NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Martin Jugenburg, this is notice that the Discipline Committee ordered that no person shall publish or broadcast 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. Jugenburg, 2020 ONCPSD 40

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. MARTIN JUGENBURG

PANEL MEMBERS:

DR. BARBARA LENT (CHAIR)
MR. J. PAUL MALETTE, Q.C.
DR. ROBERT SHEPPARD
MS LINDA ROBBINS
DR. JOHN RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS CAROLYN SILVER
MS SAYRAN SULEVANI

COUNSEL FOR DR. JUGENBURG:

MS NINA BOMBIER
MS KELLY HAYDEN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS JENNIFER McALEER
MR. DAVID ROSENBAUM*
(*Morning of June 17, 2020)

Hearing Dates: June 17, 18, 19, 24, 25 and 26, 2020
Decision Date and Release of Reasons Date: September 24, 2020

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario ("the College") heard this matter by videoconference on June 17, 18, 19, 24, 25 and 26, 2020. At the conclusion of the hearing, the Committee reserved its finding.

ALLEGATION

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

> 1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*, 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.

RESPONSE TO ALLEGATION

Dr. Jugenburg admitted 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, contrary to paragraph 1(1)33 of O. Reg. 856/93.

FACTS AND EVIDENCE

Some of the facts in this matter were included in an Agreed Statement of Facts which was made an exhibit and presented to the Committee. The Committee also heard testimony from witnesses.

AGREED STATEMENT OF FACTS

BACKGROUND

1. Dr. Martin Jugenburg ("Dr. Jugenburg") is a 45-year-old physician who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College) on May 14, 2007.

2. At the relevant time, Dr. Jugenburg owned and practised at the Toronto Cosmetic Surgery Institute ("TCSI" or the "Clinic") in Toronto, Ontario.

A. Patient A

3. In 2016, a reporter for a national news program, attended at Dr. Jugenburg's office for a televised news segment.

4. Part of the televised news segment of one minute and 51 seconds showed Dr. Jugenburg performing surgery on a draped patient and a staff member purporting to film the procedure on a cell phone. The news segment is attached as Tab 1 to the Agreed Statement of Facts.

5. On October 17, 2016, the College notified Dr. Jugenburg that the reporter had raised concerns with the College regarding this televised news segment. At the College's request, Dr. Jugenburg responded to concerns about informed consent, patient confidentiality and his use of social media.

6. On January 16, 2017, the Inquiries, Complaints and Reports Committee (the "ICRC") approved a Registrar's Appointment of Investigators under section 75(1)(a) of the Health Professions Procedural Code (the "Code") to investigate

whether in his conduct, including his advertising and use of social media, he had engaged in professional misconduct or is incompetent.

7. On May 29, 2017, the College requested that Dr. Jugenburg provide a copy of the chart of the patient on whom he performed the breast augmentation on the news segment.

8. By letter dated July 11, 2017, Dr. Jugenburg provided a copy of his patient records for the patient, who was identified as Patient A. The records were from the time of the surgery in 2016, and included related consents. The Operating Room ("OR") Note was signed by Dr. Jugenburg in 2017, though the specific date is illegible.

9. When asked by the College about the 2017 date on the OR Note for a surgery that was performed in 2016, Dr. Jugenburg advised that on that date he added the following sentences to the patient's chart: "Additionally, the patient was made aware of the fact that a TV crew will be in the operating theatre to film a segment about my snapchats. Her privacy and identity will be protected." The EMR chart history disclosed that these sentences were added by Dr. Jugenburg on June 19, 2017. A copy of the EMR chart history for Patient A's chart is attached at Tab 2 to the Agreed Statement of Facts.

10. Dr. Jugenburg acknowledges that any discussion with Patient A regarding the filming of the procedure should have been carefully documented at the time of the procedure.

B. Patient B

11. In 2016, Patient B underwent a breast augmentation, tummy tuck, and liposuction performed by Dr. Jugenburg. A copy of the general surgical consent form is attached at Tab 3 to the Agreed Statement of Facts.

12. In a follow-up appointment, Dr. Jugenburg took “before and after” photos. He and the patient were pleased with the results of the surgery. Dr. Jugenburg told her she was a six out of five. Dr. Jugenburg explained the different social media platforms used by the Clinic, including Snapchat, Instagram and Facebook, and asked if Patient B would consent to her images being posted on these. Patient B told him that she would agree to having a video of her voice on Snapchat, but did not want any images of herself to be posted. Snapchat is a social media platform upon which posted items disappear within 24 hours.

13. During the appointment, Patient B felt that Dr. Jugenburg was insensitive when he pulled up her underwear for the photos and felt that his focus was on his social media rather than her recovery. Patient B felt that she had been pressured to contribute to Dr. Jugenburg’s social media accounts.

14. Patient B signed a consent form on the computer with respect to social media. This document (attached as Tab 4 to the Agreed Statement of Facts) stated that she was providing “informed and voluntary consent to Dr. Martin Jugenburg, MD, and/or his associates to take photographs and/or video of me pre-operatively, intra-operatively, and post-operatively for the following social media platforms: Snapchat”. She signed the form on the understanding, based on her verbal instructions and Dr. Jugenburg’s assurance, that only her voice, not her image, would be posted online.

15. Following this visit, and in accordance with this consent, a posting was made on Snapchat which included Patient B’s voice, and which disappeared within 24 hours.

16. Patient B’s before/after photos were inadvertently posted on social media on two occasions after this, as a result of a mistake in Dr. Jugenburg’s office.

17. On the first occasion, Dr. Jugenburg was making a video "tour" of his Clinic for Snapchat and walked into his social media room. In the short video he states: "Let's see what Meghan is working on" and the camera pans to a shot of the computer screen, which happened to display Patient B's before and after photo. The photo displayed Patient B's entire torso, including her bare breasts. The photo did not display Patient B's face. There was no name associated with the photo. This video was posted for 24 hours on Snapchat and then automatically removed.

18. On the second occasion, there was a posting of Patient B's before/after photo on Instagram. The photo displayed Patient B's entire torso, including her bare breasts (with nipples censored). The photo did not display Patient B's face or any other identifying features. There was no name associated with the photo. A copy of the posting is attached as Tab 5 to the Agreed Statement of Facts.

19. Patient B discovered the Instagram posting with her before/after photo the day after it was made and was mortified. She contacted the Clinic, which immediately removed the image. Dr. Jugenburg telephoned the patient to apologize and confirm that it was a mistake and the photo had been taken down. He also sent her a text message apologizing for the error.

C. Audio/Video Surveillance of TCSI

(i) Background

20. In January 2012, Dr. Jugenburg opened the Toronto Cosmetic Surgery Institute on Level 2 of the Royal York Hotel. The Clinic houses private patient information and records, expensive medical equipment, and various pharmaceuticals and narcotics. The Clinic is accessible via a public elevator from street level and through the underground "Path" network in downtown Toronto.

21. The Clinic had eight security cameras installed throughout. On the advice of Royal York Hotel security, a sign was posted in the lobby of Level 2 stating, “This area is under video surveillance.” Photos of the sign are attached at Tab 6 to the Agreed Statement of Facts. A second sign stating “This area is under video surveillance” was posted in the Operating Room above the computer on the far side of the room, from where patients enter. The sign in the Operating Room was not readily visible to patients. Photos of the sign and the location of the sign in the Operating Room are attached at Tab 7 to the Agreed Statement of Facts. Dr. Jugenburg is unaware how long these cameras were operational, but believes that they became non-functional soon after their installation as he does not recall using them.

22. In January 2017, the second level of the Clinic (Level 4) opened. As part of the construction, sixteen cameras were installed on Level 4 (audio and video capable) and the eight cameras on Level 2 (video capable only) were repaired or replaced. The Clinic has experienced security incidents in the past, including break-ins and theft. Altogether, the Clinic operated a network of 24 cameras. The cameras on Level 4 recorded 24-hours a day, while the cameras on Level 2 were activated by a motion-sensor. Patients who entered the Clinic on Level 4 would not have seen any signs about video surveillance, as they were only posted on Level 2.

23. The cameras were located throughout the offices, in examination rooms, the operating room, pre-operative rooms, reception areas, hallways, administrative offices, a workroom and the staff kitchen. A diagram depicting the layout of the Clinic is attached at Tab 8 to the Agreed Statement of Facts. In the diagram, Level B corresponds to Level 2 and Level D corresponds to Level 4. The hand-written numbers depict the location of cameras within the Clinic.

24. The cameras were located in the upper corner of each room, and were not concealed. Photos showing the locations of cameras are attached at Tab 9 to the

Agreed Statement of Facts. Footage from the cameras was automatically transmitted to two video recorders which were stored in locked closets, one on each floor. Once the capacity of the recorders was reached, the footage was automatically overwritten. Once overwritten, this data was not recoverable.

25. Dr. Jugenburg's office manager kept the only key to access the locked closets housing the two video recorders. In addition, access to the video recorders was password-protected, by a password that only Dr. Jugenburg had.

26. The security system had a smartphone application whereby footage could be accessed from Dr. Jugenburg's cellular phone. This application made it possible to view and save both live and archived video surveillance footage at any time.

27. There were no signs notifying patients that they were being recorded during their patient encounters, consultations and/or procedures. He also did not tell patients that these recordings were accessible to him on his phone.

(ii) CBC Undercover Investigation

28. In December 2018, personnel from the Canadian Broadcasting Corporation (CBC) disclosed to the College that they had seen cameras mounted in the exam room of TCSI. An undercover CBC reporter attended the Clinic with a hidden camera in October 2018, posing as a patient. The following exchange took place between Dr. Jugenburg's staff and the patient:

Staff Member A:	Hi, How are you?
Patient:	Good. How are you?
Staff Member A:	Good. Good. I'm just here to take some photos for your file. So for breast augmentation, everything on top off.

Your shirt and bra. Then just have a step in front of the black backdrop when you're ready. Then we can get started.

Patient: I have a question.
Is there a camera up there?

Staff Member A: Uh, Camera?

Patient: Yeah.

Staff Member A: Yes, that's, um, for the doctor's record.

Patient: Oh. Okay.
I don't really feel comfortable being, like, unclothed in front of the camera.

Voice: Is there a room that she could go to?

Staff Member A: There's cameras all around. It's just the doctor's like…We have to record everything for, like, legal purposes. Just like the dialogue and everything like that.

Patient: Right. Okay.

Staff Member A: Everything is totally confidential. Nothing gets, um, like, posted to our social medias unless you consent.

Patient: Okay.

Staff Member A: Um, yeah, it's just for his personal record for legal purposes.

Staff Member B: Sorry about that camera thing. I know. It's in. It's all over. Um, it's to protect you too. It's just a security camera, basically. Um, and I really don't know, I think they're all, I don't know even how much he can really see out of it, and I have never seen one, so. Because I know that,

	he has to do it for his (unintelligible). Like if someone ever said something happened and it didn't or stuff like that.
Patient:	Oh. Has it happened before?
Staff Member B:	No, never.

29. The footage of the patient encounter described above is attached at Tab 10 to the Agreed Statement of Facts. On December 5, 2018, Dr. Jugenburg was contacted by the CBC. Afterward, he added signage on the reception desks on Level 2 and Level 4 and on the back of the fixed door to enter the Clinic on Level 2 (which would have been behind patients when they walked into the Clinic), indicating that the premises were under surveillance, to the existing two signs on Level 2. Photos of the signs are attached at Tab 11 to the Agreed Statement of Facts. There were no signs in any of the consultation rooms, where the video surveillance recorded patients in various states of undress.

(iii) College Investigation

30. On December 13, 2018, College investigators and Matthew Musters of Computer Forensic Inc (CFI) attended TCSI. The two video recording devices were secured from the locked closets, preventing further access or recording. The following day, College investigators returned and seized two video recorders. The recorders were turned over to CFI for analysis.

31. The video recorder from Level 2 contained video recordings of all patient encounters from October 23, 2018 to December 13, 2018. The video recorder from Level 4 contained audio and video recordings of all patient encounters from May 7, 2018 to December 13, 2018.

32. The College received 27 charts from TCSI for patients seen for consultations and procedures on November 7, 2018 and from December 2 to 12, 2018, inclusive. Video recordings from the Clinic covering the same dates were obtained from CFI. Video of each of the 27 patient encounters was recorded by Dr. Jugenburg's system. Memoranda from the College investigator describing the 2018 videos and attaching still shots from patient encounters is attached at Tab 12 to the Agreed Statement of Facts.

33. Patients who attended for consultations on these dates appeared on video in various states of undress. Their breasts, buttocks and/or genitals are exposed during the consultations. These patients were not notified that their consultations were being recorded by Dr. Jugenburg's audio/video surveillance, nor was verbal or written consent sought or obtained.

34. Patients who attended for procedures on these dates were also recorded on video, many of whom were depicted while sedated and exposed on the operating table. The patients had their breasts, buttocks and/or genitals exposed during the procedures. Various forms were provided to these patients, including consent forms. A copy of the forms provided to patients who underwent procedures at the Clinic is attached at Tab 13 to the Agreed Statement of Facts.

35. On December 18, 2018, Dr. Jugenburg emailed patients he had seen at the Clinic over the preceding two years between December 13, 2016 and December 13, 2018. A copy of the email is attached at Tab 14 to the Agreed Statement of Facts. In the email, Dr. Jugenburg stated as follows:

> I would like to inform you about an important matter involving security and patient privacy concerns.

Approximately two years ago, we installed security cameras throughout our clinic, including reception areas and examining rooms. The cameras were always visible, and signs were posted to inform our patients of the presence of video surveillance.

The video footage captured on this system was for security purposes and to protect our team and our patients. The information was stored on a highly secure IT system with access limited to me or my senior office manager.

As Canadian privacy legislation has continued to expand, both the scope of our security system and related signage should have been reviewed and updated. We have learned that we should have been more proactive in communicating the presence of the cameras through the office to you, allowing you to opt out if desired.

We did not do this, and we apologize for this oversight.

Our security system is currently disabled, and any previous recordings would be automatically deleted by the system every few weeks.

Moving forward we will ensure that any future security cameras comply with all privacy interests and expectations.

I would like to reiterate that patient safety and privacy is most important to me and my team.

We want to ensure all of our patients are provided with the best clinical care and experience when you visit our premises.

36. College Investigators interviewed 15 patients who had undergone procedures in 2018, identified from the patient charts obtained from Dr. Jugenburg's clinic. Three of Dr. Jugenburg's patients interviewed by the College advised that they did not receive the email attached at Tab 14 to the Agreed Statement of Facts. Many patients confirmed that they were not told, were unaware, and/or did not see any signs advising them that there was audio/video surveillance in Dr. Jugenburg's office recording them during patient encounters, consultations and/or procedures. Some patients confirmed that they were aware of the cameras. Three patients advised that if they had been made aware that they were being recorded by Dr. Jugenburg, they would not have consented to undergo a consultation or procedure with Dr. Jugenburg. Three of the patients who were interviewed by the College expressed that they were upset, embarrassed and/or distressed about the surveillance. Dr. Jugenburg and his staff would have seen thousands of patients in consultation between January 2017 and December 2018, all of whom would have been recorded by Dr. Jugenburg's surveillance cameras during patient encounters, consultations and/or procedures.

(iv) Other Physicians Practising at TCSI

37. At the relevant time, Dr. Jugenburg had several other physicians using his Clinic to see patients and perform procedures. These included Drs. Thomas Constantine, Oakley Smith and. Waqqas Jalil. The patients of each physician would have been recorded by the Clinic's surveillance system. The app on Dr. Jugenburg's cellular phone allowed him to view and save video surveillance footage of these patients, as well as his own.

38. Each of these physicians were interviewed by the College in March 2019. At the time of his interview with the College, Dr. Constantine had been employed with TCSI for three years. Dr. Smith rented OR space from Dr. Jugenburg and

performed surgeries in the OR approximately once a week for the two years preceding his interview with the College. He would meet his patients in a consult room prior to their surgeries. At the time of his interview with the College, Dr. Jalil had been employed with TCSI for over a year.

39. Each of these physicians confirmed that they were aware of security cameras in some areas of the Clinic, though their understanding of their location and what was being recorded differed. Dr. Constantine was unaware that his patient encounters, consultations and procedures were being recorded. Dr. Smith was told there was a camera in the OR, but never saw it and was not aware of any cameras in the consultation rooms. Dr. Jalil was aware that surveillance cameras were used, but could only recall seeing cameras in the kitchen and reception area. He was not aware of the camera in the “marking room” or the OR. Prior to the CBC story coming out, Dr. Jugenburg never discussed the cameras specifically with them.

40. After the CBC story, Dr. Jugenburg discussed the surveillance cameras with the other physicians to inform them of the status and explain that the cameras had now been disabled and any existing footage secured by the College. Dr. Jugenburg did not notify the patients seen by these other physicians using his office that they had been recorded during their patient encounters, consultations and/or procedures, or taken steps to ensure they were notified by these physicians, unless these patients had also been seen by Dr. Jugenburg and were thus included in the notification described above. The College interviewed seven of the patients from these other physicians, many of whom confirmed that they were not told, were unaware, and did not see any signs advising them that they were being recorded by the surveillance camera system at the Clinic, including in various states of undress during their patient encounters, consultations and/or procedures. Many of the patients were upset, embarrassed

and distressed about the surveillance and expressed feeling violated, shocked, speechless, and/or that their privacy had been invaded.

D. Information and Privacy Commissioner of Ontario

41. The Information and Privacy Commissioner of Ontario investigated Dr. Jugenburg's use of video surveillance cameras in his office. On September 20, 2019, the Privacy Commissioner of Ontario released its decision following its investigation of TCSI. A copy of the decision is attached at Tab 15. The IPC made the following findings:

> The IPC's Findings
>
> [30] There does not appear to be any dispute, and I find, that the collection of personal health information through the Clinic's prior video surveillance system was done without authority under the Act. As indicated above, the Clinic relied on neither consent nor other authority under the Act for collecting its patients' images through this system. I also find that, even if the Clinic was authorized to use some cameras for security purposes, the extensive network of cameras, and particularly the placement of cameras in consultation and examination rooms, was not in keeping with requirements of section 30(2).
>
> [31] I accept that the Clinic has valid security concerns (such as, for example, potential theft of expensive equipment). However, it would be an understatement to call the Clinic's response to these concerns 'excessive'. The Clinic's solution to its security concerns was to record throughout large portions of its premises, including in those areas where patients would be disrobed and at their most vulnerable. Its security concerns do

not justify such broad-scale, intrusive measures, and I find this approach in conflict with the requirements of the Act.

[32] It should have been obvious that less intrusive measures, such as the use of chaperones or a significantly more limited video surveillance system, could have addressed the same security concerns. As noted above, the Clinic has now addressed its security concerns in a way that does not violate the privacy rights of its patients: cameras are only on after hours, cameras are no longer in examination rooms (among other places), and the Clinic has indicated that they do not collect personal health information.

[33] In light of the Clinic's current limited video surveillance system, I am satisfied that the Clinic has adequately responded to the IPC's concerns about its authority and justification for placing cameras throughout its premises.

…

[40] The blanket use of surveillance cameras for non-health care purposes in this context (particularly in pre-operative, operating and examination rooms where a patient is most vulnerable and has a higher expectation of privacy) is unacceptable. As a result of my investigation, I found that the Clinic's prior video surveillance practices contravened the Act.

42. In a statement released on September 25, 2019, Brian Beamish, the Information and Privacy Commissioner stated:

Bottom line: positioning a camera in an exam room and collecting footage where patients are undressed, vulnerable, and without an opportunity to

> expressly consent violates the trust that patients must have in the medical community. Without this trust, people might avoid seeking health care when they need it … resulting in serious ramifications for the health care system in Ontario.

43. After completing its review, the IPC concluded that, given the steps taken by Dr. Jugenburg, including notifying patients and disabling the surveillance camera system in private areas, it was unnecessary to pursue the matter further and proceed to conduct a review under the *Personal Health Information Protection Act*.

ADMISSION

44. Dr. Jugenburg admits the facts specified above and admits that, based on these facts, 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, contrary to paragraph 1(1)33 of O. Reg. 856/93.

FURTHER EVIDENCE

In addition to the Agreed Statement of Facts, the Committee heard further evidence which consisted of:

- the testimony of one of the complainants, Patient A;
- the testimony of Dr. Jugenburg;
- the testimony of Ms. Victoria Cole, a nurse employed by the Toronto Cosmetic Surgery Institute (TCSI)

The Committee also considered documentary evidence which included screenshots from the news segment, email communications between Dr. Jugenburg and Patient A, portions of Patient A's clinical record at TCSI, and correspondence between Dr. Jugenburg and the College during the course of the College investigation into this matter.

The Evidence of Patient A

Patient A underwent breast augmentation surgery at TCSI in 2016. As indicated in the Agreed Statement of Facts, a portion of the procedure was filmed and broadcast on television. The television reporter later raised concerns with the College, leading the College to investigate issues pertaining to patient consent and confidentiality, and to Dr. Jugenburg's use of social media.

Patient A testified about her experience at TCSI, and about subsequent events after she became aware, almost one year later, that she had appeared in the news segment. She stated that she had been happy with the clinical care provided by Dr. Jugenburg and his staff, and had no issues in this regard.

Patient A testified that Dr. Jugenburg had spoken to her about a proposal that a national news program be permitted to film a part of her procedure, and that he had asked her if she would be willing to be "a demo patient" for this purpose. This conversation had taken place in the pre-op room, while she was waiting for her surgery, some 15 to 30 minutes prior to the procedure. Patient A stated that she had been clear with Dr. Jugenburg that she did not wish to be a demo patient, that she did not wish to be filmed, and that she did not want the television crew present in the OR for her surgery.

Patient A stated that Dr. Jugenburg telephoned her in August 2017, inquiring whether he had asked her if she had agreed to the national news program being

present at her surgery, to which she replied that she had not agreed to this. She was then able to find the television news segment from the date of her surgery, and she watched this for the first time. She was shocked and distressed to see that she had been filmed and that, for a brief period of time, a portion of her breast and nipple appeared to be visible. She believed that she could be identifiable on the news segment because her friends and family knew the date of her surgery, leading to feelings of embarrassment, and feelings of disappointment in and anger at Dr. Jugenburg for not having followed her wishes.

Patient A acknowledged that she did not recall all the details of events shortly prior to her surgery. In her testimony she was clear that she remembered her discussion with Dr. Jugenburg in the pre-op room regarding the presence of the television crew. She did not, however, remember having had any interaction with Victoria Cole, the OR nurse. She did not remember seeing the television crew, or the camera, either in the OR or in the corridor outside the room. When asked whether she recalled being asked by Dr. Jugenburg if the television crew could be present provided that they only filmed him and his assistant and not her, and having agreed to this arrangement, Patient A stated that she couldn't remember. Patient A acknowledged that her memory for these events may be impaired, in part because of the effects of the anxiolytic medication she had been given.

Although the Committee did not have significant concerns about Patient A's credibility, and believed her to be an honest witness, the Committee did have doubts about her ability to accurately recall the relevant events, particularly in relation to the period of time shortly prior to her surgery, when the discussion with Dr. Jugenburg about the presence of the television crew took place. Patient A admitted in her testimony that she may not remember everything that occurred. There are understandable reasons why this might be the case; the passage of time, the effects of the anxiolytic medication she had been given, and

the stress of the pending surgery. The result, however, is that the Committee finds that Patient A may not be in a position, currently, to provide a complete and accurate account of what occurred just prior to her surgery.

The Evidence of Dr. Jugenburg

Dr. Jugenburg testified with respect to his recollections of Patient A. He confirmed that arrangements had been made with the national news program for their television crew to be present on the day of her surgery, and that he had spoken to her about this shortly before the procedure. It was his usual practise to meet with patients in the pre-op room prior to surgery, in order to review with them the procedure, and also to enquire about whether they would consent to their images being posted to various social media platforms, which was a routine occurrence at his clinic. He recalled that Patient A did not consent to appearing on social media. He informed her that the television crew would be present and asked her if she would agree to being “a demo patient” to be filmed by them, which she also declined. Dr. Jugenburg stated that he had then asked her if it would be okay if the crew just filmed himself and his assistant, and not her; it was his recollection that Patient A agreed to this. Dr. Jugenburg stated that he then spoke to the television crew to inform them of this stipulation, to which the crew agreed, before speaking again to Patient A in the pre-op room to confirm that she would not be filmed. Dr. Jugenburg stated that Patient A did not object to this arrangement. Dr. Jugenburg acknowledged that he did not obtain her written agreement to the presence of the television crew, and stated that he now recognizes that he should have done so.

Dr. Jugenburg testified that Patient A’s procedure was uneventful. He watched the news broadcast and thought that the filming had been consistent with her wishes. Subsequently, he learned that the College was investigating after the national news program had expressed concerns. He had responded to the

College's requests for information, including by providing a copy of the OR note pertaining to Patient A's procedure. Dr. Jugenburg acknowledged that, prior to sending the OR note to the College, he had added to it a notation to the effect that Patient A was aware of the presence of the television crew at her surgery, and that her privacy would be respected.

Dr. Jugenburg stated that it was his usual practise to not complete and sign-off on his OR notes until sometime after the surgery had been completed. On this occasion he stated that he made the late additions to the note because the College had requested the patient's chart, and he realized that her consent to the presence of the television crew had not been previously documented.

With respect to the video surveillance system which Dr. Jugenburg had installed in the clinic in January 2017, his testimony was consistent with the contents of the Agreed Statement of Facts. He stated that the purpose of the enhanced video surveillance system was both security, to the benefit of both staff at the clinic and patients, and also to provide a record of staff activities, and of staff interactions with patients, in case this should be required to assist, for example, in resolving possible disputes about what had occurred. The surveillance had in fact been helpful to him on a couple of occasions, in investigating patient complaints which had proven to be unfounded. Although the system included an application on Dr. Jugenburg's phone which allowed him to view the video recordings generated by the system, he stated that he had rarely accessed these images. On the few occasions on which he had done so, this was mainly for the purpose of checking the location within the clinic of staff members, ensuring that there was someone at the front desk, for example.

Dr. Jugenburg, in his testimony, admitted that in setting up his video surveillance system he had paid insufficient attention to the privacy interests of the clinic patients. He stated that he regrets this error in judgement. He had communicated

by email with his patients in December 2018, apologizing for not having informed his patients of the presence of the surveillance cameras, and not having offered them the opportunity to “opt-out”. The College investigation later revealed that not all patients had received the email. Dr. Jugenburg testified that he had also spoken to the other physicians who practised out of his clinic, as their patients also had been surveilled by the system, but he had not himself contacted the patients of the other physicians, believing that the matter could be better handled by his colleagues, who could contact their own patients, if they chose.

There are few points of disagreement between Dr. Jugenburg’s testimony and the remainder of the evidence. He continued to express his agreement with the facts contained in the Agreed Statement of Facts, and to accept responsibility for his conduct in this regard. His acceptance of responsibility extends to the entirety of the allegations pertaining to the complainant Patient B, to Dr. Jugenburg’s admission that he failed to adequately consider the privacy interests of the patients of his clinic in installing the clinic’s video surveillance system which was in operation between January 2017 and December 2018, and to Dr. Jugenburg’s admission, in his testimony, requesting consent from Patient A to have a film crew in the room, as he was about to operate on her, was inappropriate. In placing pressure on her in the manner in which he did, he failed to properly obtain Patient A’s informed consent for the presence of the television crew at her surgery in 2016.

Dr. Jugenburg’s evidence is at odds with the evidence of Patient A on the one narrow issue of whether or not she agreed to the presence of the television crew in the OR during her surgery. Both Dr. Jugenburg and Patient A agreed that she had made clear that she did not wish to be filmed. It was Dr. Jugenburg’s recollection, however, that she had agreed to the presence of television crew provided that she wasn’t filmed, and that her privacy was assured. He stated that, if he had known that Patient A was objecting to the presence of the television

crew in the OR at all, he would not have proceeded against her wishes. He stated that there were other options whereby the news segment could have been completed without Patient A's participation. He acknowledged that he did not obtain Patient A's written consent to the presence of the television crew, and stated that he now recognized that he should have done so.

The Committee finds Dr. Jugenburg's testimony to have been credible on the material issues. His evidence, on the narrow point of disagreement between himself and Patient A was clear and consistent. It was consistent also with the testimony of Ms. Victoria Cole, with the belated entry in Patient A's clinical record, with his initial responses to the College inquiries, and with the email exchanges between Patient A and himself in August 2017. In his evidence, Dr. Jugenburg for the most part admitted to his mistakes and his errors in judgement, which enhanced his credibility.

Dr. Jugenburg did have a tendency, particularly during his extended cross examination, to avoid answering questions directly, causing him to appear disingenuous and evasive at times. He was, for example, reluctant to admit that his use of social media was partially for the purpose of advertising his services, and reluctant to acknowledge the self-serving aspect of his decision to make a late addition to Patient A's clinical record in the face of the College investigation. In light of his essential admission to the multiple allegations of professional misconduct, however, defensiveness of this nature on the part of Dr. Jugenburg is of no real consequence.

The Evidence of Victoria Cole

Ms. Victoria Cole is a registered nurse who has been a full-time employee of TCSI since April 2016. She received her degree at York University in 2006, and later completed a Master's program at the University of Toronto. Ms. Cole worked in

Labour and Delivery for approximately nine years before joining Dr. Jugenburg's clinic, where she was the operating room manager and circulating nurse.

Ms. Cole testified with regards to both her usual duties at the clinic including with respect to surgical procedures such as those undergone by Patient A, and her specific recollections of Patient A's surgery in 2016. She recalled the presence of the television crew that day, which was an unusual occurrence; indeed, this was the first time that she recalled a television crew being present at the clinic, during the course of her employment there. Ms. Cole stated that her usual practise was to ensure that her patients, and in particular her female patients, were comfortable, and felt safe, supported, and empowered, in preparation for their surgeries. With respect to Patient A, Ms. Cole recalled meeting with her alone in the pre-op room, then walking with her to the operating room, past the television crew who were standing just outside the OR.

Ms. Cole was clear in her evidence that she was not personally involved in obtaining or documenting patient consent, with respect to any issue. She stated that it was her belief, however, that Patient A had agreed to the presence of the television crew at her surgery and that, if she had believed otherwise, she would have informed Dr. Jugenburg of this and the filming would not have proceeded. Ms. Cole was surprised to learn, through a relatively recent discussion with Dr. Jugenburg, that Patient A believed that she had not consented to the presence of the television crew.

The Committee found Ms. Cole to be a credible witness, and had no concerns about the reliability of her evidence. Her testimony was clear, straightforward, and consistent. The Committee accepts Ms. Cole's evidence that she met with Patient A prior to Patient A's surgery, and accompanied her to the OR, walking past the television crew. Ms. Cole's commitment, over the course of her nursing career, to issues of safety and empowerment, particularly with respect to her

female patients, appeared to be strong and genuine. Ms. Cole's evidence supports Dr. Jugenburg's testimony that he believed that he was acting with Patient A's consent to the presence of the television crew at the time of her procedure. Ms. Cole's testimony, however, can have no bearing on the issue of Patient A's actual informed consent on this issue. Obtaining and documenting consent was Dr. Jugenburg's responsibility, and not Ms. Cole's.

DISCUSSION

The vast majority of the facts in this matter have been agreed and are set-out in the Agreed Statement of Facts. Based on these facts, Dr. Jugenburg has admitted that he engaged in conduct relevant to the practice of medicine that would reasonably re regarded as disgraceful, dishonourable or unprofessional. The only real issue in dispute between the parties was whether or not Patient A had provided consent to have the film crew present in the OR.

As with all cases, the onus was on the College to prove the allegations of professional misconduct on a balance of probabilities.

Despite Dr. Jugenburg's admission that he committed professional misconduct, the Committee finds it helpful to clarify, for the benefit of the profession and the public, the specific nature and extent of the misconduct which he committed and the Committee must also address the issue of whether or not Dr. Jugenburg obtained Patient A's informed consent to allow the film crew in the OR.

Patient A

The Committee finds that, in permitting the television crew to film Patient A's surgical procedure, Dr. Jugenburg was acting without her informed consent for this to take place. By proceeding without the consent of his patient, Dr.

Jugenburg engaged in an act which would reasonably be regarded as disgraceful, dishonourable, or unprofessional.

It is clear from the evidence that when the presence of the television crew was first discussed with Patient A during her conversation with Dr. Jugenburg in the pre-op room, her instructions were that she not be filmed. There is no evidence to the contrary on this point. When Patient A first learned that she had appeared on the television news segment contrary to her wishes and that, moreover, a portion of her breast appeared to be briefly visible, she was understandably shocked and dismayed. This was a serious violation of her privacy. Dr. Jugenburg, who had authorized the presence of the television crew during Patient A's procedure, bears responsibility for this breach.

The Committee accepts that Dr. Jugenburg believed, at the time of Patient A's surgery, that he had her agreement for the television crew to be present in order to film him and his assistant, provided that she herself was not filmed. The Committee accepts Dr. Jugenburg's evidence that he would not have proceeded contrary to his patient's expressed wishes. Dr. Jugenburg's belief that he had Patient A's agreement for the presence of the television crew is consistent with the totality of the evidence considered by the Committee, including the testimony of Ms. Cole and the belated entry in Patient A's clinical record. The Committee finds it fundamentally improbable that he would have allowed the television crew to be present knowing that Patient A objected to their presence, particularly since there were other ways in which the news segment could have been completed.

Dr. Jugenburg's belief that he was proceeding with Patient A's agreement to have the film crew in the OR, however, is not a substitute for her informed consent. For consent to be valid, it must be voluntary and informed. While the Committee finds that Dr. Jugenburg did not intend to subject Patient A to coercion, the manner in which he approached the issue of her consent to the presence of the television

crew placed her under some duress, which would have rendered her consent less than completely voluntary. Dr. Jugenburg's discussion with Patient A occurred at virtually the last minute, in a pre-op room shortly prior to the procedure. Patient A was understandably stressed and anxious waiting for her surgery. Her ability to process and reflect on the information presented to her by Dr. Jugenburg would likely have been impaired. Truly informed consent requires time for an adequate explanation of what is being proposed, the anticipated risks which in this case pertain particularly to possible breaches of the patient's privacy, and of the consequences of giving or withholding consent. Patient A. should have been provided with more time to understand and process what was being requested of her, and time to adequately consider the request and ask questions of Dr. Jugenburg, before arriving at her decision. The proposal that her surgical procedure be filmed for television was unusual to say the least, extraordinary in some respects, and accordingly Dr. Jugenburg should have approached the issue of her consent well in advance, and in a much more thoughtful and careful fashion. His discussions with her on this issue should have been contemporaneously documented in the clinical record.

The Committee finds that Dr. Jugenburg's actions in making late additions to Patient A's clinical record, documenting his belief that she was aware that the television crew would be present and that her privacy would be ensured, reflect poor judgement on his part but do not on their own constitute professional misconduct. The Committee accepts that he was not intentionally falsifying the record. For the reasons stated above, however, documentation pertaining to his discussion with Patient A on the presence of the television crew, and on the issue of her consent to this plan, ought to have been made contemporaneously, and in a more complete fashion. The wording of the late entry, and the fact that there is no notation on the record to distinguish it from the contemporaneous material in the OR note, has the potential to mislead. Dr. Jugenburg should have been more open and transparent on the issue of his late addition to Patient A's clinical

record, but we do not find that this failure constitutes disgraceful, dishonourable or unprofessional conduct.

Patient B

Dr. Jugenburg's actions, with respect to the accidental posting of Patient B's images on Snapchat and Instagram contrary to her wishes, would reasonably be regarded as disgraceful, dishonourable, or unprofessional. This was a serious breach of her privacy. Further, Patient B felt pressured to contribute to Dr. Jugenburg's social media platforms, and felt that Dr. Jugenburg was insensitive and more focused on social media than on her recovery. Although the Committee accepts that Dr. Jugenburg was not directly responsible for the breaches of Patient B's privacy, he had overall responsibility for the way in which social media platforms were utilized by his clinic. A greater degree of vigilance was required in order to protect against such serious breaches of patient confidentiality. He was responsible also for ensuring that his patients did not feel pressured or coerced to participate in his social media, which was largely for his benefit, and not the benefit of his patients. Dr. Jugenburg's failure to adequately manage these issues amounts to unprofessional conduct.

The Video Surveillance System

The video surveillance system in Dr. Jugenburg's clinic clearly operated in violation of the privacy interests of the clinic patients, including patients of both Dr. Jugenburg and the other physicians who worked there. Dr. Jugenburg should have been much more attentive to the need to safeguard the privacy of the patients of the clinic, particularly in light of the privacy breaches in relation to Patient A and Patient B, which had recently been brought to his attention. Although the clinic had legitimate security concerns, these did not justify the placement of video cameras in otherwise private patient care areas, where

patients were often undressed and exposed. The rudimentary signage purporting to inform patients of the presence of cameras was wholly inadequate for this purpose. That the patients affected were not informed that they were being recorded precluded any possibility that they could provide consent. The surveillance continued for two years, affecting thousands of patients, without their knowledge or consent. The fact that their recorded images were not disseminated on social media, broadcast to the public in any way or otherwise misused, does not diminish the harmful effects of exposing patients to such an egregious invasion of their privacy. Public trust in the integrity of the medical profession is eroded as a result. It was Dr. Jugenburg's responsibility to safeguard the privacy interests of the patients of his clinic, and his failure to do so amounts to disgraceful, dishonourable, or unprofessional conduct.

FINDINGS

The Committee accepted as correct the facts contained in the Agreed Statement of Facts.

The Committee finds that Dr. Jugenburg:

- permitted a television crew to film Patient A's surgical procedure in 2016, without her informed consent, which resulted in a major breach of her privacy;
- failed to ensure the privacy of Patient B as a result of the inadvertent posting of her images on social media on two occasions, and;
- failed to give adequate consideration to the privacy interests of the patients of TCSI, over a two year period, through the design and operation of the clinic's video surveillance system.

Having regard to these facts, the Committee finds that Dr. Jugenburg committed acts of professional misconduct under paragraph 1(1) 33 of Ontario Regulation

856/93 made under the *Medicine Act, 1991*, in that he engaged in acts or omissions 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 requests that the Hearings Office schedule a Penalty Hearing pertaining to these findings at the earliest opportunity.

DISCIPLINE COMMITTEE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Citation: *College of Physicians and Surgeons of Ontario v. Jugenburg*, 2021 ONCPSD 22

Date: May 12, 2021

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Martin Jugenburg

FINDING AND PENALTY REASONS

Heard: February 1, 2021, by videoconference

Panel:

Dr. Barbara Lent (chair)
Mr. J. Paul Malette, QC
Dr. John Rapin
Ms. Linda Robbins
Dr. Robert Sheppard

Appearances:

Ms. Carolyn Silver and Ms. Sayran Sulevani, for the College
Ms. Nina Bombier, Mr. Paul-Erik Veel and Ms. Brianne Westland, for Dr. Jugenburg
Mr. David Rosenbaum, Independent Legal Counsel to the Discipline Committee

Introduction

[1] In September 2020, the Committee found that plastic surgeon Dr. Jugenburg had committed an act of professional misconduct. Dr. Jugenburg had permitted a television crew to film a patient's surgical procedure without her informed consent, which resulted in a major breach of her privacy. He had failed to ensure the privacy of another patient as a result of the inadvertent posting of her images on social media on two occasions. He also failed to consider adequately the privacy interests of the patients of his clinic, over a two-year period, through the design and operation of the clinic's video surveillance system.

[2] The Committee's reasons for decision on that finding are found at *College of Physicians and Surgeons of Ontario v. Jugenburg*, 2020 ONCPSD 40.

[3] In February 2021, we heard a further allegation of professional misconduct against Dr. Jugenburg. At the conclusion of that hearing, we made a finding of professional misconduct on this new allegation, and we reserved our decision on penalty with regard to all of our findings.

[4] Below are the reasons for our finding regarding the third patient (Patient C), our penalty order with respect to all our findings, and our reasons for penalty.

[5] For the reasons set out below, we order Dr. Jugenburg to appear before the Committee to be reprimanded and direct that his certificate of registration be suspended for six months, to commence 30 days from the date of this order, and that a term, condition and limitation be placed upon it. We also order Dr. Jugenburg to pay the College's costs of $31,110.

Combining the proceedings

[6] Section 9.1(1)(a) of the *Statutory Powers Procedure Act*, RSO 1990, c. S.22, states:

> If two or more proceedings before a Tribunal involve the same or similar questions of fact, law, or policy, the Tribunal may:

(a) Combine the proceedings or any part of them, with the consent of the parties.

[7] On December 23, 2020, Mr. David Wright, Chair of the Discipline Committee, made an order on consent pursuant to section 9.1(1)(a) of the *Statutory Powers Procedure Act* that the allegations against Dr. Jugenburg contained in a new Notice of Hearing dated May 20, 2020 (with respect to Patient C) should be combined with the existing matter (with respect to Patients A and B) into a single proceeding.

Facts & finding on allegation regarding Patient C

[8] The parties submitted an Agreed Statement of Facts on Liability to the Committee for consideration. The agreed facts on liability are summarized below.

[9] Dr. Jugenburg performed three cosmetic surgeries on Patient C on October 16, 2013, including a facelift. Photographs of her face were taken prior to the surgery and at follow-up appointments. Prior to the procedure, Patient C had declined to provide her consent to the use of these photographs for "scientific, educational, or illustrative purposes." She had wished not to be a part of marketing or to be on the internet in any way. She considered her surgery private and of a sensitive nature and she did not want any information about her surgery disclosed publicly.

[10] Five years later, in November 2018, Patient C happened to visit Dr. Jugenburg's website. She was shocked to discover the "before and after" images of her face in the image gallery, with her eyes obscured. She immediately emailed the clinic to notify them that she had not consented to this posting, and to request that the images be immediately removed. This was done, and a member of Dr. Jugenburg's staff apologized to Patient C by email.

[11] With respect to Patient C, the clinic's procedure for verifying patient consent for the posting of patient images on the clinic website had failed. As a result, images of Patient C, which were of a sensitive and personal

nature, were posted without her consent, where they remained on the website for over five years.

Admission to the allegation regarding Patient C

[12] Dr. Jugenburg admitted that based on these facts, he 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, contrary to paragraph 1(1) 33 of O.Reg. 856/93.

Finding regarding Patient C

[13] The Committee accepted as correct the facts contained in the Agreed Statement of Facts on Liability with respect to Patient C, and found that these facts constitute professional misconduct in that Dr. Jugenburg 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.

Penalty

[14] The combined findings on liability which we took into account when considering penalty encompass both:

a. the Committee's findings set out in its decision of September 24, 2020 pertaining to the complainants Patient A and Patient B, referred to in paragraphs 1 and 2, above; and

b. the finding we made on February 1, 2021 with respect to the complainant Patient C, set out in paragraph 13, above.

Agreed Statement of Facts on Penalty

[15] The Agreed Statement of Facts on Penalty, summarized below, set out changes that Dr. Jugenburg has made to his clinic's systems, as well as training that he has undergone, to address the issues that led to the Committee's findings that he had committed professional misconduct.

[16] With respect to the operation of the video surveillance system at Dr. Jugenburg's clinic which led to violations of patient privacy, Dr. Jugenburg agreed to remove security cameras from areas where patient encounters may occur, and to post signage in every location where security cameras were operational, notifying patients that the premises are monitored by video surveillance. He voluntarily entered into an undertaking with the College to this effect, dated February 28, 2019. He has complied with the terms of this undertaking, which remains in effect.

[17] The clinic's policies regarding patient privacy and social media transparency have been updated and revised. The clinic's procedures for obtaining and confirming patient consent for the use of their images on the clinic's website, and on social media platforms have also been revised, and include additional safeguards to ensure that consent, or lack of consent, is always documented and confirmed. Dr. Jugenburg has hired a social media coordinator to prepare and post images and videos to the website and social media and to ensure that appropriate consent is in place. Finally, Dr. Jugenburg has personally reviewed all of the postings on the clinic's website to ensure that each patient has consented to the use of their images.

[18] With respect to Dr. Jugenburg's understanding of the importance of patient privacy and of the sensitivity of confidential personal health information, he has voluntarily undergone training in these areas by completing the Ontario MD Privacy and Security Training Module and a three-part privacy and security course, and he has also undergone individualized coaching. The coach provided a positive report about Dr. Jugenburg's participation, engagement and the benefits achieved.

Positions of the parties

[19] The parties agreed that the penalty for Dr. Jugenburg's professional misconduct should include a public reprimand and a suspension of Dr. Jugenburg's certificate of registration, and that he should be subject to a costs order. However, they disagreed on the length of the suspension and the amount of costs that should be awarded.

[20] The College requested a suspension of Dr. Jugenburg's certificate of registration for 12 months and an order that Dr. Jugenburg pay costs of $41,480 to the College for four days of hearing.

[21] Counsel for Dr. Jugenburg submitted that the suspension of Dr. Jugenburg's certificate of registration should be for three months and that the costs order should be for $20,740, for two days of hearing.

[22] In addition, the College sought an order that a term, condition and limitation be placed on Dr. Jugenburg's certificate of registration that he completes one-on-one instruction in professionalism, communications and informed consent with an instructor selected by the College.

Reasons for penalty

[23] The principles guiding the imposition of penalty in disciplinary proceedings are well-known and not in dispute. Foremost is the protection of the public. The penalty imposed should also denounce wrongful conduct, assist in maintaining public confidence in the integrity of the profession and in the profession's ability to regulate itself effectively in the public interest, serve as a specific deterrent to the member and as a general deterrent to the membership as a whole and, where applicable, attempt to address the rehabilitative needs of the member. The penalty imposed should be proportionate to the misconduct committed and should generally be consistent with previous decisions in similar cases.

The nature of the misconduct

[24] There are several facets to Dr. Jugenburg's professional misconduct.

[25] First, Dr. Jugenburg failed to appreciate the importance of informed consent. This failure is reflected in his authorizing the presence of a television news crew in the operating room for Patient A's surgical procedure, following his brief, last-minute discussion with her which was inadequate for the purposes of obtaining her consent to this event. This culminated in a major violation of Patient A's privacy, when she was filmed for television contrary to her wishes. Furthermore, the procedure that Dr. Jugenburg implemented in his clinic to secure patient consent to have their

images posted on his social media platforms was inadequate. The result, again, was breaches of confidentiality and patient privacy, for which Dr. Jugenburg bears responsibility.

[26] Second, Dr. Jugenburg was alarmingly insensitive to his patients' privacy interests. This is most obviously reflected in his decision to implement and operate a surveillance system at his clinic, prominently including patient care areas, which resulted in the recording of visual images of thousands of patients, often unclothed or partially clothed, most of whom had no knowledge that this system was in operation. Dr. Jugenburg's insensitivity to patient privacy concerns extended also to his use of social media. Patient B felt pressured to participate in social media. Although there was no overt coercion in this regard, Dr. Jugenburg seems to have been oblivious to the risks of posting highly personal patient images and to the potential for this practice to have a negative impact on the emotional well-being of his patients. In the case of Patient C, the failure of his clinic's procedure for verifying patient consent to the posting of her images was Dr. Jugenburg's responsibility as the director of the clinic and as the physician responsible for her care. As is clear from the evidence, some patients were seriously traumatized by these breaches of their privacy.

[27] Third, there is a troubling pattern of Dr. Jugenburg pursuing his own interests, in terms of the perceived security needs of his clinic and of his interests in publicity and in cultivating a strong social media presence, at the expense of the privacy of his patients. Physicians must always be aware, however, of the power imbalance inherent in the doctor/patient relationship and must exercise vigilance to ensure that they are not using their patients for their own purposes. Otherwise, public trust in the medical profession and public confidence that patient interests are always at the forefront of medical practice will be eroded.

[28] Fourth, as a result of the actions referred to above, Dr. Jugenburg caused harm to some of his patients. The violations of their privacy, in circumstances where they had a legitimate expectation that their most private personal health information would be protected, caused some

patients to feel distressed and traumatized. The fact that not all patients suffered harm is to be expected, as patients have different vulnerabilities and differing ways of processing and adapting to circumstances. This does not, however, diminish the negative impact that Dr. Jugenburg's actions had on some.

[29] We accept that Dr. Jugenburg did not intend to harm his patients. By his actions, however, he demonstrated a reckless disregard for their privacy interests in pursuit of his own objectives. He should have been more aware of his patients' vulnerabilities and of the risks to which he was exposing them. This was a very serious failure of professionalism.

[30] The responsible use of social media in medical practice is a relatively novel issue. This may well present new and unfamiliar challenges to physicians, such as how to ensure that consent is properly obtained, and that the interests of participating patients, including with respect to confidentiality and privacy, remain paramount. A physician whose practice includes a social media component has an obligation to ensure that the imperatives of good clinical care, in all its aspects, are respected.

[31] We considered the letters and emails of support for Dr. Jugenburg, both from his patients and from his colleagues. We accept that some of Dr. Jugenburg's patients, perhaps many, are very satisfied with the care that he provided, and that some were not troubled by his video surveillance system. Similarly, we accept that some of Dr. Jugenburg's colleagues hold his clinical skills in high regard.

[32] In arriving at a decision on penalty, however, we place little weight on these expressions of support. The fact that many patients were not harmed by Dr. Jugenburg's actions does not diminish the harm sustained by some which, in light of the impact statements we reviewed, was severe. Dr. Jugenburg's clinical knowledge and skills cannot lessen the impact of the other areas of clinical practice, notably judgment and sensitivity to patient vulnerabilities, in which he was lacking.

Aggravating factors

[33] The most prominent aggravating factor, in our view, is the multifaceted and longstanding nature of Dr. Jugenburg's professional misconduct.

[34] Dr. Jugenburg's misconduct affected many patients, numbering in the thousands with respect to the video surveillance system, and persisted over a period of years. The magnitude of the misconduct is an aggravating factor.

[35] An additional aggravating factor is that, initially, Dr. Jugenburg's understanding of the risks to which he was exposing his patients was slow to develop. He was warned in late 2016 of patient concerns with respect to privacy violations on social and other media, yet he nevertheless proceeded with installing a video surveillance system that resulted in even more egregious and ongoing violations of patient privacy. Similarly, with respect to patient consent to appear on social media, it wasn't until relatively recently that Dr. Jugenburg took the initiative to personally review all postings to ensure that consent was in place. He should have acted more expeditiously to address the concerns brought to his attention. By failing to do so, he conveyed the impression that, at the time, he still wasn't considering these issues to be a high priority.

Mitigating factors

[36] The strongest mitigating factor, in our view, is that it appears that Dr. Jugenburg has now taken full responsibility for his misconduct. His insight, albeit slow to develop as noted above, now appears to be good.

[37] We note that Dr. Jugenburg did not contest the vast majority of the multiple allegations made by the College. This allowed much of the hearing to proceed by way of an Agreed Statement of Facts, thus reducing hearing time and associated costs and sparing most of the complainants from having to testify.

[38] Dr. Jugenburg has taken steps to improve the procedures in his clinic to obtain patient consent to the use of their images on social media. He has

revised his written consent form, instituted safeguards to ensure that consent or lack thereof is clear and hired a social media coordinator to assist with this process. Although the College took issue with some of the revisions, suggesting that Dr. Jugenburg was still not giving adequate attention to consent, we find that his efforts to improve his clinic's procedures in this area do speak to his improved insight.

[39] Dr. Jugenburg has accepted that his understanding of issues pertaining to patient privacy and the sensitivity of health care information was deficient. He has pursued remediation in the areas in which his knowledge and judgment were lacking, as evidenced by the rehabilitative programs and counselling which he has undertaken, notably the Ontario MD Privacy and Security Training Module, Privacy and Security for Toronto Academic Health Science Network (TAHSN) hospitals, and individual counselling pertaining to Health Privacy Coaching for Physicians with Kate Dewhirst of Kate Dewhirst Health Law. Dr. Jugenburg's commitment to his rehabilitation is a strong indicator of his insight and his sincerity in addressing his deficiencies.

[40] Dr. Jugenburg responded to the privacy concerns raised by his surveillance system by disabling the system and replacing it eventually with a new one, which better safeguarded patient privacy. He also made an attempt to notify patients, after the fact, about what had occurred with the previous system. We find that this attempt, albeit somewhat belated, to correct a surveillance system whose flaws should have been apparent from the outset, eventually resulted in positive change.

[41] Finally, the Committee finds that Dr. Jugenburg's lack of a prior disciplinary history with the College is a mitigating factor. Although this could logically also be seen as simply the absence of an aggravating factor, previous decisions of the Discipline Committee have found it to be mitigating and, in any event, the effect is the same. This is not a case of a physician who has failed to learn from previously imposed sanctions, leading to possible inferences of intractable deficiencies in insight, poor response to remediation, or ungovernability. With respect to Dr. Jugenburg there is, in

fact, evidence to the contrary which hopefully suggests a favourable prognosis.

Prior cases

[42] A general principle guiding the imposition of penalty is that similar factual circumstances should attract similar penalties. Although not binding on the Committee, prior decisions of the Discipline Committee in similar cases can assist the Committee by providing guidance as to an appropriate range of penalties and enhancing consistency in the regulatory process to the benefit of the profession and the public.

[43] In considering the prior cases that were presented to us, we note that the facts of this case are unique. Although there are prior cases pertaining to the importance of informed consent and to the misuse of personal health information, and cases involving the surreptitious recording of patients and others without their knowledge, in none of these cases are the facts similar to those in Dr. Jugenburg's case. The parties acknowledged that this was so.

[44] That said, some of the cases we reviewed raised issues that resonated with some aspects of Dr. Jugenburg's misconduct and provided some guidance for what an appropriate length of suspension might be.

[45] In *College of Physicians and Surgeons of Ontario v. Brooks*, 2016 ONCPSD 29, Dr. Brooks misused his status as a regulated health professional to access the confidential health records of two individuals with whom he had a close personal connection, resulting in a serious breach of confidentiality and violation of these patients' rights to privacy. Dr. Brooks accepted responsibility and the Committee found he had engaged in disgraceful, dishonourable or unprofessional misconduct. The Committee ordered a five-month suspension of his certificate of registration, a reprimand, a requirement that he complete individualized instruction in medical ethics and that he pay costs of $5,000. This case differs from Dr. Jugenburg's in that, among other things, Dr. Brooks had a personal connection with the complainants whose personal health information he misused.

[46] In *College of Physicians and Surgeons of Ontario v. Di Paola*, 2016 ONCPSD 48, Dr. Di Paola repeatedly accessed confidential and sensitive personal health information of two patients at the Centre for Addiction and Mental Health, over a two year period, without consent or legal authority. Dr. Di Paola had a close personal connection with both patients. She admitted to the allegations and the Committee found she had engaged in disgraceful, dishonourable or unprofessional conduct. The Committee ordered a reprimand, a suspension of Dr. Di Paola's certificate of registration for three months, that Dr. Di Paola complete individualized instruction in medical record-keeping and that she pay costs of $5,000. We note, again, that Dr. Jugenburg had no personal connection with any of the patients whose personal health information he misused, in contrast to Dr. Di Paola, and thus his motivations were quite different.

[47] Dr. Jugenburg referred to several cases that involved nurses who misused their authority as regulated health professionals to improperly access medical records of patients not under their care, or of other individuals known to them (*College of Nurses of Ontario v. Quinn*, 2018 CanLII 62038 (ON CNO); *College of Nurses of Ontario v. Church-Labrie*, 2020 CanLII 45992 (ON CNO); *College of Nurses of Ontario v. Trudel*, 2018 CanLII 62040 (ON CNO)). The Discipline Committee of the College of Nurses of Ontario ordered, amongst other things, suspensions in these cases of either three or four months.

[48] Dr. Jugenburg also relied on *Ontario College of Pharmacists v. Shenouda*, 2018 ONCPDC 10. In that case, the Ontario College of Pharmacists Discipline Committee found that a pharmacist had breached patient privacy by posting prescriptions on a Facebook page, accessible to a large number of people in a public forum. The Committee ordered, amongst other things, that the pharmacist's certificate of registration be suspended for three months total, two months of which could be remitted by participation in remediation.

[49] In *College of Physicians and Surgeons of Ontario v. Jiaravuthisan*, 2016 ONCPSD 50, Dr. Jiaravuthisan, in his physical examinations of two

patients, failed to communicate adequately with them about the nature and purpose of his examinations, failed to ensure patient understanding and consent and failed to respect the dignity and privacy of his patients. Dr. Jiaravuthisan admitted the facts as alleged, and that this conduct would reasonably be regarded as disgraceful, dishonourable or unprofessional. He undertook with the College to resign his certificate of registration and not to reapply, and the Committee ordered a reprimand and costs of $5,000. A significant distinguishing feature of this case from Dr. Jugenburg's is that Dr. Jiaravuthisan failed to take sufficient care to maintain spatial boundaries: with both patients he placed his hands on a sensitive area without warning or explanation.

[50] By contrast, several other cases submitted were so different from Dr. Jugenburg's case that we did not consider them to provide much guidance, if any.

[51] In *College of Physicians and Surgeons of Ontario v. Martin*, 2018 ONCPSD 61, Dr. Martin, amongst other deficiencies in his care of two transgender adolescents, failed to obtain properly informed consent in the prescription of cross-sex hormones. He admitted the facts as alleged, admitted that he had failed to maintain the standard of practice of the profession, and admitted that he was incompetent. Dr. Martin had a prior disciplinary history with the College with respect to a range of issues and this was an aggravating factor. Dr. Martin resigned from the College and undertook not to reapply for registration to practise medicine in Ontario or elsewhere. The Committee ordered a reprimand and costs of $6,000. This case was significantly different from Dr. Jugenburg's: the misconduct involved adolescent patients, Dr. Martin's treatment decisions posed a significant risk of harm, and there were findings of both a "gross failure" to meet the standard of practice and incompetence.

[52] In *College of Physicians and Surgeons of Ontario v. Hwang*, 2019 ONCPSD 33, Dr. Hwang surreptitiously made audio and video recordings of a number of individuals, most of them not patients, in an intensely invasive manner resulting in egregious violations of their privacy. He was

criminally charged with voyeurism contrary to Section 162 of the *Criminal Code*, convicted, and sentenced. In the disciplinary proceedings, Dr. Hwang entered a plea of no contest to allegations of disgraceful, dishonourable or unprofessional conduct, conduct unbecoming a physician, and having been found guilty of an offence relevant to his suitability to practise medicine. The Committee accepted a joint submission and ordered that Dr. Hwang's certificate of registration be revoked, that he be reprimanded, and that he pay costs of $6,000. This case bears little similarity to that of Dr. Jugenburg, aside from the fact of the video recordings made without patient knowledge or consent, as Dr. Hwang's conduct was criminal in nature and his motivation was the expression of deviant sexuality.

[53] A general conclusion, based on the above, is that misconduct by regulated health professionals involving breaches of patient privacy, misuse of personal health information, and disregard for informed consent attracts significant sanctions including reprimands, costs and often suspensions of various lengths of up to several months in duration. However, given the unique set of facts that make up Dr. Jugenburg's case, the prior decisions are of limited assistance in assessing what an appropriate length of suspension would be in this case.

Decision on penalty

[54] Dr. Jugenburg is to appear before us to be reprimanded. A public reprimand is expected to send a strong message to Dr. Jugenburg, to the profession and, importantly, to the public that the misconduct committed by Dr. Jugenburg is serious, unacceptable and that it needs to be denounced in the strongest terms.

[55] We find that a significant suspension of Dr. Jugenburg's certificate of registration is required in order to fairly express the principles of denunciation of wrongful conduct, specific and general deterrence and maintenance of public confidence in the reputation and integrity of the profession. Dr. Jugenburg, by his actions, permitted egregious violations of patient privacy which affected a great many patients over a prolonged

period of time. His actions had a lasting effect on some of his patients, leaving them in some cases traumatized, with diminished trust in the medical profession. Patients have a right to know that their personal health information will remain confidential, safe and secure. Particular vigilance is required in safeguarding the sort of sensitive personal images such as those captured in a cosmetic surgery practice. Dr. Jugenburg's seeming indifference to these issues was appalling and is deserving of significant sanction.

[56] That said, we find that Dr. Jugenburg's accepting responsibility for his misconduct, his development of insight and his commitment to remediation in the areas in which his understanding and judgment were lacking, constitute a strong mitigating factor. We are satisfied that he has the ability to learn from his mistakes, and that he has developed a better understanding into issues of patient privacy and consent. Remediation of the member is an important aspect of penalty.

[57] Balancing the severity of the misconduct committed with the positive steps Dr. Jugenburg has taken with respect to rehabilitation and his potential for a successful return to practice, a six-month suspension of Dr. Jugenburg's certificate of registration is fair, necessary, and appropriate.

[58] At the hearing, the College requested that the suspension of Dr. Jugenburg's certificate of registration commence 15 days after the date of our order. Dr. Jugenburg submitted a draft order that called for the suspension to begin 30 days after the date of the order. The Committee invited the parties to deliver written submissions as to the appropriate start date. The College indicated that the decision was in our hands. We were satisfied based on submissions from Dr. Jugenburg that the appropriate start date was 30 days after the date of our order. This will allow Dr. Jugenburg time to communicate with his patients, address any time-sensitive appointments and arrange for referrals to other surgeons for patients who wish to have their procedure during the time Dr. Jugenburg is suspended, as well as provide timely notice to his employees.

[59] We include a term in our order requiring Dr. Jugenburg to take one-on-one instruction in professionalism, communication and informed consent with an instructor selected by the College. This instruction is to be somewhat broader in scope and more tailored to the particular areas of Dr. Jugenburg's practice than the remediation which he has undertaken thus far. The instruction will solidify and expand on the gains he has made. The protection of the public will be enhanced as a result.

[60] Finally, we agree with the parties that this is a suitable case in which to order costs. We order Dr. Jugenburg to pay costs to the College, at the usual tariff rate, equivalent to three hearing days. This is a fair division of costs between the parties, at a hearing in which the College was mostly, but not entirely, successful in proving its case.

Order

[61] The Discipline Committee orders and directs:

1. Dr. Jugenburg is to attend before the panel to be reprimanded.

2. The Registrar is to suspend Dr. Jugenburg's certificate of registration for a period of six months, commencing 30 days after the date of this order.

3. The Registrar is to place the following term, condition and limitation on Dr. Jugenburg's certificate of registration effective immediately:

    a. Dr. Jugenburg shall successfully complete one-on-one instruction in professionalism, communication, and informed consent with an instructor selected by the College within 60 days of the date of this order.

4. Dr. Jugenburg is to pay costs to the College of $31,110 within 30 days of the date of this order.