

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Christian Andrew Proulx, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients 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. Proulx,
2018 ONCPSD 16**

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. CHRISTIAN ANDREW PROULX

PANEL MEMBERS: **DR. P. GARFINKEL (CHAIR)**
MAJOR A.H. KHALIFA
DR. E.STANTON
MR. P. PIELSTICKER
DR. D. HELLYER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS E. GRAHAM

COUNSEL FOR DR. PROULX:

MS J. MCKENDRY

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date: February 6, 2018
Decision Date: February 6, 2018
Release of Written Reasons: April 4, 2018

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 6, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and is incompetent. The Order set out the Committee’s penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Christian Andrew Proulx committed an act of professional misconduct:

1. under clause 51(1)(b.1) 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 engaged in sexual abuse of a patient;
2. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991 (“O. Reg. 856/93”), in that he has failed to maintain the standard of practice of the profession; and
3. under paragraph 1(1)33 of Ontario Regulation 856/93 in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Proulx is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Proulx entered a plea of no contest to the allegations 2, 3 and the allegation of incompetence in the Notice of Hearing. Counsel for the College withdrew the allegation that Dr. Proulx engaged in sexual abuse of a patient.

THE FACTS

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

PART I – FACTS

1. Dr. Christian Proulx is 50 years old. Dr. Proulx received his certificate of independent practice from the College of Physicians and Surgeons of Ontario in 2003, and his specialist qualification in family medicine in 2006. Before July 2016, Dr. Proulx practised medicine in St. Catharines, Ontario.

PATIENT A

2. In approximately 2013, Dr. Proulx met Patient A, who was his neighbour. Beginning in August 2013, Dr. Proulx prescribed monitored drugs to Patient A, as set out below. This continued until January 2016:

Date	Drug Description	Quantity	Days' Supply
2013/08/02	Ratio-Oxycocet/5mg & 325mg/Tab	120.0	15
2013/08/24	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	25
2013/09/12	Ratio-Oxycocet/5mg & 325mg/Tab	120.0	15
2013/09/19	Novo-Lorazem/1mg/Tab	60.0	20
2013/10/07	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	25
2013/11/01	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	25
2013/11/26	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2013/12/13	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2013/12/31	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/01/17	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	25
2014/01/23	Statex/5mg/Tab	20.0	2

Date	Drug Description	Quantity	Days' Supply
2014/02/01	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/02/19	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/03/06	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/03/24	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/04/10	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/04/26	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/05/11	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/05/25	Novo-Morphine SR/30mg/SR Tab	28.0	14
2014/05/27	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/06/12	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/06/27	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/07/12	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/07/25	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/08/11	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/08/24	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/09/08	PMS-Clonazepam-R/0.5mg/Tab	50.0	25
2014/09/08	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/09/19	PMS-Clonazepam-R/0.5mg/Tab	60.0	30
2014/09/19	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/10/06	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/10/12	PMS-Clonazepam-R/0.5mg/Tab	50.0	25
2014/10/12	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/10/31	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/11/15	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/12/01	PMS-Clonazepam-R/0.5mg/Tab	60.0	15
2014/12/01	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2014/12/17	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2015/01/02	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2015/01/19	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	17
2015/02/02	PMS-Clonazepam-R/0.5mg/Tab	50.0	13
2015/02/02	Sandoz Oxycodone/Acetaminophen/5mg & 325mg/Tab	200.0	17
2015/02/09	Sandoz Oxycodone/Acetaminophen/5mg & 325mg/Tab	200.0	16
2015/02/24	Mylan-Clonazepam/0.5mg/Tab	50.0	25
2015/02/24	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/03/11	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/03/26	Mylan-Clonazepam/0.5mg/Tab	50.0	25
2015/03/26	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/04/09	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/04/24	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/05/08	Mylan-Clonazepam/0.5mg/Tab	50.0	25
2015/05/08	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/05/23	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/06/05	Mylan-Clonazepam/0.5mg/Tab	50.0	13

Date	Drug Description	Quantity	Days' Supply
2015/06/05	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/06/19	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/07/04	Mylan-Clonazepam/0.5mg/Tab	60.0	35
2015/07/04	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/07/13	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/07/27	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/08/10	Mylan-Clonazepam/0.5mg/Tab	60.0	15
2015/08/10	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/08/26	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/09/10	Mylan-Clonazepam/0.5mg/Tab	50.0	12
2015/09/10	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/09/21	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/10/02	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/10/14	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	12
2015/10/26	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	12
2015/11/09	Mylan-Clonazepam/0.5mg/Tab	60.0	30
2015/11/09	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	12
2015/11/25	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/12/11	Mylan-Clonazepam/0.5mg/Tab	60.0	30
2015/12/11	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/12/18	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2015/12/29	Mylan-Clonazepam/0.5mg/Tab	60.0	30
2015/12/29	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2016/01/12	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16
2016/01/25	Ratio-Oxycocet/5mg & 325mg/Tab	200.0	16

3. Despite beginning to prescribe to her in 2013, Dr. Proulx did not see Patient A in any clinical setting until 2015. Dr. Proulx only saw Patient A clinically on two occasions: in February, 2015 and January, 2016. These are also the only two dates on which Dr. Proulx billed OHIP for his care and treatment of Patient A.
4. In January and February 2016, the College received two reports raising concerns about Dr. Proulx's prescribing to Patient A:
 - (a) First, the College was contacted by a physician who had treated Patient A in an Emergency Department after she took an impulsive overdose of olanzapine and clonazepam with the intent to end her life. He reported that although Patient A's Ontario Drug Benefit profile indicated that Dr. Proulx had been repeatedly

prescribing 200 tabs of Percocet to Patient A every 16 days, she denied taking the medication; and

- (b) Second, a relative of Patient A's advised the College that she was concerned that Dr. Proulx was prescribing 200 Percocet to Patient A every two weeks and taking half the medication back from her.

5. In his initial response to the College, Dr. Proulx submitted to the College as follows (attached at Tab 1 [to the Statement of Uncontested Facts on Liability]):

[...] I came to know Patient A as she was my neighbor, although we were not acquainted; I knew her to see her. One day, I do not recall the date, Patient A approached me and asked if I was a doctor. When I responded that I was, she asked me to be her family doctor as she was in need of one. When I told her I was accepting new patients and would be pleased to see her in my office, she explained that she had transportation issues (no vehicle, pain with ambulation) and that she needed help with her medications. She gave a history of myofascial pain and depression. I believe Patient A also told me she had irritable bowel syndrome or Crohn's disease. Importantly, she felt her pain was largely responsible for her depression, and in the past she had used the medication Oxycontin with good effect.

With this information, I suggested that Patient A come to my medical office so that I could initiate a proper patient chart where I could record her history, symptoms, etc. and set out her treatment plan. Unfortunately Patient A was insistent that she was unable to come into the office and begged me to provide a prescription that day because of her transportation difficulties. Against my better judgment, I wrote her a prescription for Oxycontin, accompanied by a discussion about how to take the medication, as well as potential side effects. Patient A returned to my door about two weeks later reporting that she felt a lot better. She asked if I would renew her prescription. Again, against my better judgment, I agreed to write another prescription (including one for Clonazepam to deal with her anxiety), but insisted that she needed to come and see me in the office for future care. Patient A did attend an appointment in my office, in February, 2015, and she told her current health problem was depression/anxiety. It was at this appointment that we decided to trial her on a short course of the mood stabilizer Olanzapine, as I felt she had difficult-to-treat depression, query bipolar disorder. In November 2015 I referred Patient A for Psychiatric support, diagnostic clarification and treatment suggestions through a Hospital.

Unfortunately, I believe that February 2015 was the only time Patient A came to see me in my office. You have the record for this visit. I regret that I continued to renew prescriptions for her outside of my medical office. I really thought I was

helping her, and Patient A did report improvement in her symptoms. Although I now realize this was a sloppy and unprofessional approach, I believed I was acting in Patient A's best interest and was motivated by altruistic compassion for her unfortunate situation.

In late January 2016, as reports came in to me as her family physician from a couple of hospital attendances, I spoke with Patient A and she agreed to taper off the Oxycocet, which I understand she has since done successfully. I have not seen Patient A since, but I understand that her psychiatrists have been refilling her medications for her.

What I could have done better

There is no debate that I failed to follow a number of College policies and guidelines where medical record-keeping, boundaries, and prescription writing are concerned, in particular, by not seeing Patient A in my office and writing prescriptions as I did, I was unable to document each of our patient encounters and all of her pertinent patient-related information, including physical assessments, diagnostic tests, discussions about risk/benefits of treatment, family history, etc.

What I will do better

I take ownership for these actions and acknowledge that this was not appropriate or professional. I acknowledge that interacting with a patient outside of the formal clinical setting about clinical issues, providing prescriptions at her request, failing to provide a proper clinical assessment, etc. does not adhere to the College's expectations around medical record-keeping, prescription writing, and professional boundaries in general. [...]

6. The College requested further information from Dr. Proulx about various aspects of his response, including the circumstances under which he came to be prescribing to Patient A prior to having seen her in the clinic in 2015, as attached at Tab 2 [to the Statement of Uncontested Facts on Liability]. Dr. Proulx refused to respond to that request.
7. Dr. Proulx's account to the College of his relationship with Patient A and the reasons for his prescribing to her outside of a clinical setting were untruthful, and incomplete. In fact, the following occurred:
 - (a) Patient A initially approached Dr. Proulx about obtaining narcotics as a joke, including because she didn't have any money, and/or by asking Dr. Proulx if he could prescribe her "something fun";

- (b) Dr. Proulx agreed to prescribe narcotics to Patient A. Dr. Proulx devised the specifics of their arrangement;
- (c) Dr. Proulx prescribed narcotics to Patient A about 200 pills at a time, approximately every 16 days, and sometimes more frequently than that. Of the 200 pills Patient A obtained each time, Dr. Proulx would take the first 100 pills, and purchase most or all of the remaining 100 pills from Patient A for between \$2.50 and \$3.50 per pill. He would typically pay her \$3.00 per pill. Sometimes Patient A would keep approximately 20 pills for her own use. All payments by Dr. Proulx to Patient A for the pills were made in cash;
- (d) The transactions were arranged through text messaging. Often, Dr. Proulx would pick Patient A up in his car, drive her to the pharmacy, and write her a prescription in the pharmacy parking lot. Patient A would go into the pharmacy and fill the prescription, paying for it either through her Ontario Drug Benefit coverage, or with cash provided to her by Dr. Proulx;
- (e) Dr. Proulx falsely told Patient A he needed the pills to treat his lymphoma, and that his own doctor wouldn't prescribe them to him. Dr. Proulx does not have lymphoma;
- (f) There were occasions on which Patient A went to the pharmacy without Dr. Proulx. On those occasions, Patient A would collect the prescription from Dr. Proulx's mailbox, go to the pharmacy to fill the prescription, and meet Dr. Proulx afterwards for the exchange;
- (g) Dr. Proulx had a similar arrangement with respect to prescribing and buying narcotics with Patient A's then-boyfriend, Mr. X. Patient A introduced Mr. X to Dr. Proulx. Sometimes the three of them would drive to the pharmacy together. Patient A continued to receive prescriptions from Dr. Proulx after she terminated her relationship with Mr. X;
- (h) Dr. Proulx advised Patient A that their arrangement was a secret, that it was illegal, and that that if the College ever discovered it, he would be in a lot of trouble and that Patient A would probably face criminal charges; and
- (i) After the College notified Dr. Proulx of its investigation into his prescribing to Patient A, Dr. Proulx contacted Patient A. Dr. Proulx told Patient A that he was being

investigated, that they would both be in trouble and/or go to jail, and that she specifically would be in trouble. He told her not to speak to the College investigators.

Expert evidence – Dr. Karen Ferguson

8. As part of its investigation, the College obtained independent opinions from Dr. Karen Ferguson, attached at Tabs 3, 4, 5, and 6 [to the Statement of Uncontested Facts on Liability]. A copy of Dr. Ferguson’s curriculum vitae is attached at Tab 7 [to the Statement of Uncontested Facts on Liability].

9. Dr. Ferguson had significant concerns with Dr. Proulx’s prescriptions for opioids and benzodiazepines. She opined that Dr. Proulx fell below the standard of practice of the profession, that his care displayed a lack of knowledge, skill, or judgment, and that clinical practice, behaviour or conduct was likely to expose his patients to harm or injury:
 - (a) Most patients were prescribed opioids without a full assessment of their pain and often when they were quite new to Dr. Proulx’s practice. In many cases, Dr. Proulx initiated opioids after only a few visits when he had not performed a full history or physical examination regarding the pain or tried other non-opioid medications;
 - (b) In most cases, Dr. Proulx made no determination regarding patients’ potential for addiction or documented discussion regarding functional status, adverse effects, and risks of opioids before prescribing opioids to them;
 - (c) In many cases, the opioids were prescribed when Dr. Proulx did not have any results of investigations regarding patients’ pain. The actual indication for the opioids was not clear for several of the patients. In some cases, opioid prescriptions were initiated for one diagnosis, then apparently continued for another diagnosis;
 - (d) Dr. Proulx typically prescribed very large quantities of opioids, writing prescriptions for 200-300 tablets of short-acting opioids or benzodiazepines or 3-month supplies of chronic opioids, with no documented use of “part-fill” prescriptions which can reduce opioid misuse;
 - (e) Many of the patients were prescribed relatively high doses of opioids. In the majority of charts reviewed in which Dr. Proulx prescribed chronic opioids, most patients

were prescribed a Morphine Equivalent Dose (“MEQ”) greater than 200 mg/day. There was no evidence that Dr. Proulx monitored these patients any more carefully. There was minimal documentation regarding the nature, location or severity of their pain, or their functional status and minimal screening for potential opioid misuse;

- (f) There were further concerns regarding documentation surrounding the opioid prescriptions. Most charts did not include any documentation that patients were advised of the potential adverse effects. There was no documented assessment of the patient’s individual risk for addiction and no documentation as to whether the patient had any past history of addiction prior to prescribing the opioids. There was no use of a formalized addiction risk screening tool or narcotic treatment agreement, and urine drug screens were performed extremely rarely. Only three patients had documented urine drug screens. One urine drug screen yielded an abnormal result, but was not repeated. Several of the patients demonstrated features of inappropriate opioid such as lost medications, early prescription renewals, and requests to escalate the dosage. In the majority of the aspects of care where opioids were prescribed, Dr. Proulx did not demonstrate enough diligence in his documentation and monitoring to determine that they were being used safely; and
- (g) For several patients, the records appeared to indicate that the patients were obtaining excessively large quantities of opioids from Dr. Proulx that were not documented anywhere in their chart notes. There were prescriptions for several thousands of tablets of opioids without any documentation or patient encounters associated with these prescriptions. For two patients to whom he had prescribed opioids, including Patient A’s ex-boyfriend, Dr. Proulx had no patient chart whatsoever.

10. Specifically with respect to Patient A, Dr. Ferguson opined that:

- (a) The care Dr. Proulx provided to Patient A did not meet the standard of practice of the profession:
 - (i) Dr. Proulx provided medical care to this patient outside of an office setting, without adequate documentation. This aspect of Dr. Proulx’s care fell well below the standard of care with respect to record-keeping. Any prescription requires documentation of an assessment, diagnosis, and the name and quantity

of the medication prescribed. Prescriptions for controlled substances such as opioids and benzodiazepines require an even higher level of caution, including knowledge of the patient's clinical status, diagnosis, assessment of risk of misuse, and documentation of informed consent. Dr. Proulx did not document any history regarding the cause of Patient A's pain, any previous investigations, other medications she had taken for the pain, past history of substance abuse, functional status, and he did not document a physical Examination prior to prescribing opioids. He also did not document the quantities or dosages of opioids and benzodiazepines that he was prescribing on an ongoing basis for her;

- (ii) Dr. Proulx's care also failed to meet the standard of practice of the profession in terms of the requirements for prescribing. Before prescribing a drug, physicians must have current knowledge of the patient's clinical status. This can only be accomplished through an appropriate clinical assessment of the patient. Dr. Proulx did not appear to have performed a thorough clinical assessment of Patient A prior to prescribing the medications she had requested. He also did not document that he was prescribing Oxycocet and clonazepam regularly to this patient.
- (b) Dr. Proulx's care displayed a severe and ongoing lack of judgment evidenced by his prescriptions for large quantities controlled substances to an acquaintance who he had not adequately assessed regarding the indication or safety of the opioids and benzodiazepines. This was not a single lapse in judgment; and
- (c) Dr. Proulx's conduct in this case was likely to expose Patient A to harm or injury, since she was at high risk for opioid misuse or overdose, given her past history of overdose and her current substance use. Patient A had in fact taken an overdose, and Dr. Proulx was not monitoring to ensure that Patient A was using the opioids he prescribed to her safely. Furthermore, the lack of oxycodone on her urine drug screen at the time of the overdose raised questions for Dr. Ferguson as to whether it was being diverted.

PART II – PLEA OF NO CONTEST

11. Dr. Proulx does not contest the facts specified above, and he does not contest that, based on these facts:

- (a) he engaged in professional misconduct, in that:
 - (i) he failed to maintain the standard of practice of the profession contrary to section 1(1)2 of O Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”); and
 - (ii) 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, under paragraph 1(1)33 of O. Reg. 856/93; and
- (b) is incompetent as defined by subsection 52(1) of the of the Health Professions Procedural Code, which is schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18.

RULE 3.02 OF THE DISCIPLINE COMMITTEE’S RULES OF PROCEDURE

Rule 3.02 of the Discipline Committee’s Rules of Procedure regarding a plea of no contest states as follows:

3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:

- (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;

- (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
- (c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

FINDING

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts on Liability. Having regard to these facts, the Committee found that Dr. Proulx committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession, and in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional. The Committee also found that Dr. Proulx is incompetent.

AGREED STATEMENT OF FACTS REGARDING PENALTY

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

Dr. Proulx's Undertaking

1. On July 4, 2016, during the College's investigations, Dr. Proulx resigned his prescribing privileges with respect to narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and all other monitored drugs, and he undertook not to issue new prescriptions or renew existing prescriptions for any of those substances. A copy of Dr. Proulx's executed undertaking is attached at Tab 1 [to the Agreed Statement of Facts regarding Penalty].

Dr. Proulx's Resignation

2. On July 11, 2016, during the College's investigations, Dr. Proulx resigned his membership in the College of Physicians and Surgeons of Ontario, as attached at Tab 2 [to the Agreed Statement of Facts regarding Penalty].
3. In a submission to the Inquiries, Complaints and Reports Committee in respect of its investigations, Dr. Proulx emphasized that he had permanently resigned his membership in the College, and that he has no intention of ever practising medicine in Ontario, or any other jurisdiction. A copy of Dr. Proulx's submission to the ICRC dated February 21, 2017 is attached at Tab 3 [to the Agreed Statement of Facts regarding Penalty].
4. Dr. Proulx advises that after resigning his membership, he began receiving intensive outpatient addiction treatment for active alcohol and substance abuse. He advises that his program of recovery is ongoing.

PENALTY AND REASONS FOR PENALTY

Submissions on Penalty

Counsel for the parties made a joint submission as to an appropriate penalty and costs order. Counsel for Dr. Proulx and counsel for the College submitted that the appropriate penalty is immediate revocation of Dr. Proulx's certificate of registration and that Dr. Proulx appear before the panel to be reprimanded. In addition, it was proposed that Dr. Proulx pay to the College the costs of a one-day hearing, in the amount of \$5,500.00, within thirty days of the order.

Law and Legal Principles

The Committee notes that by resigning from his membership with the College, Dr. Proulx is not immune from the disciplinary process of his regulatory body. The Committee has the jurisdiction to impose a penalty it determines appropriate, including revocation of the certificate of registration, even in the presence of a member's resignation from membership with the College.

In the *College of Nurses of Ontario v. Mark Dumchin*, 2016 ONSC 626, the Divisional Court states at para 42:

“The purpose of s. 14 [of the Code] is to ensure that a member cannot frustrate the disciplinary process by resigning unilaterally. The panel’s interpretation not only limits but removes the College’s important sanctioning powers which include suspension and the imposition of conditions as well as revocation. This would serve to encourage members to resign to avoid the consequences of their misconduct, whatever its nature. To allow such an interpretation to stand is antithetical to the overarching public protection purposes of the statutory Disciplinary Regime: ensuring that members are held accountable to their regulator for the prime objective of protection of the public.”

The Committee’s decision on penalty is guided by well-recognized penalty principles. The Committee’s decision is based first, and most importantly, on the principle of protection of the public. The Committee is also cognizant that the penalty should serve as a general deterrent to the profession and a specific deterrent to the member; express the profession’s denunciation of the misconduct; be proportionate to the misconduct; uphold the honour and reputation of the medical profession and maintain public confidence in the College’s ability to regulate the profession in the public interest; and where applicable, rehabilitation of the member.

The Committee is aware that a joint submission on penalty must be accepted, unless to do so would bring the administration of justice into disrepute, or would otherwise be contrary to the public interest (*R. v. Anthony-Cook*, 2016 SCC 43).

The Committee also recognizes that it is not required to impose the “least restrictive” penalty which would be consistent with its objectives (*CPSO v. McIntyre* (2017)).

Analysis

The Committee accepted that the proposed penalty satisfies the guiding principles considered in determining the appropriate penalty in this case. Most importantly, the public will be protected as Dr. Proulx is no longer permitted to practise medicine. In addition, the revocation of Dr. Proulx's certificate of registration serves as a general deterrent to the members of the profession. The public reprimand expresses the abhorrence of the profession for Dr. Proulx's professional misconduct.

Failure to Maintain the Standard of Practice of the Profession and Incompetence

A paramount responsibility of the College is to protect the public. The College does so by ensuring that physicians maintain the standards of practice and demonstrating to the public that it takes its responsibility of regulating the profession very seriously by disciplining those members who transgress those standards. The public and the profession cannot and, indeed, will not tolerate a physician who fails to maintain the standard of practice of the profession or is incompetent, nor will it tolerate a physician who does not comply with College policies which exist to protect the public.

The Committee found that Dr. Proulx failed to maintain the standard of practice of the profession in his prescribing of controlled substances to his patients and also that he is incompetent. Dr. Proulx acknowledged that he failed to comply with the College's policies regarding prescribing and medical records. The Committee considered the potential physical and emotional harm that can be inflicted on members of our society who become addicted to a controlled substance through the inappropriate or excessive prescribing of those substances by their physician. The Committee was very concerned with Dr. Proulx's excessive and inappropriate prescribing of controlled substances to his patients, as well as his failure to adequately monitor those patients. In addition, Dr. Proulx failed to adequately record in the medical record his patient encounters.

It was noted in the expert opinion that Dr. Proulx often failed to take an appropriate history or conduct a proper physical examination or pain assessment before prescribing controlled

substances to a patient. The diagnosis or reason for prescribing a controlled substance was often unclear and Dr. Proulx failed to make an adequate medical record of patient encounters.

Dr. Proulx also failed to monitor patients or follow up abnormal drug screens for those patients for whom he was prescribing narcotics.

Physicians must demonstrate that they have the knowledge, skill and judgment to provide good quality of care. Dr. Proulx failed in this regard in prescribing controlled substances not only to his patients, but also to individuals who were not his patients. By doing so, Dr. Proulx put his patients and other persons in harm's way.

The "opioid crisis" has become a significant public health problem in our society. While there may be several factors that contribute to the "opioid crisis," physicians who prescribe narcotics inappropriately or prescribe excessive doses of narcotics to patients contribute to the current crisis. Dr. Proulx's prescribing of controlled substances, that he knew were addicting, was reckless in terms of the amounts prescribed and his failure to monitor. This demonstrates a blatant disregard for his patients' safety and wellbeing. In addition, the friends and family members of addicted individuals often become unintended victims.

There is also the concern when excessive amounts of controlled substances are prescribed to a patient or the patient is given frequent refills or refills for "lost bottles of drugs." This presents an increased risk for diversion to third party individuals, potentially putting those individuals in harm's way. Dr. Proulx did not appear to assess that risk.

Dr. Proulx also demonstrated a significant lapse in judgment in prescribing to an acquaintance and blurred appropriate boundaries. Dr. Proulx participated in a scheme, initially with his neighbor, Patient A, and later, also with Patient A's boyfriend, Mr. X, to obtain controlled substances. Prescriptions were written for Patient A and Mr. X in the absence of a clinical assessment or a pain assessment and without any clear medical indication. The scheme was devised to divert narcotics prescribed to Patient A and Mr. X to Dr. Proulx in return for payment in cash.

This misconduct involved Dr. Proulx exploiting vulnerable individuals in order to secure narcotics for his own personal use. This was not a case of a lack of insight, as Dr. Proulx knew very well that what he was doing was wrong. This was also not a case where Dr. Proulx had a single lapse of judgment. Rather, Dr. Proulx demonstrated a profound lack of judgment that went on for years.

This despicable behaviour, exploitation of vulnerable individuals and lack of judgment will not be condoned and must be met with a severe penalty. The findings of failing to maintain the standard of practice of the profession and incompetence demand a very stringent penalty.

Honesty and Integrity

There are certain characteristics that a physician must possess that the public and the profession consider vital. Honesty and integrity are two of those critical characteristics that are required not only to uphold the honour and reputation of the profession, but also to maintain public trust in the profession. By his actions, Dr. Proulx demonstrated that he was neither honest, nor an individual with integrity.

Dr. Proulx's account to the College of his relationship with Patient A was not truthful.

In addition, Dr. Proulx was not truthful when he told Patient A that he needed narcotics for a disease that he did not have and that his own doctor would not prescribe him narcotics.

Furthermore, Dr. Proulx refused to respond to a request for further information in regard to the circumstances under which he came to be prescribing controlled substances to Patient A prior to having seen her in his clinic in 2015. He also attempted to obstruct a College investigation. He used coercive tactics to intimidate Patient A into remaining silent about their drug diversion scheme and not to cooperate with a College investigation. By doing so Dr. Proulx abused the power imbalance that exists between a physician and a patient. In addition, by exploiting vulnerable individuals, Dr. Proulx put his own selfish personal needs ahead of their well-being.

Dr. Proulx's scheme to use vulnerable individuals to divert narcotics to himself was egregious, will not be tolerated by the public or the profession, and demands a stringent penalty.

It cannot be emphasized enough by this Committee that physicians' involvement in professional regulation and governance is a privilege not a right of the profession. The public must have the confidence that the College will regulate the profession in the public interest. A serious sanction must follow if a physician does not respect this principle.

As noted in the decision of the Alberta Court of Appeal in *Adams v. Law Society of Alberta* (2000):

“Self-regulation is based on the legitimate expectation of both government and public that those members of a profession who are found guilty of conduct deserving sanction will be regulated - and disciplined – on an administrative law basis by the profession's statutorily prescribed regulatory bodies. Thus, a professional disciplinary hearing is not a criminal hearing; it is an administrative hearing. Admission or proof of the alleged professional conduct (or incompetence) is not the same as a plea or finding of guilt in a criminal matter. Rather, it is a finding of conduct deserving of sanction or incompetent practice based on administrative principles, including applicable evidentiary rules. A professional misconduct hearing involves not only the individual and all the factors that relate to that individual, both favourably and unfavourably, but also the effect of the individual's misconduct on both the individual client and generally on the profession in question. This public dimension is of critical significance to the mandate of professional disciplinary bodies.”

Summary of Aggravating Factors

Given the foregoing analysis, the Committee considered that the following factors were aggravating in the circumstances of this case:

- Dr. Proulx's improper prescribing was done repeatedly over an extended period of time;
- The improper prescribing involved multiple patients and in some cases individuals who were not his patients;
- Dr. Proulx's inappropriate and reckless prescribing of controlled substances put his patients and others in harm's way and he breached their trust; and
- Dr. Proulx demonstrated contempt for his regulatory body by not responding to a request from the College for further information.

Mitigating Factors

The Committee noted the following mitigating factors:

- This is Dr. Proulx's first appearance before the Discipline Committee.
- Dr. Proulx pled no contest to the allegations, thus avoiding a lengthy and costly hearing. In addition, witnesses were not subjected to the strain and burden of testifying in a contested hearing.

Case Law

Counsel for the parties submitted several prior decisions of the Discipline Committee. The Committee accepts the general principle that like cases should be treated alike. While the Committee appreciates that prior decisions of the Discipline Committee may be of assistance in its determination of an appropriate penalty, the Committee is not bound by those decisions. Further, each case before it is unique and the Committee must carefully consider the specific facts of the case before it, as well as the mitigating and aggravating factors.

While the previous cases referred to by counsel are not identical to the present case, based upon the review of these previous decisions, the Committee accepted that revocation of Dr. Proulx's certificate of registration and a public reprimand are appropriate in view of the seriousness of Dr. Proulx's professional misconduct and incompetence.

Conclusion

In summary, Dr. Proulx's professional misconduct was multifaceted and egregious. It involved failing to maintain the standard of practice of the profession and disgraceful, dishonourable and unprofessional conduct. The Committee also found that he is incompetent. He demonstrated dishonesty, contempt for his regulator, and a lack of integrity and judgment as well as putting his patients and others in harm's way.

The public places their trust in the medical profession. The public trusts that their physician will possess the necessary knowledge, skill and judgment to provide quality medical care to their patients, and that their physicians will place the interest of the patient before their own. Dr. Proulx breached that trust in many ways.

After carefully considering the extent and seriousness of Dr. Proulx's professional misconduct and incompetence, including the aggravating and mitigating factors, the Committee concluded that revocation is the only penalty that is appropriate in this case. It not only protects the public, but serves to maintain public confidence in the College's ability to regulate the profession in the public interest.

ORDER

The Committee stated its finding of professional misconduct and incompetence in paragraphs 1 and 2 of its written order of February 6, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

3. the Registrar revoke Dr. Proulx's certificate of registration, effective immediately.
4. Dr. Proulx attend before the panel to be reprimanded.
5. Dr. Proulx pay costs to the College in the amount of \$5,500.00 within 30 days of the date this Order becomes final.

At the conclusion of the hearing, counsel for Dr. Proulx indicated that Dr. Proulx waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand in Dr. Proulx's absence. The Committee is dismayed that Dr. Proulx failed to attend his own hearing or receive the reprimand personally.

TEXT of PUBLIC REPRIMAND
Delivered February 6, 2018
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. CHRISTIAN ANDREW PROULX

Dr. Proulx,

We find you have dishonoured the profession by your conduct. Your behaviour repeatedly displayed exceptionally poor judgment that goes far beyond a mere knowledge deficit.

You ignored your patient's needs and put your self-interest first, contrary to everything we are taught about the practise of medicine.

You took advantage of vulnerable people ignoring the power imbalance between patients and doctors.

Clinically your work is exceptionally poor both in and out of your clinical office. These practices ignored all the principles regarding assessment, diagnosis, management and recording.

These practices exposed your patients and others to significant harms, and by pleading no contest and by your absence at these proceedings we see no evidence of remorse for the harms you have caused others.

This is not an official transcript