NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Paul Russell Hanson, this is notice that the Discipline Committee ordered a ban on publication of the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing. This order was made under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Hanson, 2020 ONCPSD 22

DISCIPLINE COMMITTEE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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

B E T W E E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PAUL RUSSELL HANSON

PANEL MEMBERS:

DR. DENNIS PITT (CHAIR)
MR. PETER PIELSTICKER
DR. PAUL GARFINKEL
MR. MEHDI KANJI
DR. JOHN RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS LISA BROWNSTONE
MS EMILY GRAHAM

COUNSEL FOR DR. HANSON:

MR. ANDREW MATHESON
MS KARA SMITH
MR. HAKIM KASSAM

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. JESSE HARPER

Hearing Date: February 12, 2020
Decision Date: May 8, 2020
Release of Reasons Date: May 8, 2020

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on February 12, 2020. On that date, the Committee found that Dr. Hanson committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession; in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and in that he has been found guilty of an offence that is relevant to his suitability to practise. The Committee proceeded to consider the matter of penalty and at the conclusion of the hearing, the Committee reserved its finding on penalty. These are the Committee's Decision and Reasons for Decision on Liability and Penalty.

THE ALLEGATIONS

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

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

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

3. under clause 51(1)(a) of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act*, *1991*, S.O. 1991, c.18, ("the

Code") in that he has been found guilty of an offence that is relevant to his suitability to practise.

It was also alleged that Dr. Hanson is incompetent as defined by subsection 52(1) of the Code.

THE FACTS

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

PART I – FACTS

A. Background

1. Dr. Hanson is 61 years old. He first received his certificate of registration authorizing independent practice from the College in 1992, and is a general practitioner with offices in Windsor and Chatham, Ontario.

B. File #7212620

2. In 2010, Dr. Hanson was charged with having committed fraud over $5,000, contrary to s. 380(1) of the *Criminal Code of Canada*. It was alleged that Dr. Hanson had defrauded OHIP and the Ministry of Health and Long-Term Care ("MOHLTC") by billing OHIP for insured services not provided. A copy of the Information is attached at Tab 1 to the Agreed Statement of Facts and Admission (Liability).

3. On August 26, 2010, Dr. Hanson was interviewed by police. A transcript of Dr. Hanson's police interview is attached at Tab 2 to the Agreed Statement of Facts and Admission (Liability).

4. On May 9, 2013, in the Ontario Court of Justice, the criminal charge of fraud over $5,000 was withdrawn, after Dr. Hanson pleaded guilty to an offence under s. 37.1(1) of the *Health Insurance Act* for failing to maintain records as may be necessary to establish whether he provided an insured service to a person between January 1, 2000 and February 4, 2009. Upon being convicted of the s. 37.1(1) offence, Dr. Hanson was ordered to pay $2,500 in restitution and a $7,500 fine. A transcript of the May 9, 2013 proceedings is attached at Tab 3 to the Agreed Statement of Facts and Admission (Liability).

5. At the guilty plea to the s. 37.1(1) offence on May 9, 2013, the following facts were agreed:

> a) The investigation began with the MOHLTC providing information to the OPP Anti-Rackets Health Fraud Investigation Team in September, 2007. The MOHLTC's focus was billing combinations submitted by Dr. Hanson between January 2000 and February 2008 with respect to four separate insured services for the same patient on the same service date: general assessments, sigmoidoscopies, pulmonary function tests, and EKGs.
>
> b) With respect to sigmoidoscopies, numerous patients interviewed by police stated they did not have the sigmoidoscopy procedure for which Dr. Hanson had billed. For the patients who were interviewed, the OPP determined that the total for services not rendered but billed by Dr. Hanson totaled $5,048. When Dr. Hanson was interviewed by police, he stated that when he performed sigmoidoscopies, it was rarely necessary for him to insufflate (activate the air

pump on the sigmoidoscope). This was an acknowledgment that he did not necessarily complete the full procedure that was required.

c) A preliminary hearing was conducted. Approximately 40 witnesses testified. Many witnesses testified that they did have a sigmoidoscopy, which was not in accordance with what they had told the OPP or what they had submitted to the OHIP through verification letters. Many of the patients who had originally indicated that they had not received sigmoidoscopies were misled by the erroneous indication on the questionnaires that a sigmoidoscopy is “a procedure whereby a laxative is required”. Others at the preliminary hearing testified that they did have rectal exams, but they could not testify with any certainty as to whether it was a digital exam, a sigmoidoscopy or simply any other type of rectal examination, and the evidence was tenuous as to whether the procedure was performed. Lastly, there were witnesses who testified unequivocally that no such rectal exam had been rendered by Dr. Hanson.

d) It was determined (by the Crown) after a thorough analysis of the witness testimony from the preliminary hearing that, on the basis of what could be proven to a criminal standard, Dr. Hanson owed approximately $2,500 to the Ministry in restitution for services billed but not rendered.

e) As it pertains to sigmoidoscopy procedures, Dr. Hanson did not maintain accurate patient records necessary to establish whether or not he in fact had performed the insured service to the person.

C. File #7214569

6. In light of the issues raised in the matter resolved in the Ontario Court of Justice on May 9, 2013, College investigators were appointed to investigate whether Dr. Hanson, in his general medicine practice, engaged in professional misconduct or is incompetent,

with a particular focus on general assessments, sigmoidoscopies, pulmonary function tests, and EKGs.

7. Two medical inspectors were retained to review 30 of Dr Hanson's patient charts (15 charts from the 2000 to February 2008 timeframe, and 15 charts after February 2008): Dr. Jerome Jadd, a family physician (Report at Tab 4 to the Agreed Statement of Facts and Admission (Liability)), and Dr. Jonathan Love, an internist (Report at Tab 5 to the Agreed Statement of Facts and Admission (Liability)).

8. Dr. Hanson failed to meet the standard of practice for the profession for record-keeping as set out in the report of Dr. Jadd, whose conclusions included the following:

> a) Dr. Hanson's general assessments often consisted of sparse functional inquiries; and often lacked many details such as a review of current problems, medications, therapeutic plans, and responses to treatment; in one patient, recent significant medical events were not reviewed. Dr. Hanson also performed general assessments too soon after a patient's last general assessment, without documented justification;
>
> b) Some Cumulative Patient Profiles were not up to date and lacked information;
>
> c) Some of Dr. Hanson's progress notes did not reflect patients' ongoing management, and it was often difficult to interpret or follow the patient's story without reference to consultants' notes and imaging results. As a result, it can be difficult to appreciate a patients' significant ongoing issues;
>
> d) Dr. Hanson documented using acronyms, the meaning of which were not always clear;

e) In documenting prescriptions, Dr. Hanson failed to record the dose, quantity and potential side effects of a narcotic and NSAID [non-steroidal anti-inflammatory drug]; failed to record the name of the medication prescribed; failed to document a discussion regarding overdose potential and other risks in prescribing Elavil, an antidepressant; Dr. Hanson prescribed Champix for smoking cessation to a patient diagnosed with depression, without recording the potential for exacerbation of depression with this medication;

f) Some of Dr. Hanson's notes had inconsistencies, including recording a family history of colon cancer as "no" when it was also documented that the patient's brother had colon cancer; Dr. Hanson recorded that a patient had been a six pack year smoker and quit three years earlier on the CPP, and recorded "Smoker N prev" in the note of a functional inquiry;

g) Dr. Hanson failed to record follow-up on test results received (such as a head CT) or on conditions arising at prior visits (such as leg swelling/cellulitis treated in the ER); and

h) Some of Dr. Hanson's psychosocial notes were too sparse.

9. Dr. Hanson failed to meet the standard of practice for the profession for patient care as set out in the report of Dr. Jadd, whose conclusions included the following:

a) Performing pulmonary function tests without indication in 6 patients, and incomplete charts displaying a lack of indication in 3 patients;

b) Performing EKGs without indication in 4 patients, and incomplete charts displaying a lack of indication in 2 patients;

c) Interpreting pulmonary function tests in 19 charts which lacked written pulmonary function interpretation and related documentation; and

d) Interpreting EKGs in 18 charts as these lacked written interpretation of the tests and related documentation of same.

10. Dr. Hanson displayed a lack of judgment as set out in the reports of Dr. Jadd and Dr. Love, whose conclusions in this regard included the following:

a) Performing general assessments, EKGs, spirometry without indication;

b) Performing diabetes checks on two patients when the blood work did not support a diagnosis of diabetes.

c) Failing to adequately document a patient's complaint of new onset chest pain with left arm numbness. His history-taking, examination, assessment and plan did not meet the standards expected. The potential seriousness of the complaint did not appear to have been appreciated by Dr. Hanson.

d) Inconsistency in the medical record of the patient's complaint of shortness of breath but active lifestyle including exercising by bike 7 times a week and normal respiratory systems on review.

e) Prescribing an NSAID to a patient despite cautionary comments made by a nephrologist and treated this same patient who has chronic severe kidney disease for a urinary tract infection twice without sending urine for culture and sensitivity.

11. Dr. Hanson failed to meet the standard of practice of the profession with respect to patient care as set out in the report of Dr. Love, whose conclusions in this regard included the following:

a) Dr. Hanson failed to meet the standard of care with respect to documenting sigmoidoscopies in 17 of 30 charts, and demonstrated a lack of skill in documentation in 2 charts;

b) Dr. Hanson lacked knowledge and judgement in 13 charts in the area of medical record keeping and standard terminology; failure to workup rectal bleeding in patients over 50; proper use of fecal occult blood testing; and management in cob-rectal polyps;

c) Performing sigmoidoscopies without indication in 7 patients, thereby subjecting these patients to unnecessary intrusive testing;

d) There was a risk of harm in 9 patients as it pertains to rigid sigmoidoscopies only regarding the potential risk of a missed lesion when not properly referred for colonoscopy, and a delay in treatment.

D. File #99430

12. In September 2015, Ms A complained to the College about an appointment her daughter, Patient B, had had at Dr. Hanson's Chatham office in August 2015 for the administration of a vaccine. In her complaint, Ms A stated the vaccine had been administered by a female staff member, and not Dr. Hanson.

13. In responding to this complaint, Dr. Hanson provided inconsistent, inaccurate and misleading information to the College regarding:

a) The identity of the person who administered the vaccine; and

b) The charting with respect to Patient B's appointment.

14. In his responses to the College, Dr. Hanson claimed that he had administered the vaccine to Patient B. In fact, the vaccine was administered by his receptionist, Emily Lindsay.

15. Dr. Hanson provided the College with a typewritten patient encounter note for Patient B's appointment. In his initial responses to the College, Dr. Hanson claimed that he had made this patient encounter note contemporaneously, but that he had done so outside of the Electronic Medical Record ("EMR"), and that he arranged for his receptionist to scan it into EMR (see responses of August 19, 2016, December 8, 2016 and November 22, 2017, attached at Tabs 6, 7 and 8 to the Agreed Statement of Facts and Admission (Liability)). Initially, Dr. Hanson advised the College that he was unable to recall the specific circumstances regarding why he had created the chart note outside of the EMR (see response dated September 18, 2017, attached at Tab 9 to the Agreed Statement of Facts and Admission (Liability)). Finally, in a subsequent response to the College (dated April 10, 2018, attached at Tab 10 to the Agreed Statement of Facts and Admission (Liability)), Dr. Hanson admitted that the note had not been made contemporaneously, and that he had created it after he received notice of Ms A's complaint when he realized that there was no patient encounter note for that visit. Further, he finally acknowledged that the note did not originate from the EMR, and had never been scanned into the EMR.

16. During the College investigation, the receptionist advised the College that Dr. Hanson approached her and asked her "take responsibility for the mistake with the chart note".

PART II – ADMISSION

17. Dr. Hanson admits the facts at paragraphs 1 to 16 above, and admits that, based on these facts, he engaged in professional misconduct:

a) under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/83"), in that he has failed to maintain the standard of practice of the profession;

b) under paragraph 1(1)33 of O. Reg. 856/83, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and

c) under clause 51(1)(a) of the Health Professions Procedural Code which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18, in that he has been found guilty of an offence that is relevant to his suitability to practise.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission (Liability). Having regard to these facts, the Committee accepted Dr. Hanson's admission and found that he committed an act of professional misconduct: in that he has failed to maintain the standard of practice of the profession; in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional; and in that he has been found guilty of an offence that is relevant to his suitability to practise.

Counsel for the College withdrew the allegation of incompetence upon the finding of professional misconduct.

EVIDENCE ON PENALTY

The parties submitted an Agreed Statement of Facts (Penalty), which was filed as an exhibit and presented to the Committee.

DR. HANSON'S PRIOR HISTORY AT THE COLLEGE

July 2001 -Complaints Committee- File #45151

1. On July 24, 2001, the Complaints Committee considered a complaint relating to Dr. Hanson's care and treatment of a patient on Coumadin, who suffered a debilitating stroke and died after Dr. Hanson discontinued that medication. A copy of the July 2001 Complaints Committee decision regarding File #45151 is attached at Tab 1 to the Agreed Statement of Facts (Penalty).

2. The Committee was of the view that Dr. Hanson had failed to provide appropriate care to the patient:

> the Committee is particularly concerned about Dr. Hanson's decisions to continue Coumadin when Mr. B. became his patient and then discontinue its use in April 2000 without relevant medical support for these decisions. The Committee is also of the view that Dr. Hanson failed to properly monitor Mr. B. while he was on Coumadin. The Committee finds further that Dr. Hanson failed to take appropriate steps in regard to Mr. B.'s elevated blood glucose levels. Finally, having reviewed Dr. Hanson's medical records in the course of the investigation in this matter, the Committee is concerned about the quality of his records.

3. The Complaints Committee referred Dr. Hanson to the Quality Assurance Committee regarding clinical issues and record-keeping.

July 2001 - Complaints Committee - File #45703

4. On July 24, 2001, the Complaints Committee considered a complaint related to Dr. Hanson's care and treatment of a patient with a knee injury. A copy of the July 2001 Complaints Committee decision regarding File #45703 is attached at Tab 2 to the Agreed Statement of Facts (Penalty).

5. The Committee concluded that Dr. Hanson failed to properly assess, investigate and treat the patient's complaints of left knee pain:

> In short, it is the Committee's view that Dr. Hanson improperly diagnosed Ms S's knee problem. Dr. Hanson found Ms S. to have chondromalacia patellae. The Committee has taken into account the assessments made by Dr. W. and Dr. M. who both diagnosed [the patient] as having a meniscal tear.

6. The Complaints Committee referred Dr. Hanson to the Quality Assurance Committee regarding clinical issues.

August 2001 - Discipline Committee Decision

7. On August 27, 2001, the Discipline Committee found that Dr. Hanson committed an act of professional misconduct in that he falsified a record relating to his practice. Dr. Hanson admitted that allegation. That Discipline Committee decision, a copy of which is attached at Tab 3 to the Agreed Statement of Facts (Penalty), is briefly summarized in the following paragraphs.

8. The College received a complaint from a patient's widow and daughter relating to Dr. Hanson's care and treatment of a deceased patient. An x-ray report from February 1998 regarding a density in the right lung reported that malignancy was possible, and suggested further assessment with CT scan. Dr. Hanson did not see the patient again until mid-December 1998, when the patient attended with complaints of chronic cough. An x-ray report from December 1998 reported that there were multiple soft tissue masses in both lung fields, consistent with metastasis. The patient was subsequently diagnosed with metastatic squamous cell carcinoma of the lung and died in June 1999.

9. In investigating this complaint, the College requested that Dr. Hanson provide his original medical record for the patient. The Discipline Committee found, based on Dr. Hanson's guilty plea and the uncontradicted forensic evidence before it, that Dr. Hanson falsified medical records of the patient about which the complaint was lodged. The forensic evidence established that entries in the chart were not contemporaneously made, in fact, two entries were made more than a year after the patient encounters, and it was probable that an entire page of notes was a re-write and was not prepared on the dates the document bore.

10. By way of penalty, the Discipline Committee:

(a) directed the Registrar to suspend Dr. Hanson's certificate of registration for a period of six months, three months of which were to be suspended if Dr. Hanson completed a course in ethics approved by the Registrar no later than March 1, 2002, all costs of the course to be borne by Dr. Hanson; and

(b) ordered that Dr. Hanson pay costs to the College in the amount of $2,500.00.

11. Dr. Hanson completed a course in medical ethics with Ms Abbyann Lynch in January 2002. Ms Lynch's report, dated January 28, 2002, is attached at Tab 4 to the Agreed Statement of Facts (Penalty).

March 2004 – Undertaking

12. In 2004, Dr. Hanson was diagnosed with substance dependence. As a result of this diagnosis, on March 19, 2004, Dr. Hanson entered into an undertaking with the College whereby he relinquished his prescribing privileges with respect to all controlled drugs and substances included in Schedules I, II, III, IV, and V of the *Controlled Drugs and Substances Act*, *1996*, c.l9. A copy of the March 2004 undertaking is attached at Tab 5 to the Agreed Statement of Facts (Penalty).

April 2009 – Undertaking

13. On April 16, 2009, Dr. Hanson entered into an undertaking with the College, as summarized below. A copy of the April 2009 undertaking is attached at Tab 6 to the Agreed Statement of Facts (Penalty).

14. The College received information regarding Dr. Hanson's standard of practice in the course of two investigations conducted under the former s. 75(a) of the Health Professions Procedural Code, which resulted in a May 2009 decision of the Discipline Committee as set out below, and, based on this information, it had concerns with respect to Dr. Hanson's care and treatment of patients, including penile enhancement procedures. As a result of the investigations and in partial resolution of the May 2009 Discipline Committee matter, Dr. Hanson undertook to:

(a) continue not to prescribe narcotics or targeted substances, including Fentanyl and Versed, as set out in the undertaking dated March 19, 2004;

(b) cease performing any surgical procedures, including all procedures performed on the male and female genitourinary tracts;

(c) restrict his cosmetic practice to minor procedures including Botox cosmetic injections, collagen cosmetic injections, and the removal of skin tags, warts and moles;

(d) undertake a Physician Review Program (“"PREP”) assessment, as set out in the undertaking;

(e) engage a supervisor acceptable to the College to review all aspects of his practice and to meet with him at least once every two weeks for the first three months, and once every four weeks thereafter if, in the opinion of the clinical supervisor, no concerns were raised in the first three months. The period of clinical supervision would cease upon the delivery of a report setting out any recommendations from the PREP assessment; and

(f) submit to a re-inspection of his practice by a clinical assessor selected by the College after approximately twelve months from the date of the Undertaking.

15. The report containing the results of Dr. Hanson’s PREP assessment, dated September 2, 2009, is attached at Tab 7 to the Agreed Statement of Facts (Penalty).

16. Dr. Antony Hammer was approved as Dr. Hanson’s clinical supervisor pursuant to the April 2009 undertaking. They met three times in July and August 2009. Dr. Hammer reported on those meetings on September 24, 2009, as attached at Tab 8 to the Agreed Statement of Facts (Penalty). In accordance with the Discipline Committee’s Order, the clinical supervision was terminated after the College received the PREP

assessment report indicating that during the assessment, Dr. Hanson demonstrated minor performance deficiencies.

17. Dr. Solomon Stern was retained to conduct there-inspection of Dr. Hanson's practice and opined, based on the charts he reviewed, that the care provided by Dr. Paul Hanson met the standard of care of a family physician practicing in a community like Windsor, Ontario. Dr. Stern's re-inspection report, dated July 23, 2010, is attached at Tab 9 to the Agreed Statement of Facts (Penalty).

Mav 2009 - Discipline Committee Decision

18. On May 11, 2009, the Discipline Committee found that Dr. Hanson had committed an act of professional misconduct in that he failed to maintain the standard of practice of the profession, and 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. Dr. Hanson admitted those allegations.

19. The May 2009 Discipline Committee decision, a copy of which is attached at Tab 10 to the Agreed Statement of Facts (Penalty), was based on two separate investigations under the formers. 75(a) of the Health Professions Procedural [Code] prompted by two public complaints, including regarding Dr. Hanson's diagnosis, treatment and management of a prostatic abscess. The second investigation was prompted by an anonymous letter which expressed concerns regarding Dr. Hanson's performance of penile enhancement procedures and his advertising.

20. In carrying out the first investigation, the College retained an expert to review 20 of Dr. Hanson's patient charts. This first expert opined that Dr. Hanson did not meet the standard of practice of the profession in the treatment provided to the patients in 8

charts. In 3 other charts, the treatment and care provided by Dr. Hanson did not meet the standard of practice with respect to operative reports.

21. In summary, the aspects of care that the first expert identified as failing to maintain the standard included Dr. Hanson's:

(a) lack of operative records;

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

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

(d) decision to proceed with a hydrocelectomy procedure.

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

23. In the course of conducting the second investigation, the College retained a second expert, to provide an opinion on 3 patient charts with regard to penile enhancement using subcutaneous collagen injections.

24. The second expert opined that Dr. Hanson failed to meet the standard of practice of the profession due to:

(a) inadequate documentation;

(b) incomplete investigation;

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

(d) performing unproven and ineffective procedures.

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

26. By way of penalty, and taking into account Dr. Hanson's April 2009 undertaking (described above), the Discipline Committee ordered and directed that Dr. Hanson:

(a) appear before it to be reprimanded; and

(b) pay costs to the College in the amount of $3,650.

June 2010 - Inquiries, Complaints and Reports Committee Decision- File 7211893

27. On June 28, 2010, the Inquiries, Complaints and Reports Committee ("ICRC") considered an investigation into Dr. Hanson's prescribing practices. A copy of the June 2010 ICRC decision is attached at Tab 11 to the Agreed Statement of Facts (Penalty).

28. A pharmacist contacted the College advising that on July 20, 2008, Dr. Hanson had phoned in a prescription for 120 tablets of Imovane 7.5mg, in the name of a family member. The pharmacist also advised that when Dr. Hanson attended in person to pick up the prescription, he initially informed the pharmacist that the patient was a different family member and that it was only later, when speaking with a colleague, that the pharmacists learned that the prescription had been for the first family member.

29. In his response to the College, Dr. Hanson stated that he had renewed a prescription that had originally been made by the family member's family physician, as that physician was unavailable to do so. When asked by the College to provide confirmation of the facts outlined in his response, Dr. Hanson advised that he would

seek the family member's consent to obtain the necessary information to provide said confirmation, but that he would not be able to do so in the absence of that family member's consent. The confirmation requested was not received by the College.

30. The ICRC was troubled by the lack of information confirming the specific circumstances that Dr. Hanson asserted led to his extraordinary step of prescribing medication to his family member, but also by the fact that Dr. Hanson prescribed what would appear to be an unreasonably large amount of medication to that person. In the ICRC's opinion, the circumstances involving Dr. Hanson did not adequately fit within the exceptions outlined in the College's policy regarding *Treating Self and Family Members*. There was no information before the ICRC to suggest that there was an emergency situation requiring Dr. Hanson to act as he did, or that there were no other physicians available to renew the family member's prescription.

31. The ICRC required Dr. Hanson to appear before a panel of the Committee to be cautioned regarding the inappropriateness of prescribing to family members, and the very limited situations in which it is deemed to be acceptable for a physician to treat himself/herself or his/her family members.

March 2012 - ICRC Decision- File #79887

32. On March 21, 2012, the ICRC considered a complaint related to Dr. Hanson's care and treatment of a patient who developed metastatic lung cancer and died in May 1999. The complaint was regarding care that Dr. Hanson had provided in 1998 and 1999, and was received in September 2010. A copy of the March 2012 ICRC decision is attached at Tab 12 to the Agreed Statement of Facts (Penalty).

33. On the basis of the available records, the Committee concluded that Dr. Hanson had ordered and had likely received but failed to follow-up on an abnormal chest x-ray

report that could not exclude malignancy and which suggested further assessment with CT, which Dr. Hanson did not arrange for.

34. The ICRC cautioned Dr. Hanson to ensure that he follows up appropriately on abnormal test results.

October 2012 - ICRC Decision - File #79666

35. On October 3, 2012, the ICRC considered a complaint related to Dr. Hanson's care and treatment of a patient who developed gangrene in her leg and required amputation. A copy of the October 2012 ICRC decision is attached at Tab 13 to the Agreed Statement of Facts (Penalty).

36. An expert retained to review Dr. Hanson's care opined that his patient care met the standard of practice of the profession. However, the expert expressed concerns regarding the quality of Dr. Hanson's records. The Committee also had concerns regarding the thoroughness of his medical records.

37. The ICRC counseled Dr. Hanson regarding the completeness of his records.

March 2015 - ICRC Decision - File #94691

38. On March 18, 2015, the ICRC considered a complaint related to Dr. Hanson's administrative practice of automatically faxing his prescriptions to a pharmacy adjacent to his clinic. Dr. Hanson's routine practice was to have prescriptions sent electronically to the adjacent pharmacy and printed there, instead of providing them directly to patients and offering them a choice as to where they wished to pick up their prescriptions. Some of the prescriptions were unsigned at the time of transmission. A copy of the March 2015 ICRC decision is attached at Tab 14 to the Agreed Statement of Facts (Penalty).

39. The ICRC concluded that Dr. Hanson's electronic prescribing interfered with patient choice, created the appearance of a conflict of interest, may interfere with patient care (particularly for patients who have another usual pharmacy and on multiple medications) and breached confidentiality by printing prescriptions at a pharmacy without patient consent. The Committee was also concerned that Dr. Hanson sent prescriptions to the pharmacy electronically without signing them properly, and it was unclear that the mechanism used to deliver the prescriptions to the pharmacy printer had the appropriate authorization.

40. The ICRC's disposition was two-fold. It required Dr. Hanson to:

(a) attend at the College to be cautioned in person regarding the inappropriateness of directing patients to the adjacent pharmacy by automatically sending prescriptions, which is a breach of patient confidentiality if they don't consent and may impact patients' continuity of care; and

(b) complete a Specified Continuing Education and Remediation Program ("SCERP"), consisting of:

(i) one-on-one coaching in ethics; and
(ii) self-directed learning, consisting of a review and written summary of the Canadian Medical Association (CMA) Code of Ethics, the College Practice Guide (particularly the section on conflict of interest), and the following two College policies: *Prescribing Drugs and Physicians' Relationships with Industry Practice, Education and Research*.

41. Dr. Hanson completed coaching in ethics with Ms Gail Siskind in November 2015. Ms Siskind's report, dated December 2015, is attached at Tab 15 to the Agreed

Statement of Facts (Penalty). During Dr. Hanson's coaching in ethics, Ms Siskind reviewed the self-directed learning essay Dr. Hanson prepared. It is attached at Tab 16 to the Agreed Statement of Facts (Penalty).

April 2015 - ICRC Decision - File #96376

42. On April 22, 2015, the ICRC considered a complaint from a patient who lived outside of Ontario, and who had seen Dr. Hanson on one occasion for a renewal of prescriptions for three medications prescribed by a different physician. The patient complained about Dr. Hanson's conduct during this encounter. A copy of the April 2015 ICRC decision is attached at Tab 17 to the Agreed Statement of Facts (Penalty).

43. In reviewing Dr. Hanson's record of this encounter, the Committee was concerned with the content of his clinical notes as they were very brief (his assessment consisted of a single word, "stable"), and overall, were lacking in the detail and substance expected of a physician as set out in the College's policy on *Medical Records*.

44. The ICRC required Dr. Hanson to complete a SCERP on record-keeping, including the creation of complete and accurate records, as well as quality assurance of record maintenance ("2015 SCERP"), consisting of:

(a) the Medical Record-Keeping course; and

(b) a reassessment, consisting of a review of a minimum of 15 charts approximately six-months following completion of the course.

45. On November 23, 2015, Dr. Hanson completed the Medical Record-Keeping course. The certificate of completion, and the report card, are attached at Tabs 18 and 19 to the Agreed Statement of Facts (Penalty).

46. The reassessment of Dr. Hanson's practice pursuant to the 2015 SCERP was completed in 2017. Dr. Ross Avery was retained to conduct the reassessment of Dr. Hanson's practice, who opined that Dr. Hanson failed to maintain the standard of practice of the profession for record keeping in 15 out of 15 charts reviewed. Dr. Avery's reports, dated January 17, 2017 and April 25, 2017, are attached at Tabs 20 and 21 to the Agreed Statement of Facts (Penalty).

July 2016 - ICRC Decision - File #100602

47. On July 20, 2016, the ICRC considered a patient complaint related to Dr. Hanson's care and conduct in the context of a February 2016 appointment for right knee pain after she had received recommendations for treatment from her physiotherapist. A copy of the July 2016 ICRC decision is attached at Tab 22 to the Agreed Statement of Facts (Penalty). A decision of the Health Professions Appeal and Review Board dated September 25, 2017 confirming the ICRC's Jul y 2016 decision is attached at Tab 23 to the Agreed Statement of Facts (Penalty).

48. The Committee was not satisfied with Dr. Hanson's approach to assessment and management of the patient's knee injury. It was not satisfied with Dr. Hanson's medical record keeping, and overall found the records to be sparse and incomplete. The chart did not support that Dr. Hanson took a full history of the knee injury or completed a proper examination. The EMR indicated that the patient encounter lasted at most three minutes. The Committee saw nothing to indicate that he did a full assessment. It was not satisfied that Dr. Hanson respectfully acknowledged the physiotherapist's opinion, or, if he disagreed with it, that he took any time to discuss with the patient the basis for any differences in their respective advice.

49. Overall, the ICRC had concerns about Dr. Hanson's:

(a) assessment and management of knee injuries;

(b) record-keeping (including comprehensive documentation of history and physical examination, documentation of investigations including retention of imaging requisitions and documentation of management plan);

(c) ability to have courteous and respectful interactions with patients;

(d) willingness to respectfully acknowledge another provider's opinion (in this case, a physiotherapist's opinion), and how to better manage such a scenario and a patient's receipt of potentially different messages.

50. The ICRC's disposition was two-fold. It required Dr. Hanson to:

(a) appear before a panel of the Committee to be cautioned respecting assessment and management of knee injuries, communications, record-keeping, and professionalism; and

(b) complete a SCERP, consisting of:

(i) the completion of two CMPA e-modules on documentation; and
(ii) self-directed learning, consisting of reviews and written summaries of relevant Clinical Practice Guideline(s)/literature regarding assessment and management of knee injuries; College Policy Statement #4-12 *Medical Records*, College Policy Statement #3-16 P*hysician Behaviour in the Professional Environment*, the College's Practice Guide and the Canadian Medical Association (CMA) Code of Ethics; and a report reflecting on why he has recurrent problems with professionalism, what he has learned from one-on-one coaching previously mandated by this Committee, and how he will make changes to his practice to avoid further complaints.

51. Dr. Hanson's certificates of completion for the CMPA e-modules, Documentation I: Charting Medical Records, and Documentation II: Principles of Medical Record Keeping are attached at Tab 24 to the Agreed Statement of Facts (Penalty).

52. Dr. Hanson's review and written summaries are attached, as follows:

(a) Assessment and Management of Knee Pain (Tab 25 to the Agreed Statement of Facts (Penalty));

(b) Medical Code of Ethics (Tab 26 to the Agreed Statement of Facts (Penalty));

(c) Recurrent Problems with Professionalism (Tab 27 to the Agreed Statement of Facts (Penalty)).

January 2018 - ICRC Decision - File #105210

53. On January 17, 2018, the ICRC considered a patient complaint about Dr. Hanson's management of a patient on Warfarin. A copy of the January 2018 ICRC decision is attached at Tab 28 to the Agreed Statement of Facts (Penalty).

54. The ICRC was concerned that Dr. Hanson failed to follow up on the results of an INR test when he did not receive them in the usual period of time, especially given that the patient was somewhat poorly compliant and was at high-risk of adverse events. The ICRC stated that it was incumbent on Dr. Hanson to follow upon her results in a timely fashion, which he had failed to do. The ICRC was also concerned with Dr. Hanson's poor overall monitoring of the patient's INR levels, and that the documentation did not contain any indication of what was done in response to the various results.

55. The ICRC required Dr. Hanson to attend at the College to be cautioned in person with respect to following the College's policy Test Results Management regarding critical results, and the policy Medical Records regarding adequate record-keeping and with respect to proper follow up of a patient on anticoagulation.

February 2018- Undertaking

56. On February 22, 2018, Dr. Hanson entered into an undertaking with the College as set out below, in light of the negative reassessment reports of Dr. Ross Avery conducted pursuant to the 2015 SCERP as described at paragraphs 44 and 46 above. A copy of the February 2018 undertaking is attached at Tab 29 to the Agreed Statement of Facts (Penalty).

57. As a result of the negative reassessment reports, Dr. Hanson undertook to:

(a) practice under the guidance of a clinical supervisor acceptable to the College for 12 months, meeting with the clinical supervisor once every week for the first month, and once every month thereafter to review at least 10 patient charts during the first month and 10-15 charts at every meeting thereafter; and

(b) undergo a reassessment of his practice approximately 6 months after completing the period of clinical supervision.

58. Pursuant to the February 2018 undertaking, Dr. Imran Ibrahim was approved as Dr. Hanson's clinical supervisor. Dr. Ibrahim's reports dated March 27, 2018, April 3, 2018, April 11, 2018, April 18, 2018, May 15, 2018, June 27, 2018, July 24, 2018, August 28, 2018, October 9, 2018, November 6, 2018, December 11, 2018, January 22, 2019, February 12, 2019, March 26, 2019 and April 16, 2019 are attached at Tab 30 to the Agreed Statement of Facts (Penalty).

59. In his final report dated April 16, 2019, Dr. Ibrahim made the following observations in general:

(a) The quality of documentation of patient encounters had improved significantly. While Dr. Hanson was lacking the standard pattern of SOAP note in the beginning, it was a usual practice for him in April 2019. The history and clinical examination were documented in more detail in April 2019 than before and the SOAP notes showed correlation between them to reflect a productive physician -patient encounter.

(b) The cumulative patient profile documentation was widely used for regular patients.

(c) Dr. Hanson made good use of documentation tools like chronic disease management flow sheets, annual physical review charts, and Rourke growth & development monitoring charts.

(d) Dr. Hanson volunteered for self-directed learning and chose topics for discussion on each meeting to improve his clinical understanding of different areas of his knowledge. He had subscribed to and had started using CME resources on regular basis in his every day practice like www.uptodate.com.

60. During the course of supervision, Dr. Hanson and Dr. Ibrahim formally discussed topics for improvement in knowledge and their practical application in the day-to-day family medical practice, including:

(a) post-CABG care in community;
(b) use of mental health questionnaires, for example, PHQ-9, HADS, HAMD-7;
(c) opioid man[a]ger and its use;

(d) acne rosacea;
(e) back pain:
(f) Twinrix vaccination;
(g) left lower quadrant pain in adults;
(h) CHADS2 score and its practical application;
(i) hip examination;
(j) lower respiratory tract infections;
(k) practical application of thyroid function test;
(l) clinical assessment and management of psychotic presentations;
(m) ankle examination and related differential diagnosis;
(n) CVD Risk calculation in EMR and practical implications;
(o) modern oral hypoglycemic agents;
(p) COPD management guidelines;
(q) knee examination and related differential diagnosis;
(r) diabetic neuropathy diagnosis and management;
(s) antibiotic guidelines for common uses in family medicine;
(t) systemic lupus erythematosus: diagnosis, investigations and management;
(u) rheumatoid arthritis and its diagnosis, investigations and management;
(v) gout and its diagnosis, investigations and management;
(w) investigations and management;
(x) common adverse drug reactions or related problems in elderly;
(y) anemias and their classification, diagnosis, investigations and management; and
(z) depression, anxiety and related syndromes and their presentations, diagnosis and management.

61. Dr. Hanson first adopted an Electronic Medical Recordkeeping EMR system. called HealthScreen, in approximately 2001. He transitioned from HealthScreen to OSCAR in 2013 and, as referenced in Dr. Ibrahim's March 29, 2019 report, from OSCAR

to Accuro in March 2019. In his April 16, 2019 report, Dr. Ibrahim stated that Dr. Hanson's transition to the new EMR had been relatively smooth, and that it demonstrated Dr. Hanson's willingness and efforts to improve and learn new systems. He also stated that Dr. Hanson had improved his team or staff at his clinics to improve efficiencies and provide best health care, and that Dr. Hanson worked hard to ensure training of new EMR for his staff in a timely fashion, which was reflected by appropriate chart entries and scheduling by his staff.

62. Dr. Mamdouh Andrawis has been retained to conduct the reassessment of Dr. Hanson's practice. That reassessment is currently underway.

July 2018 - ICRC Decision - File# 108048

63. On July 25, 2018, the ICRC considered a patient complaint related to Dr. Hanson's prescribing, his diagnosis of lung disease, and his performance of an excision biopsy. A copy of the Jul y 2018 ICRC decisions attached at Tab 31 to the Agreed Statement of Facts (Penalty).

64. The ICRC took No Further Action with respect to the complaints regarding Dr. Hanson's diagnosis and his performance of a biopsy. With respect to prescribing, the Committee was concerned that Dr. Hanson had inappropriately prescribed the complainant a Non-Steroidal Anti-Inflammatory Drug ("NSAID"), which are contraindicated in patients with chronic kidney disease and diabetes. The Committee determined that the appropriate disposition was to accept a Remedial Agreement from Dr. Hanson for self-study regarding the use of NSAIDs, with a focus on the risks in elderly patients with renal dysfunction.

65. Dr. Hanson's Remedial Agreement, dated August 16, 2018, is attached at Tab 32 to the Agreed Statement of Facts (Penalty). His self- study report, dated December 16, 2018, is attached at Tab 33 to the Agreed Statement of Facts (Penalty).

December 2018 - ICRC Decision - File 1102442

66. On December 5, 2018, the ICRC considered a complaint related to Dr. Hanson's care and treatment of a thumb injury. The patient alleged that Dr. Hanson acted in a rude and unprofessional manner and failed to assess her painful thumb unless she underwent a complete physical examination first. A copy of the December 2018 ICRC decision is attached at Tab 34 to the Agreed Statement of Facts (Penalty).

67. The Committee issued advice to Dr. Hanson to perform and document a proper examination of the presenting complaint, and to communicate adequately and professionally with patients, including providing an explanation about the need for preventative medicine, physical examinations.

HEALTH MONITORING

68. On July 2, 2019, Dr. Hanson entered into an undertaking with the College whereby he agreed to participate in a five-year treatment and monitoring program with regard to his opioid use disorder; sedative, hypnotic and anxiolytic use disorder; and bipolar disorder ("health monitoring undertaking"). Two of Dr. Hanson's treating physicians had contacted the College expressing concern for Dr. Hanson's capacity after Dr. Hanson was treated in the intensive care unit for hypercapnic respiratory failure and decreased level of consciousness due to a drug overdose. His urine toxicology screen was positive for morphine, Oxycodone and tricyclic antidepressants. A copy of Dr. Hanson's executed health monitoring undertaking is attached at Tab 35 to the Agreed Statement of Facts (Penalty).

69. Dr. Hanson has been compliant with the 2019 health monitoring undertaking.

CURRENT PRACTICE

70. As of October 2019, Dr. Hanson practices medicine at walk-in clinics in Chatham and Windsor, Ontario. He no longer maintains a family medicine practice although there is nothing prohibiting him from doing so. He also advises that he no longer performs sigmoidoscopies, pulmonary function tests, or EKGs, and is prepared to restrict his certificate of registration to this effect.

71. Dr. Hanson admits the facts at paragraphs 1 to 70 above.

In addition to the Agreed Statement of Facts (Penalty), Dr. Hanson, on consent of the College, tendered a brief of letters of support and a short written statement in which he expressed remorse. Dr. Hanson did not testify.

Andrawis Reassessment Report

By Notice of Motion dated April 1, 2020, counsel for Dr. Hanson brought a motion to re-open the penalty phase of the hearing in order that Dr. Hanson tender into evidence the Reassessment Report of Dr. Mamdouh Andrawis dated February 29, 2020 (the "Andrawis Reassessment Report"), and permitting the parties to make submissions regarding the Andrawis Reassessment Report. By order dated April 6, 2020, the Committee granted the relief sought.

On April 6, 2020, the parties provided the Discipline Committee with a Supplemental Agreed Statement of Facts on Penalty. It states in part:

3. At the time of the hearing on February 12, 2020, and as indicated at paragraph 62 of the Agreed Statement of Facts on Penalty (Exhibit 3), the reassessment of Dr. Hanson's practice by Dr. Mamdouh Andrawis pursuant to his 2018 undertaking was underway.

4. On February 29, 2020, Dr. Andrawis completed his reassessment of Dr. Hanson's practice. Dr. Andrawis's report, and cover email from the College's Case Compliance Manager are attached at Tab 1 [to the Agreed Statement of Facts on Penalty].

POSITIONS ON PENALTY

The parties did not agree on penalty. Counsel for the College submitted that the appropriate penalty would be revocation of Dr. Hanson's Certificate of Registration, and requiring Dr. Hanson to attend for a reprimand. The College also sought costs for a one - day hearing, in the amount of $10,370.00.

Counsel for Dr. Hanson agreed to the public reprimand, but submitted that the appropriate penalty would be suspension of Dr. Hanson's Certificate of Registration for 12 months, clinical supervision for a 12-month period thereafter, an assessment of Dr. Hanson's practice six months after the end of the period of clinical supervision, and a requirement that the Registrar impose a condition on Dr. Hanson's certificate of registration stating that he will not conduct sigmoidoscopies, EKGs and pulmonary function tests.

PENALTY AND REASONS FOR PENALTY

For the reasons set out below, the Discipline Committee orders immediate revocation of Dr. Hanson's certificate of registration, a public reprimand and payment of costs for the one day hearing in the amount of $10,370.

Penalty Principles

The principles which guide the imposition of an order under section 51(2) of the Code in College disciplinary proceedings are well established. The protection of the public is paramount. The order should serve as a specific deterrent to the member and as a general deterrent to the profession. The order and reasons should express the profession's denunciation of the member's misconduct. It should strive to maintain the public's confidence in the integrity of the profession and in the College's ability to govern the profession in the public interest. The order should serve to rehabilitate the member when appropriate. The order should be proportionate to the misconduct and reasonably consistent with previous disciplinary decisions in similar cases.

It is for the Committee to weigh these principles in light of the specific facts and circumstances of the case, including both aggravating and mitigating factors, in order to arrive at an order which is appropriate.

Aggravating Factors

There were a number of aggravating factors in this case.

(i) Scope and Nature of the Misconduct

The finding of professional misconduct in this case is based on a wide range of activity, which took place over 18 years. In addition to repeated failures with respect to record keeping, there were numerous and varied clinical concerns, including findings that Dr. Hanson subjected his patients to unnecessary procedures, putting them at risk of harm. The fact that his misconduct was not an isolated incident but rather repeated misconduct involving several patients and several clinical records and covering a range of activities over a lengthy period of time is an aggravating factor. The fact that he put patients at risk of harm is also an aggravating factor.

The Committee was also very concerned that OHIP could not evaluate what services had actually been conducted. Dr. Hanson showed disregard for the OHIP payment system by not adequately recording the procedures. The OHIP system relies on the honesty and integrity of physicians to bill accurately and in accordance with the criteria for payment set out in the *Health Insurance Act* and regulations, including the schedule of benefits. It is a privilege to have an honour system for the payment of one's professional services, and it must not be abused. The fact that Dr. Hanson's misconduct involved a failure to properly support his claim for OHIP funds is an aggravating factor, because he knew or should have known that the public trusts doctors to treat the limited funds available for health care responsibly. There have been many decisions from this Committee on the importance of maintaining the integrity of the OHIP billing regime.

(ii) Lack of Integrity / Dishonesty

With respect to the incident involving the vaccine administered by his receptionist, Dr. Hanson displayed a lack of integrity and he fabricated a clinical record. The patient's mother stated that a female staff member had administered a vaccine to her daughter, rather than Dr. Hanson. Dr. Hanson responded to the complaint in an evasive and inconsistent manner, which was misleading to the College. The issue was not the delegation of the act, but who administered the vaccine and when the clinical note was created. At first, in his response to the College dated August 19, 2016, Dr. Hanson flatly denied that the female member of staff administered the vaccine. Rather, he told the College that he gave the injection. He persisted in this denial over several years. Further, he initially suggested that he wrote an encounter note contemporaneously with the encounter but that he had failed to scan it into the electronic medical record ("EMR") system at the time and was planning to have his staff do so later. This was also untrue. Further, after learning of the College investigation, he advised his receptionist that she would have to take responsibility for the mistake in charting. It was only in April 2018 that he acknowledged that the note was made at a later time. It was highly improper of

Dr. Hanson to ask his receptionist to accept responsibility for his misconduct. This whole incident speaks to a lack of the integrity required of a medical professional. Dr. Hanson's deceit and the fact he asked his receptionist to accept the blame are both aggravating factors.

(iii) Prior History of Complaints and Discipline

Dr. Hanson's previous history with the College is also a significant aggravating factor. Dr. Hanson has a long history of involvement with the College's Inquiries, Complaints and Reports Committee (ICRC), its predecessor committee, and the Discipline Committee. This is the third Discipline Committee hearing regarding Dr. Hanson and he has been the subject of 11 prior decisions of the ICRC or the Complaints Committee. While the Committee appreciates that decisions of the ICRC or the Complaints Committee are not findings of misconduct, the fact that Dr. Hanson has been the subject of so many prior complaints and dispositions by the ICRC / Complaints Committee is concerning. Dr. Hanson's lengthy history with the College is an aggravating factor.

Mitigating Factors

By making an admission of professional misconduct, Dr. Hanson saved the College the expense of a contested hearing and saved several witness from having to testify. The Committee recognized this as a mitigating factor.

While the Committee considered that often an admission may, in some circumstances, indicate acceptance of responsibility for one's actions, the Committee did not give much weight to this factor in this case, as Dr. Hanson has admitted his wrongdoing on previous occasions, only to have the behaviour recur. The Committee did not place any weight on Dr. Hanson's expression of remorse in his brief written statement. This will be discussed further below in the context of insight and the prospects for rehabilitation.

Counsel for Dr. Hanson submitted that the passage of time could be considered a mitigating factor. That is, some of the findings relate to conduct that occurred several years ago. The importance of fashioning an order which responds to the penalty principles is not diminished by the passage of time. This has been recognized by courts in the criminal context where it has been held that the passage of time does not diminish the need for a denunciatory sentence given the seriousness of the crime (*R. v. J. S. S.*, 1995 CanLII 1076 (ON CA)). While discipline proceedings are not criminal proceedings, the purpose of an order under section 51(2) of the Code includes specific and general deterrence and denunciation of the misconduct. These principles remain important despite the passage of time. The Discipline Committee considered the impact of the passage of time in *Ontario (College of Physicians and Surgeons of Ontario) v. Taylor*, 2017 ONCPSD 17 (CanLII) ("*Taylor*"), which was upheld on appeal. In *Taylor*, the Discipline Committee considered *R v. S* (H), 2014 ONCA 323, in which the Court of Appeal considered a similar argument with respect to the passage of time. The Ontario Court of Appeal quoted with approval the decision of the Alberta Court of Appeal in *R. v. S.S.*, 1992 ABCA 352, which stated: "The only sentencing principles which may be affected by the lapse of time are those of individual deterrence and rehabilitation." The decision went on to note, "that if despite having led an exemplary life, the offender lacks remorse, any potential discount must be less than it otherwise would have been."

A demonstration of remorse can be a mitigating factor, even though a failure to show remorse cannot be considered an aggravating factor. In this case, Dr. Hanson has submitted a statement in which he expresses remorse. The Committee's difficulty, however, is that Dr. Hanson has already had several opportunities at rehabilitation without success and has expressed remorse in the past, yet continued to engage in professional misconduct, including acts of deceit. As will be discussed in greater detail below, the Committee was not persuaded that this is a case in which specific deterrence and rehabilitation should be the governing principles on penalty in light of the particular facts of this case and Dr. Hanson's lengthy history. Consequently, the

Committee did not find the passage of time to be a mitigating factor in this case, because it was not persuaded that Dr. Hanson truly has insight into his misconduct. The Committee also notes that many of the facts supporting the finding of professional misconduct were not historical in nature. In particular, the deceit, misrepresentations and falsification of a clinical record with respect to Patient B occurred within the last five years.

The absence of harm is not a mitigating factor (*Ontario (College of Physicians and Surgeons of Ontario) v. Savic*, 2019 ONCPSD 40 (CanLII),) ("*Savic*").

Prior Opportunities for Remediation

Overall, the Committee was seriously concerned with the frequency of complaints in respect of Dr. Hanson, which led to 11 prior ICRC / Complaints Committee decisions, resulting in four cautions, one advice, and numerous orders aimed at Dr. Hanson's remediation. In addition, this is Dr. Hanson's third appearance before the Discipline Committee. The Committee recognizes that it is not to fashion a penalty that punishes Dr. Hanson for his past misconduct. To the contrary, punishment is never the purpose of an order under section 51(2) of the Code. In determining an appropriate order, however, the Committee must take into account Dr. Hanson's history, including the prior opportunities for remediation, and the extent to which misconduct reoccurs.

Dr. Hanson's misconduct in the current case occurred during the following time periods:

1. The OHIP billing issues upon which the criminal conviction was based occurred between January 1, 2000 and February 4, 2009;

2. The clinical and record-keeping issues identified by Dr. Jadd and Dr. Love stemmed from a review of 15 charts from the 2000 to February 2008 timeframe, and 15 charts after February 2008; and

3. The incident involving the vaccine administered by Dr. Hanson's receptionist occurred on August 27, 2015 and Dr. Hanson then made several misrepresentations to the College regarding this incident until April 10, 2018 when he finally admitted that the clinical note had not been made contemporaneously, and that he had created it after he received notice of Ms A's complaint.

As such, the misconduct in this case spans an 18-year time frame. With respect to Dr. Hanson's prior history with the College, the first complaint considered by the Complaints Committee involved conduct in or around April 2000, and led to a referral to the Quality Assurance Committee regarding clinical issues and record-keeping. The complaint to the College in September of 2010 (decision by ICRC March 21, 2012), however, with respect to the patient who developed metastatic lung cancer and died involved care provided by Dr. Hanson in 1998 and 1999. The last complaint in evidence was considered by the ICRC in December of 2018 and resulted in the ICRC providing advice to Dr. Hanson to perform and document a proper examination of the presenting complaint and to communicate adequately and professionally with patients. The conduct at issue in this case overlaps with Dr. Hanson's numerous prior dealings with the College.

The Committee carefully examined the nature of the misconduct at issue in these proceedings, the degree to which the deficiencies underlying the present misconduct have been the subject matter of prior complaints or discipline, the past opportunities afforded to Dr. Hanson for rehabilitation and the extent to which Dr. Hanson has benefitted from these opportunities .

Clinical Deficiencies

Dr Hanson has admitted that he failed to meet the standard of practice for the profession for patient care as set out in the reports of Dr. Jadd and Dr. Love.

The Agreed Statement of Facts indicates that, following Dr. Hanson's conviction under s.37 (1) of the *Health Insurance Act* in 2013, the College appointed two medical inspectors to review 30 of Dr. Hanson's patient files: Dr. Jerome Jadd, a family physician, and Dr. Jonathan Love, an internist. The medical inspectors expressed significant concerns regarding Dr. Hanson's ability to meet the standard of practice with regard to both record keeping and patient assessment and treatment. These deficits were with regard to both Dr. Hanson's skills and his judgement.

For example, Dr. Jadd found that many tests were performed without indications (six pulmonary function tests and four EKGs). There were also difficulties in interpreting tests (19 charts with pulmonary function tests and 18 charts with EKGs lacked interpretation and related documentation). Dr. Jadd found that Dr. Hanson displayed a lack of judgement, including due to his performing general assessments, EKGs and spirometry without indications and performing diabetic checks when the blood work did not support a diagnosis of diabetes. Since he did not record age, weight and height of the patients, he would not have been able to interpret pulmonary function. Other examples included: failing to follow up and document a new patient's complaint of new onset chest pain with left sided numbness, and prescribing a NSAID to a patient in spite of cautions from a nephrologist regarding the patient's severe, chronic renal disease. He ordered Lasix for a patient's edema in spite of the fact that his examination revealed no edema.

Dr. Love also concluded Dr. Hanson lacked knowledge and judgement. There were many problems identified with record keeping and misuse of acronyms, but there were also many clinical failings identified, such as not working up rectal bleeding or not properly using fecal occult blood testing. Dr. Love noted that numerous patients received sigmoidoscopies without indication. He also noted these tests often exposed the patient to a risk of harm, especially given the use of rigid sigmoidoscopies and the potential of a missed lesion when a patient was not properly referred for follow-up treatment.

Deficits and concerns with respect to Dr. Hanson's clinical care have been brought to the College's attention on a number of occasions since July 2001. These are summarized in the Agreed Statement of Facts on Penalty, and include the following:

- In July 2001, the Complaints Committee considered a complaint regarding Dr. Hanson's treatment of a patient on an anti-coagulant who suffered a stroke and died after Dr. Hanson stopped this medicine. The Committee was of the view that Dr. Hanson failed to provide appropriate care for, and to properly monitor, this patient;

- On the same day, the Complaints Committee concluded that a second patient of Dr. Hanson's who presented with a knee injury, had not been properly assessed, investigated and treated;. Dr. Hansom was referred to the Quality Assurance Committee regarding clinical issues;

- One month later, in August 2001, the Discipline Committee found that Dr. Hanson had committed an act of professional misconduct in that he had falsified a record. This related to a complaint involving a deceased patient and a density in the right lung on x-ray. Radiology had recommended a follow-up CT scan to rule out malignancy, which was never done. Ten months later, when the patient attended with chronic cough, an x-ray showed multiple soft tissue masses. The patient died the following June of metastatic lung cancer;

- In May 2009, the Discipline Committee issued a decision based on two separate investigations based under the former section 75 of the Code. Those investigations considered allegations involving Dr. Hanson's diagnosis, treatment and management of prostatic abscesses and concerns regarding Dr. Hanson's performance of penile enhancement procedures. In partial resolution of the allegations stemming from those investigations, Dr. Hanson had entered

into an undertaking in April 2009 in which he agreed in part to (i) cease performing any surgical procedures; (ii) undertake a Physician Review Program ("PREP"); (iii) engage a supervisor acceptable to the College to review all aspects of his practice; and (iv) submit to a re-inspection of his practice by a clinical assessor. The physician retained to conduct the reassessment concluded that Dr. Hanson's practice met the standard of care.

- On March 21, 2012, the ICRC considered a complaint related to Dr. Hanson's care and treatment of a patient who developed metastatic lung cancer and died. The complaint was with regard to care that had been provided in 1998 and 1999. The ICRC concluded that Dr. Hanson had ordered and had likely received but failed to follow-up on an abnormal chest x-ray report;

- In July 2016, in response to another patient complaint, the ICRC was not satisfied with Dr. Hanson's approach to assessment and management of a patient's knee injury. There was no evidence of a full history or a completed proper examination regarding the knee injury. The ICRC concluded that the clinical encounter appeared to have lasted, at most, three minutes. The ICRC also found that an earlier recommendation from a physiotherapist was not acknowledged in a respectful manner.

- On January 17, 2018, the ICRC considered a patient complaint about Dr. Hanson's management of a patient on Warfarin. The ICRC was concerned that Dr. Hanson did not follow-up appropriately and was concerned about his poor overall monitoring of the patient. The ICRC issued a caution requiring Dr. Hanson to review medical policies regarding patients on anticoagulants.

- On February 22, 2018, as a result of negative reassessment reports, Dr. Hanson agreed to practice under the guidance of a clinical supervisor; and

- In July 2018, the ICRC expressed concern about Dr. Hanson's prescribing and accepted a remedial agreement from Dr. Hanson for self-study regarding the use of NSAIDs, with a focus on the risks in elderly patients with renal dysfunction. The ICRC was concerned that Dr. Hanson inappropriately prescribed a NSAID, which had been contraindicated given the patient's chronic kidney disease and diabetes.

- Later that year, in December 2018, the ICRC considered a patient complaint regarding treatment of a thumb injury and Dr. Hanson's unprofessional manner in dealing with this person. The patient complained that Dr. Hanson refused to assess her thumb unless she underwent a complete physical examination. The ICRC issued advice to Dr. Hanson to perform and document a proper examination of the presenting complaint and to communicate adequately and professionally with patients, including providing an explanation about the need for preventative medicine and physical examinations. It is noteworthy that Dr. Hanson was under supervision with Dr. Ibrahim at the time of the conduct leading to this complaint.

This history shows that Dr. Hanson's clinical deficiencies, in addition to the deficiencies detailed above with respect to record keeping, have been varied and persistent. Although there have been instances in which Dr. Hanson has shown periods of improvement, these have been followed by further complaints and concerns.

Deficiencies re Honesty and Integrity

The Committee had serious concerns with respect to the fact that this is the second time that Dr. Hanson has been found to have falsified a medical record.

In August 2001 (see *Ontario (College of Physicians and Surgeons of Ontario) v. Hanson*, 2001 ONCPSD 29 (CanLII)), Dr. Hanson was found to have committed an act of

professional misconduct in that he had falsified a medical record. Dr. Hanson admitted this allegation at the time. After Dr. Hanson had provided his original medical record for this patient, forensic evidence established that some entries in the chart were made more than a year after the patient encounters. In addition, it was probable that an entire page of notes was rewritten. Dr. Hanson received a six-month suspension, three months of which were to be suspended if he were to take a course in medical ethics.

The Committee was struck by the similarities between the 2001 investigation and findings and the current case. Both involved falsifying documents, attempts at deceiving the College, and persistent misrepresentation to the College over several years. Such falsification cannot be tolerated. Further, physicians must be truthful in response to College investigations. It is challenging for the College to discharge its obligations if its members are not honest.

What is also striking is that Dr. Hanson had completed a significant amount of education in ethics prior to engaging in the deceitful conduct regarding the vaccine administered by his receptionist. Pursuant to the August 2001 Discipline Committee decision, Dr. Hanson completed ethics training with Ms. Abbyann Lynch. She reported some improvement in his understanding and she hoped, in his behavior. In June 2010, the ICRC considered a complaint that in July 2008, Dr. Hanson prescribed Imduane in a large quantity for a family member. The pharmacist that filled the prescription advised that Dr. Hanson said it was for a different person. He also refused to permit confirmation that the family member required the medication, stating that he required that person's consent. In addition to the dishonesty, this incident involved a breach of College policy regarding prescribing to family members – he prescribed a large quantity, in a non-emergency situation, in setting where another physician could be available.

As a result of an ICRC decision in March 2015, related to a complaint about his faxing pharmacy prescriptions to one particular pharmacy without giving patients the option to

choose, Dr. Hanson was required, among other things, to (i) take ethics training and (ii) complete a self-directed learning essay describing the situation leading to the need for learning, what he had learned and how his prescribing practice had changed. He saw Ms. Gail Siskind for a second round of individualized ethics instruction. Ms. Siskind reported that she found him to be "attentive and professional, demonstrating introspection." However, on the very same day that Dr. Hanson completed his training with Ms. Siskind (November 28, 2015), Dr. Hanson submitted a falsified document to the College in response to the current complaint (i.e., the patient encounter note that he indicated he had created contemporaneously upon administration of the vaccine). The Committee finds that Dr. Hanson was not committed to the behavioral change to which he professed and was able to mislead others.

Another ICRC decision was issued in July 2016, after Dr. Hanson examined a patient's knee following an injury. The ICRC found that not only did his care show clinical and recording deficiencies, but also he disputed an earlier opinion by a physiotherapist, but did not sufficiently explain his difference of opinion to the patient. The Committee was concerned about his lack of courtesy and respect with this patient. On this occasion, the ICRC required him to complete a specified continuing education or remediation program (SCERP) which included self- directed learning regarding professionalism and ethics, in addition to review of the Clinical Practice Guidelines on examination of the knee. The ICRC required Dr. Hanson to write another ethics essay, which he completed in 2018. In this new essay, he made no reference to the new complaint and copied, almost word for word, the essay he had written in response to the March 2015 complaint involving faxing patient prescriptions to one particular pharmacy without giving patients the option to choose. He did not seem to take the exercise seriously.

With regard to these ethical breaches, there was a stark contrast between what patients said occurred in clinical encounters and Dr. Hanson's own statements. He seemed to be protecting himself and blaming either the patients or the EMR.

In the case involving Patient B, who received a vaccine from Dr. Hanson's receptionist, Dr. Hanson has admitted that he provided inconsistent, inaccurate and misleading information to the College regarding: a) The identity of the person who administered the vaccine; and b) The charting with respect to Patient B's appointment. The misrepresentations that arose from the incident occurred between 2015 and 2018, despite all of the training Dr Hanson had previously received on ethics.

Insight and Remorse

Whether a physician has true insight and remorse is a significant consideration in crafting an appropriate order under section 51(2) of the Code. If a physician is truly invested in his or her own rehabilitation, then the Committee will take this into account in weighing the penalty principles. The Committee questioned whether Dr. Hanson has insight into his deficiencies, given his repeated appearances before the College, the mandated courses and policy reviews, as well as the clinical supervision he has experienced. Once called to account by the College, Dr. Hanson often acknowledged his deficiencies (although not always immediately). Insight, however, also requires an understanding of the factors that led to the misconduct in the first place. On a number of occasions, Dr. Hanson blamed the patients, the family members, or the EMR, rather than acknowledging his role in the difficulties. Without insight and an appreciation of the factors that led to the misconduct, there is a concern that the misconduct will be repeated.

The Committee finds that Dr. Hanson lacks true insight. The Discipline Committee finds the comments in *Ontario (College of Physicians and Surgeons of Ontario) v. Wu*, 2020 ONCPSD 1 (CanLII), equally applicable in this case: "true insight and the ability to benefit from remedial interventions require more than repeated apologies and the apparent expectation of indefinite opportunities for corrective action."

Dr. Hanson has had ample opportunities for remediation, without lasting benefit. The Committee finds that Dr. Hanson's failure to remediate is similar to that observed in *Savic*, in which the Discipline Committee stated, "While Dr. Savic has responded to the direction of the College in the sense that he completed the educational courses required of him, attended cautions, and worked under supervision, the Committee finds that they have had little or no impact and that he had made few of the fundamental changes necessary".

As set out above, Dr. Hanson has been given numerous opportunities to remediate his practices. The Committee notes that Dr. Hanson improved at times, but these improvements were not sustained. For example, Dr. Ibrahim provided approximately one year of supervision in 2018 and 2019, and noted clinically significant deficiencies at the beginning of his supervision, but then improvement in Dr. Hanson's practices. The Committee was struck, however, by the significant deficiencies in Dr. Hanson's practice that existed at the beginning of Dr. Ibrahim's 2018 supervision (in areas such as history taking, physical examination, laboratory tests and record keeping) in light of the extensive involvement of the College in addressing Dr. Hanson's deficiencies prior to that time. It is also important to realize that Dr. Ibrahim's evaluations were based on reviews of charts which Dr. Hanson had not always been accurate in completing, and that such supervision does not speak to Dr. Hanson's integrity and honesty.

The Andrawis Reassessment Report

As detailed above, the penalty phase of the hearing was re-opened so that the Committee could consider the Andrawis Reassessment Report. In the Andrawis Reassessment Report, Dr. Andrawis concludes that Dr. Hanson is a skilled physician, that his charting consistently meets the standard of care, and that Dr. Hanson does not expose his patients to danger and does not lack judgement or knowledge. Counsel for Dr. Hanson and counsel for the College made written submissions as to the impact of the Andrawis Reassessment Report regarding the appropriate penalty.

Counsel for Dr. Hanson submits that the Andrawis Reassessment Report is the most up to date, best evidence with respect to Dr. Hanson's motivation and ability to comply with College requirements. Counsel further submits that the Andrawis Reassessment Report shows that Dr. Hanson has been willing, able and successful in the completion of all College requirements and shows that the improvements Dr. Hanson demonstrated under clinical supervision with Dr. Ibrahim have had a lasting effect. Counsel for Dr. Hanson submits that this shows that Dr. Hanson is not ungovernable or unsuitable for rehabilitation.

Counsel for the College submits that the Andrawis Reassessment Report is of no assistance to Dr. Hanson, given his serious, persistent and repeated professional misconduct. Counsel submits that the Andrawis Reassessment Report does not establish that Dr. Hanson is remediable or governable, as: (i) it does not address Dr. Hanson's irremediable ethical misconduct; (ii) it demonstrates that at least one of Dr. Hanson's deficient record-keeping practices (use of non-standard abbreviations) persists, and (iii) when considered in the context of Dr. Hanson's prior history with the College, it is consistent with Dr. Hanson's pattern of making apparent improvements to his clinical deficiencies, but ultimately failing to sustain those improvements.

Counsel for the College submitted that notwithstanding the Andrawis Reassessment Report, revocation is required to achieve public protection, specific and general deterrence, and to maintain public confidence in the College's ability to regulate the profession.

The Committee considered the Andrawis Reassessment Report and the evidence of recent improvements by Dr. Hanson. While Dr. Hanson has shown recent practice improvements in some areas of concern (i.e. certain charting deficiencies), the Committee notes that Dr. Hanson has had repeated opportunities to remediate, which often result in only short-term improvements. His history with the College shows that

improvements are rarely sustained. Further, the Andrawis Reassessment Report does not address the repeated ethical breaches (detailed above). The Committee is also concerned that the Andrawis Reassessment Report suggests that Dr. Hanson continues to lack insight, as he continues to deflect blame for his use of non-standard abbreviations to his EMR system.

Prior Cases

The Committee is not bound by its prior decisions , but prior cases may serve as a guide to the appropriate penalty in the current case. The Committee considered the following cases:.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Hill*, 2017 ONCPSD 21 (CanLII)), the member was a solo practitioner in a family practice. He was found to have deficits in his clinical care of many patients, as well as poor record keeping. He was found to have falsified charts, including duplicating notes from one chart to another. He was self-represented during the liability phase of the hearing, but did not attend the penalty hearing and no one attended on his behalf. The Committee revoked his certificate of registration, largely due to the dishonesty and the lack of insight displayed by the member. Unlike the current case, Dr. Hill had no prior history with the College and did not admit the allegations.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Wu*, 2020 ONCPSD 1 (CanLII), a family physician was found to have failed to maintain the standard of practice in multiple cases. Moreover, he engaged in behaviour that actively misled the College in their investigations. The Committee found that these omissions and misrepresentations extended beyond simple poor judgment and reflected a propensity to mislead the College, which caused the Committee significant concern with respect to Dr. Wu's governability. The Committee has similar concerns with respect to Dr. Hanson. Like Dr. Hanson, Dr. Wu also had an extensive earlier history with the College. Like Dr.

Hanson, Dr. Wu expressed shame and remorse, but he had expressed these on previous occasions and continued with his extensive misconduct. The Discipline Committee ordered that Dr. Wu's certificate of registration be revoked.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Schwarz*, 2019 ONCPSD 54 (CanLII), the member's certificate of registration was revoked. This case is distinguishable in that it involved a complaint of sexual abuse by a vulnerable patient. Dr. Schwarz developed a false medical history and record for this patient that made her seem unstable. His behaviour was deemed to be planned and predatory. The Committee did not find this case of assistance in reaching its decision as the facts are too dissimilar.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Patel*, 2015 ONCPSD 22 (CanLII)) the member (a general practitioner) admitted that he engaged in professional misconduct by having failed to maintain the standard of practice of the profession in his care of 25 patients, and that he had engaged in disgraceful, dishonourable or unprofessional conduct, specifically; inadequate supervision of staff; improper delegation of controlled acts; improperly prescribing and/or directing staff to prescribe to patients; inappropriately having staff care for and treat patients in his absence; inappropriate billing to OHIP; and breaching his undertaking with the College. Dr. Patel also admitted that he was incompetent in that his professional care of 25 patients displayed a lack of knowledge, skill or judgment that was of such a nature or to such an extent that his practice should be restricted or that he is unfit to continue to practise. Further, Dr. Patel did not contest further allegations of professional misconduct as a failure to maintain the standard of practice of the profession, and as disgraceful, dishonourable and unprofessional misconduct on his part. The Committee found that Dr. Patel's delegation practices, and his billing offences, represented a serious breach of public trust and revoked his certificate of registration.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Savic*, 2019 ONCPSD 40 (CanLII)), the member was found to have contravened a term, condition or limitation on his certificate of registration. He prescribed or authorized prescriptions for four drugs after entering into an undertaking that prohibited him from doing so. Like Dr. Hanson, he prescribed tests (EKGs, stress tests) without indication and did not meet the standard expected in overall management and record keeping. He had had an extensive history with the College and did not improve after repeated efforts at rehabilitation. He was found to be ungovernable and the Committee revoked his certificate of registration.

The Committee considered several other cases which resulted in lesser penalties. In *Ontario (College of Physicians and Surgeons of Ontario) v. Kakar*, 2019 ONCPSD 20 (CanLII), a psychiatrist who went beyond the scope of his practice when he treated a patient with gout with allopurinol, was found to have falsified the medical record and extensively copied a report of a psychologist without attribution. His records also displayed numerous deficiencies. He received a 6-month suspension. However, the proposed penalty was made by a joint submission, and this was the member's first appearance before the Discipline Committee, so the facts differ significantly from Dr. Hanson's situation.

In *Ontario (College of Physicians and Surgeons of Ontario) v. Alexander*, 2018 ONCPSD 60 (CanLII), the member was found to have misled the College by backdating agreements for opioid therapy for several patients. This was his third appearance before the Discipline Committee and he had been the subject of other complaints and a caution by the ICRC. The Committee found that Dr. Alexander had failed to remediate, despite having previously been made aware of his deficiencies during his various attendances with the College. Dr. Alexander admitted the allegations; counsel for the College and counsel for Dr. Alexander made a joint submission as to an appropriate penalty and costs order. The Committee found that Dr. Alexander cooperated with the College, acknowledged the serious deficiencies in his clinical practice and took voluntarily steps to remediate, which included completing three courses that focused on

deficiencies identified in his practice. The Committee accepted the joint submission and ordered a reprimand, a 6-month suspension and terms, conditions and limitations on his certificate of registration

In *Ontario (College of Physicians and Surgeons of Ontario) v. Rivlin*, A. S. S., 2013 ONCPSD 2 (CanLII), Dr. Rivlin admitted the allegations of professional misconduct on the basis that he had been found guilty of an offence relevant to his suitability to practise; and that he had engaged in disgraceful, dishonourable or unprofessional conduct. Dr. Rivlin had pleaded guilty in the Ontario Court of Justice to one count of fraud over $5,000 and one count of possession of a prohibited weapon with ammunition. Dr. Rivlin had admitted to fraudulently billing OHIP in the amount of $168,794.21. At the time of his guilty plea and sentencing, Dr. Rivlin had made restitution to OHIP in the amount of $200,000. The Committee accepted the joint submission by the parties on penalty and ordered a 12-month suspension of Dr. Rivlin's certificate of registration, a reprimand and costs. The Discipline Committee in that case agreed with the trial judge that the circumstances surrounding the weapons offence were "very unusual" and stated that they gave little weight to that particular incident in assessing Dr. Rivlin's suitability to practise medicine, or the proposed penalty Dr. Rivlin had no prior criminal or discipline history. The Committee did not find this case to be of assistance as the facts are too dissimilar.

In support of its arguments regarding the relevance of the Andrawis Reassessment Report, counsel for Dr. Hanson relies on two additional cases. In *Hicks v. Law Society of Upper Canada*, 2006 ONLSAP 1, the Law Society's Appeal Panel reversed a Hearing Panel's finding of governability based on recent evidence of improvement in the member's behaviour. It is submitted that Dr. Hanson's recent improvements should lead to the same finding. Counsel for the College submits that Dr. Hanson's case is not analogous, as Mr. Hicks' misconduct did not involve dishonesty, which alleviated any concern that future misconduct would go undetected, and that Mr. Hicks offered a credible explanation for much of his misconduct (and that explanation is not present in

this case). The Committee accepts the College's submission and agrees that the Hicks case is distinguishable because there were no issues with respect to deceit and dishonesty in that case.

Counsel for Dr. Hanson also relies on the recent case of *College of Physicians and Surgeons of Ontario v. Fenton,* 2020 ONCPSD 11 ("*Fenton*"). In *Fenton*, the Committee rejected the College's request for a finding of ungovernability and revocation, finding that there was not sufficient evidence of recurrent contempt for the College to support that conclusion. The Committee distinguished *Fenton* from previous cases of the Committee on the basis that in those previous cases, the members had not demonstrated any improvement or change in their behaviour over years. Counsel for Dr. Hanson submits that Dr. Hanson has shown sustained improvements in practice and ongoing compliance with College requirements over recent years, and as such a finding of ungovernability and revocation is not appropriate. Counsel for the College submits that in *Fenton*, the member's prior history was much less significant than Dr. Hanson's and there was no repetition of prior misconduct that resulted in the second Committee hearing. On that basis, counsel for the College submits that *Fenton* is distinguishable. The facts in the *Fenton* case are very different. The scope, duration and nature of the misconduct in Dr. Fenton's case was quite different from that in Dr. Hanson's case.

Conclusion

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The parties are in agreement that a reprimand is an appropriate term of any order. The Discipline Committee agrees.

While revocation is a very serious penalty, it is open to the Committee to consider it in each case. It is not for only the most serious misconduct, as reaffirmed by the Divisional Court in *College of Physicians and Surgeons of Ontario v McIntyre*, 2017 ONSC 116 (CanLII), which states:

> The principle of "the least restrictive sanction", referred to by the Supreme Court of Canada in *Solomon* (which is a criminal case) is a well-known criminal law principle of sentencing imposed by statute…which requires the judge to take into account that "an offender should not be deprived of liberty, if less restrictive sanctions may be appropriate in the circumstances." There is no equivalent statutory provision governing the imposition of penalties by a discipline committee, which is not surprising given that the central function of the discipline committee is not to "punish" offenders, but rather to govern its members for protection of the public.

Given the serious, repetitive nature of Dr. Hanson's misconduct and the fact that he has not benefitted from repeated efforts at rehabilitation, the Committee concludes that revocation of his certificate of registration is the only appropriate order. Only revocation will protect the public, maintain public confidence in the College's ability to govern the profession in the public interest and provide for general deterrence. Revocation also expresses the abhorrence of the profession for Dr. Hanson's behavior. Given Dr. Hanson's significant prior history with the College and the absence of any sustained improvement, the Committee concludes that the focus of the penalty order should not be on rehabilitation.

The parties are also in agreement that it is appropriate that Dr. Hanson pay the College costs in the amount of $10,370, being the Tariff rate for a one day hearing. The Committee agrees that Dr. Hanson should be ordered to pay costs in that amount. The parties differed as to time that should be allowed to pay cost. The College sought payment within 30 days of the Order and Dr. Hanson requested 90 days to pay costs. The Committee is prepared to give Dr. Hanson 90 days to pay the cost order.

ORDER

Therefore, the Committee orders and directs:

1. Dr. Hanson shall appear before the Committee to be reprimanded;

2. The Registrar to revoke Dr. Hanson's certificate of registration, effective immediately; and

3. Dr. Hanson is to pay to the College costs in the amount of $10,370 within 90 days of the date of this Order.

TEXT of PUBLIC REPRIMAND
Delivered April 23, 2021
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. PAUL RUSSELL HANSON

This is not an official transcript

Dr. Hanson:

We have carefully considered your multiple episodes of professional misconduct.

Your first involvement with the College was a complaint considered in 2000, over 20 years ago. Your College history includes failure to maintain the standard of practice for patient care, failure to maintain appropriate patient records, billing OHIP for insured services that were not adequately supported by the documentation and dishonesty by providing inconsistent, inaccurate and misleading information to the College.

You have admitted your deficiencies and undertaken rehabilitation on many occasions. The rehabilitation attempts have included advice and cautions along with SCERPs including ethics coaching and self-directed learning imposed by the College's ICRC, plus a reprimand and suspension of your certificate of registration arising from previous appearances before this Committee. Over the years, you entered into undertakings to relinquish prescribing privileges with respect to all controlled drugs, to cease to perform any surgical procedures, to restrict cosmetic practice to minor procedures, to undergo PREP assessment, supervisions, re-inspections, and health monitoring for opioid use disorder. Rehabilitation has not been successful and you have repeatedly relapsed.

In our view, there are no further methods of resolving your deficiencies. Your practice as a physician, including work in a walk-in clinic, has significant patient care responsibilities and professional lapses can put patients at risk.

Your license to practice medicine had to be revoked because the public must be protected.

This reprimand is concluded.