this letter.

<u>Penile Enhancement Procedures</u>

16. The College retained the services of a urologist, Dr. K, to provide an opinion on 3 patient charts with regard to penile enhancement using subcutaneous collagen injections.

17. Dr. K provided an opinion with respect to the 3 charts and prepared a report, dated June 17, 2008. A copy of this report is attached at Tab 4 [to the Agreed Statement of Facts]. Dr. K opined that Dr. Hanson failed to meet the standard of practice of the profession due to:

(i) inadequate documentation;

(ii) incomplete investigation;

(iii) failing to address underlying emotional and/or physical problems; and

(iv) performing unproven and ineffective procedures.

Admission

18. Dr. Hanson admits that his performance of 3 penile enhancement procedures were acts that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

Advertising

19. On July 4, 2008, the College sent a letter to Dr. Hanson requesting information regarding his advertising for the penile enlargement procedure, including how it adheres to the College's advertising policy.

Dr. Hanson's response regarding advertising

20. Dr. Hanson will be restricting his practice in accordance with his undertaking to the College, dated April 16, 2009 (the "Undertaking"). In the Undertaking, Dr. Hanson has agreed to review all advertising with respect to his practice or his clinic before it is released and will not authorize publication unless it conforms with published regulations and College policies in respect of advertising.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Hanson's admission and found that he committed acts of professional misconduct in that he has failed to maintain the standard of practice of the profession and has engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

PENALTY AND REASONS FOR PENALTY

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

Counsel for the College emphasized the general principles when imposing a penalty on a physician who has committed an act of professional misconduct. The penalty should protect the public and uphold public confidence, which has been shaken by the physician's conduct, as well as uphold the honour of the profession. The penalty should also serve as a deterrent against future unprofessional behaviour for the member and send a message to the membership at large that such behaviours are not tolerated. Lastly, an appropriate penalty aims to help rehabilitate the member.

Counsel for Dr. Hanson noted that although the Committee can accept or reject a joint submission, the law requires that departure from such a proposal should only occur where it is found to be contrary to the public interest or would bring the administration of justice into disrepute.

The joint proposal on penalty takes into account a comprehensive undertaking executed between Dr. Hanson and the College on April 16, 2009. This undertaking, with its restriction of office urology and office cosmetic procedures, as well as clinical supervision, and a re-inspection of his practice after 12 months, will provide immediate and ongoing public protection. In addition, the agreement of Dr. Hanson to submit to the intensive PREP assessment and remediation, at his own expense, and to abide by all its recommendations, will provide further public protection and physician remediation.

A penalty should be fair and just and in keeping with previous penalties imposed by the Committee. Counsel for the College presented four similar cases in its book of authorities to the Committee for consideration. All four cases included in the book of authorities were cases of record keeping deficiencies and illustrated that the proposed joint submission on penalty of a reprimand, payment of costs to the College and inclusion of the results of the hearing in the public register was in line with previous (recently decided) cases.

It is also important, however, to appreciate that each case before the Discipline Committee is unique and all the specific aggravating and mitigating factors must be carefully considered.

Aggravating factors in this case include Dr. Hanson's history before this Committee. In August 2001, Dr. Hanson was found to have committed an act of professional misconduct under paragraph 1(1)16 of O. Reg. 865/93, in that he falsified a record relating to his practice. Accurate and complete record keeping is essential to safe patient care. All experts in this case agreed that Dr. Hanson's patient records and operative notes were deficient. Thorough and complete patient charts serve to aid in a physician's own care of their patients and are vital should other health care providers become involved in patient care.

With respect to the penile enhancement procedure that Dr. Hanson advertised for and performed in his office, the expert opinion of Dr. K was that it was unlikely to cause any real harm to patients, except that they paid for a procedure which was not proven to be effective or have any lasting effect. The public places great trust in the medical profession and to exploit vulnerable patients by preying on their lack of knowledge and their hopeful expectations for personal improvement cannot be tolerated by the College. The Committee agrees with the justifiably extensive undertaking in which Dr. Hanson has agreed to cease to perform any surgical procedures on the male and female genitourinary tracts, and that should he breach any term of the undertaking, such behaviour may constitute an act of professional misconduct. In addition, the undertaking specifies that in future advertisements, Dr. Hanson will conform to the published regulations and College advertising policies.

Mitigating factors which the Committee considered included Dr. Hanson's cooperation with the hearing process and his admission to allegations 1 and 2 in the Notice of Hearing. His cooperation significantly reduced the time and costs of the hearing. The most significant mitigating factor is the executed comprehensive undertaking of terms, conditions and limitations on his certificate of registration.

ORDER

Therefore, the Committee ordered and directed that:

1. Dr. Hanson appear before it to be reprimanded, with the fact of the reprimand recorded on the register.

2. Dr. Hanson pay costs to the College in the amount of $3,650 within thirty (30) days from the date of this Order.

3. The results of this proceeding be included in the register.

Attached as Appendix “A” to the original Order was the Undertaking, Acknowledgment and Consent of Paul Russell Hanson to the College of Physicians and Surgeons of Ontario, dated April 16, 2009.

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