Indexed as: Hanson (Re)

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

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

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. PAUL RUSSELL HANSON

PANEL MEMBERS: DR. B. ADAMS (CHAIR)
DR. N. DE
DR. P. KLOTZ
P. BEECHAM
R. SANDERS

Hearing date: August 27, 2001

Decision date: August 27, 2001

DECISION AND REASONS FOR DECISIONS

This matter came to the hearing before the Discipline Committee of the College of Physicians and Surgeons of Ontario, at Toronto, on August 27, 2001.

ALLEGATIONS

It was alleged the Notice of Hearing that Dr. Paul Russell Hanson, a member of the College has committed an act of professional misconduct:

1. under paragraph 1(1)16 of Ontario Regulation 865/93 made under the *Medicine Act*, 1991 ("O. Reg. 856/93"), in that he falsified a record relating to his practice;
2. under paragraph 1(1)33 of O. Reg. 856/93 in the he committed an act or omission relevant to the practice as disgraceful, dishonourable or unprofessional; and
3. under paragraph 1(1)2 of O. Reg. 856/93, in that he failed to maintain the standard of practice of the profession.

The College Prosecutor withdrew the allegations of 2 and 3.

The particulars are that Mr. Brian Lindbloom, a Forensic Document Examiner, in a report dated April 25, 2000, sets out evidence of Dr. Hanson's falsification of the medical recorded of the patient about which the complaint was lodged.

Dr. Hanson entered a plea of guilty to that allegation.

Prosecutor for the College read into the record a Statement of Agreed Facts, and also introduced as an exhibit a Joint Document Book.

STATEMENT OF AGREED FACTS

1. Dr. Hanson was born July 1, 1958. He is presently 43 years of age and resides in Winsdor, Ontario.

2. Dr. Hanson received his medical degree from Jagiellonian University in Krakow, Poland in 1985. He subsequently completed an internship and residency training in urology at Dalhousie University in Halifax, Nova Scotia.

3. Dr. Hanson qualified for his LMCC in 1989 and became licensed to practice medicine in the Province of Ontario on August 4, 1992. He began practicing as a family physician in Windsor, Ontario in September 1992.

4. The allegation is related to a complaint concerning Dr. Hanson's care and treatment of a deceased patient. The medical records of the patient are attached at Tab A of the Joint Document Book.

5. On about February 18, 1998, the patient attended Dr. Hanson complaining of a cough, fever, nosebleeds. Dr. Hanson referred the patient for a chest x-ray made a referral to an otolaryngologist.

6. The x-ray report dated February 19, 1998, reported as follows:

   There are no previous films for comparison.

   The heart is normal in size. The pulmonary vasculature appears normal.

   There is a 2 cm slightly irregular density in the right base posteriorly suspicious for intraparenchymal lung nodule. Malignancy is possible. It would be of value to compare with any previous films if any could be made available. Otherwise further assessment with CT scan is suggested.

   The rest of the lungs appear clear.

7. Dr. Hanson did not see the patient again until December 15, 1998.

8. The patient was back in Dr. Hanson's office on October 14, 1998 and received a flu shot and tetanus-diptheria vaccine apparently without a doctor's visit. Dr. Hanson did not see the patient that day.

9. On December 15, 1998 (approximately 10 months later), the patient attended Dr. Hanson with complaints of chronic cough. Dr. Hanson referred the patient for a chest x-ray. The x-ray report dated December 15, 1998, reported the following:

There is mild cardiomegaly.

There are multiple soft tissue masses present in both lung fields the largest measuring 5.5 cm in diameter in the right lower lobe. The appearances are consistent with metastasis. There is a trace of fluid noted in the right costophrenic angle.

10. Dr. Hanson's chart records that a verbal CXR report was received stating: ". . . *Met Hosp: multiple metastatic lesions. Situation discussed with Dr. X. Plan: Abd. US, bone scan. Dr. X will see ASAP."*

A visit by the patient and his spouse followed on December 18, 1998 in which the above was discussed.

11. After this visit there are no more entries in Dr. Hanson's chart. Visits to Dr. X, Dr. Y and Dr. Z followed for the treatment of metastatic squamous cell carcinoma of the lung. The patient passed away on June 26, 1999.

12. The widow of the patient, complained to the College by letter dated August 25, 1999 (Tab B of the Joint Document Book). The patient's daughter, also complained to the College by letter dated September 21, 1999 (Tab C of Joint Document Book). The College wrote to Dr. Hanson informing him of the complaint and advising that the College would be investigating (Tab D of the Joint Document Book). Dr. Hanson was also provided a copy of the College's brochure explaining the complaints process (Tab E of Document Book).

13. On October 19, 1999, the College sent a further letter to Dr. Hanson advising him of the substance of the widow's complaint to the College and advising him that he is entitled to respond within thirty days. Dr. Hanson was also provided with a consent to release of medical records form and asked to provide a copy of his office records pertaining to the patient.

14. By letter dated November 8, 1999, Dr. Hanson responded to the College (Tab F of Joint Document Book) and forward what he represented to be a copy of his medical records to the College. On the second page of his letter, Dr. Hanson stated that he asked the patient " *. . . to make an appointment for follow-up in three weeks time, and gave him a chest x-ray requisition for this test to be done down the road at the x-ray department in the Urgent Care Centre. The patient apparently did the chest x-ray done, however unfortunately I did not receive this report in my office from Diagnostic Care. As the patient did not return to my office for follow-up as requested, unfortunately I had no indication at all that he had even gone for the x-ray at that time. I have a good number of patients in my practice, and as I mentioned earlier, once I give them instructions to make a follow-up appointment, it is their responsibility to do so."*

15. The widow responded to the College by letter dated November 26, 1999 (Tab G of the Joint Document Book) stating that Dr. Hanson ". . . *did not ask my husband to make an appointment for follow up in three weeks like he claims. The usual procedure is don't call us, we will call you if there is a problem.*"

16. Dr. Hanson provided further comment to the College by letter dated December 14, 1999 (Tab H of the Joint Document Book).

17. A College investigator attended at Dr. Hanson's office on February 23, 2000. A copy of the investigator's memorandum is at Tab I of the Joint Document Book.

18. The Complaints Committee considered the complaint against Dr. Hanson on March 1, 2000. The Committee requested further investigation into concerns regarding the contents of Dr. Hanson's medical records. Arrangements were made with Dr. Hanson's office to pick up his original medical records on March 2, 2000. A memorandum from the College investigator in respect of her attendance at Dr. Hanson's office to pick up the original medical records is attached at Tab J of the Joint Document Book.

19. The original of Dr. Hanson's records were provided to Mr. Brian Lindbloom, an expert forensic document examiner. The report of Mr. Brian Lindbloom dated April 25, 2000 is at Tab K of the Joint Document Book.

There was no evidence entered by Mr. Shantz, Counsel for Dr. Hanson, disputing the information in either the Statement of Agreed Facts or in the Joint Document Book.

The information in Mr. Lindbloom's report was the most compelling evidence presented. He concluded:

1. "*The entries reading "[the patient]"December 2 – 24, re: billing codes A007 & 46 and the final entry for February 18, 1998, that may read Physician, were written with an ink different form that used for the other entries on Question 1(a). Furthermore, these entries were produced sometime after Question 23 (ie. February 1999) and Question 28 (March 9, 1999) were received and placed in the file. These entries are not contemporaneous"*

2. *Indentations similar in content and formatting to various entries on Question 1(a) were found on Question 4(2), Question 8, Question 10 – 12, that are dated December 17 & 22, 1997 and April 8, 1998. There is a strong probability that these unsourced impressions may be form an earlier version of appointment notes for December 17,1997, February 18,1998, and October 14, 1998. Given that these dates 3 current entries are on the face side of the same sheet on appointment notes for December 15,1998 and December 18, 1998, it is probable that the entire Questions (a&b) page is a rewrite and was not, therefore, prepared on the dates this document bears.*

There was no contradiction or questioning of this evidence by the defence.

The Panel reviewed the Statement of Agreed Facts and the Joint Document Book and the submissions of Counsel for the College and Counsel for Dr. Hanson, and accepted his plea of guilty, in that he committed an act of professional misconduct under paragraph 1(1)16 of O. Reg. 856/93.

SUBMISSIONS

The Panel then heard submissions as to penalty.

Counsel for the College presented a proposed order for penalty which was agreeable to Counsel for Dr. Hanson and Dr. Hanson.

Counsel for the College emphasized that altering patient records is a very serious, inappropriate activity. Altering of records provides false information about a patient, may lead to inaccuracies in management and on occasion has been done to shift responsibility. Public confidence is shaken when a physician falsifies a record, and is conduct which cannot be tolerated. Also, falsification of patients records cast shadows on the integrity of the profession.

Dr. Hanson only at a late hour agreed to a plea of guilty, when the report of Mr. Lindbloom was made evident. By not agreeing earlier to a plea of guilty and accepting what he did was wrong, he also extended the grieving period for the family of his patient.

Counsel for Dr. Hanson agreed with the proposed order and mentioned that by entering a plea, the hearing was shortened. He pointed out that Dr. Hanson practises in an area where there is a very severe shortage of physicians. Also, Dr. Hanson has a large practice and removing him from practice for a long time would not serve his patients well. Also they would like any suspension to start later rather than earlier, so that Dr. Hanson would have more time to arrange for care of his patients while he is under suspension.

The Discipline Panel considered all the evidence submitted as to penalty and the proposed order, and felt that the evidence showed some problems with record-keeping in general and also felt the amount requested for costs should be greater, or even the costs of the Panel for one day is more than the costs requested.

The Panel was told, that when there is an agreement as to penalty, it should only be changed if there is great concern that the proposed penalty was a grave miscarriage of justice. Panel should not make minor changes to an agreed penalty order. On this basis the Panel agreed with the submission as to penalty and issued the following order.

ORDER

1. The Discipline Committee orders that Dr. Hanson attend before it to be reprimanded, with the fact of the reprimand to be recorded on the register.

2. The Discipline Committee directs the Registrar to suspend Dr. Hanson's certificate of registration for a period of six months, three months of which will be suspended if Dr. Hanson completes 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.

3. The Discipline Committee orders that the suspension of Dr. Hanson's Certificate of Registration commence on or before October 29, 2001.

The Discipline Committee orders that Dr. Hanson pay costs to the College in the amount of $2,500.00 by December 31, 2001.

Dr. Hanson waived his right to an appeal and all members of the Panel participated in administering the reprimand.