NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Schwarz, this is notice that the Discipline Committee ordered a ban on the publication, including broadcasting, of the names of patients, or any information that would identify patients, referred to orally or in the exhibits filed at the hearing, 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. Schwarz, 2020 ONCPSD 18

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. PETER ROBERT SCHWARZ

PANEL MEMBERS: **MR. J.P. MALETTE, Q.C (CHAIR) -**
DR. ANDREW TURNER
DR. ERIC STANTON
MS ELLEN MARY MILLS
DR. KRISTEN HALLETT

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS RUTH AINSWORTH

COUNSEL FOR DR. SCHWARZ:

MR. WAYNE BRYNAERT

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS JENNIFER MCALEER

Hearing Date: February 19, 2020
Decision Date: February 19, 2020
Release of Reasons Date: April 15, 2020

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on February 19, 2020. Following the conclusion of the hearing, the Committee released a written order stating its finding that the member is incompetent and committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession in his care of patients, and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATION

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

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

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

3. under paragraph 1(1)1 of O. Reg. 856/93, in that he contravened a term, condition or limitation on his certificate of registration.

The Notice of Hearing further alleged that Dr. Schwarz is incompetent.

FACTS AND ADMISSION

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

PART I – FACTS

Dr. Schwarz

1. Dr. Peter Robert Schwarz ("Dr. Schwarz") is a 51-year-old family physician. He received his certificate authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College") in 1995. He obtained CCFP certification on June 13, 1995.

2. At the relevant times, Dr. Schwarz practiced as a general/family physician in a solo practice in Sault Ste Marie, Ontario.

Background

3. In August 2016, in the context of another investigation, the College obtained Narcotics Monitoring System information regarding Dr. Schwarz's prescribing to patients. The College subsequently obtained Cumulative Patient Profiles for 12 drop-in patients to whom Dr. Schwarz prescribed opioids and controlled substances.

Incompetence / Failure to Maintain the Standard of Practice

4. On March 28, 2017, on the basis of the information set forth in paragraph 3, the Inquiries, Complaints and Reports Committee of the College ("ICRC") approved an appointment of investigators to inquire into whether Dr. Schwarz had committed professional misconduct in his prescribing and medical record keeping.

5. The College selected 25 charts to review, including the 12 drop-in patients.

6. Dr. Schwarz provided complete charts for 5 of the 25 patients. With respect to the remaining 20 patients, Dr. Schwarz was unable to confirm that he had provided complete patient records. Counsel for Dr. Schwarz advised that these patients were

drop-in patients for whom Dr. Schwarz had not initially opened a patient record. Instead, he had filed notes for these patient encounters “by date”.

7. Counsel for Dr. Schwarz advised that Dr. Schwarz had recently taken a Medical Record Keeping Course following which he had changed his practice and now opened a chart for all drop-in patients.

8. Counsel for Dr. Schwarz confirmed that Dr. Schwarz would not have seen prior records (i.e., records filed “by date” and not by patient name) at the time of any drop-in patient’s subsequent visit.

Reports of Dr. Chris Giorshev

9. The College retained the services of Dr. Chris Giorshev, a family physician with expertise in emergency medicine, chronic pain management and addictions medicine, to provide an independent expert opinion on the care provided by Dr. Schwarz to the 25 patients. Dr. Giorshev interviewed Dr. Schwarz and reviewed his patient charts.

10. Dr. Giorshev’s report dated December 10, 2017 and addendum report dated January 3, 2018 are attached at Tabs 1 and 2 to, and form part of, the Agreed Statement of Facts and Admission. Dr. Giorshev’s curriculum vitae is attached at Tab 3 to the Agreed Statement of Facts and Admission.

11. In his report, Dr. Giorshev opined that Dr. Schwarz did not meet the standard of practice of the profession, demonstrated a lack of judgment, and posed a risk of harm to patients in 23/25 of the charts reviewed.

12. Dr. Giorshev identified significant deficiencies in Dr. Schwarz’s care of patients which he categorized into two groups – chronic pain and addiction patients.

i. Chronic Pain Patients

1. Decision to initiate opioids for pain patients:

- Dr. Schwarz's decision to initiate opioids was far below the standard of care, demonstrated a lack of judgment and posed a risk of harm to patients and/or the public (in terms of drug diversion). This included:

    - Failure to perform a comprehensive documentation of the patient's pain condition, general medical condition and psychosocial history, psychiatric status, and substance abuse history, such that it was not possible to understand what Dr. Schwarz was treating based on the documentation;

    - Failure to independently confirm patients' self-reported prescribing history before prescribing opioids. That is, patients reported to Dr. Schwarz that they were taking opioids (including at high doses) and Dr. Schwarz began prescribing opioids to these patients without confirming the pre-existing prescription. This placed patients at high risk of overdose and death if they were in fact opioid naïve, and placed the public at risk resulting from drug diversion;

    - Failure to risk stratify patients;

    - Failure to determine if patients had a pain condition where opioids were indicated;

    - Failure to perform urine drug screens;

    - Failure to document informed consent discussion.

2. Conducting an opioid trial/long-term monitoring opioid therapy:

- Dr. Schwarz fell below the standard of care, demonstrated a lack of judgment and posed a risk of harm to patients and/or the public with respect to conducting an opioid trial and long-term monitoring of opioid therapy. This included through:

    - Failure to document whether patients were advised to avoid driving until a stable dosage was achieved. A sedated driver is a risk to both the patient and the public;

    - Failure to reasonably document monitoring of aberrant behaviour or use urine drug screens;

    - Failure to adequately address aberrant behaviour when it arose (Dr. Giorshev noted there were multiple instances of early release for self-escalation and lost or stolen medications documented in the individual case summaries), which posed a high risk of harm for patients and the public;

    - Failure to document risk discussion pertaining to combining sedating medications with high dose opioids. This included, in one case, prescribing an elderly patient extremely high dose opioids as well as benzodiazepines, without documenting or evaluating the risks, which included a high risk of death for this patient.

ii. Addictions Patients

- Dr. Schwarz's care of addictions patients fell below the standard of care, demonstrated a lack of judgment and posed a risk of harm to patients and/or the public. This included through:

- Failure to document an adequate evaluation of the patient's clinical conditions prior to prescribing Suboxone;
- Failure to document a diagnosis of opioid dependence to justify prescribing Suboxone;
- Failure to document contraindications to the prescribing of Suboxone, including during pregnancy, and failure to perform pregnancy tests prior to initiating Suboxone on female patients. This put both the patient and any possible fetus at risk;
- Failure to adhere to the Centre for Addiction and Mental Health (CAMH) clinical practice guidelines, in that he:
    - Failed to document withdrawal prior to induction. Patients who are initiated on Suboxone without being in withdrawal can experience precipitated withdrawal, which is dangerous for the patient;
    - Failed to reassess patients within one to three days of induction or otherwise follow up with patients in a timely fashion. Often, he did not see patients for a month or two following induction;
    - Failed to monitor clinically unstable patients as frequently as required. Clinically unstable patients require more frequent monitoring, but Dr. Schwarz saw patients once or twice per month regardless of the patient's clinical stability;
    - Prescribed double the recommended starting dose of Suboxone;
    - Failed to supervise patients' doses during the first two months of treatment;
    - Provided inappropriate take-home doses, including to patients who had not achieved clinical stability. Dr. Giorshev found that Dr. Schwarz's care deviated markedly from the CAMH guideline and the standard of care, as he routinely gave patients 5-6 carries from the outset, including to patients who did not display clinical stability. Inappropriately giving take-home doses to unstable

addictions patients represents a significant risk for diversion and a significant harm to the patient and the public;

- Performed urine drugs screens infrequently (once every one or two months, rather than twice a week to biweekly), a routine which can easily be gamed by addictions patients;

- Inappropriately permitting a patient's mother to supervise her son's urine drug screen. Dr. Giorshev opined that this represented inappropriate monitoring.

iii. Individual Patient Concerns

13. Further concerns relating to individual patients are set out in Dr. Giorshev's report, dated December 10, 2017, at pp. 9-49.

14. In addition, Dr. Giorshev highlighted two particularly troubling cases at p. 5 of his report.

iv. Dr. Giorshev's Interview of Dr. Schwarz

15. Dr. Giorshev interviewed Dr. Schwarz on December 8, 2017 in order to understand if his deficiencies resulted from a lack of knowledge skill or judgment. Dr. Giorshev was satisfied that there was no significant lack of knowledge; however, he opined that this interview raised additional concerns regarding Dr. Schwarz's significant lack of judgment in his care of chronic pain and addictions patients. Dr. Giorshev outlined these additional concerns in his report dated December 10, 2017 at pp. 6-7.

v. Lack of Oversight and Reliance on Pharmacists

16. Dr. Giorshev opined that one of the most concerning issues in his review of Dr. Schwarz's care related to Dr. Schwarz's lack of oversight of addictions patients (i.e., failure to ensure withdrawal prior to induction; failure to assess patients in a timely manner after induction, and failure to assess patients frequently enough to ensure they were benefitting from the therapy and were not being harmed). When asked about this in his interview, Dr. Schwarz responded that pharmacists in his area were experienced in dispensing Suboxone, and that he expected that pharmacists would continually reassess his patients and then recommend or make dose adjustments along the way. Dr. Schwarz specifically described that the pharmacist would be the clinical assessor for his patients, and that he relied on the pharmacist to manage patients.

17. Dr. Giorshev noted that as the physician, Dr. Schwarz is responsible for the evaluation and reassessment of patients. He is responsible for ensuring that the patients are receiving proper care. It is outside the scope of practice of pharmacists to practice medicine and it is not legal for them to independently change an opioid prescription. Dr. Giorshev opined that Dr. Schwarz's lack of oversight demonstrated a significant lack of care for his patients and significant lack of judgment that was a risk of harm to his patients and the public.

18. On February 7, 2018, two pharmacists who dispensed Suboxone to patients of Dr. Schwarz were interviewed by the College investigator. Pharmacist A advised that he had been dispensing Suboxone to Dr. Schwarz's patients for four to five years. Pharmacist B advised that he had been doing so for three to four years.

19. The pharmacists advised of a number of steps they took with respect to Suboxone patients (such as taking a medical history, explaining the difference between addiction and drug dependence, monitoring the first dose for adverse reaction and requiring patients to adhere to a prescribing schedule).

20. With respect to ensuring withdrawal prior to induction, both pharmacists advised that they would confirm patients were in withdrawal prior to providing the first dose of Suboxone. However, it was understood and agreed that Dr. Schwarz would also verify withdrawal prior to issuing the prescription;

21. With respect to assessing patients:

- Both pharmacists advised that their pharmacies monitored patients for aberrant behaviour. However, neither pharmacy completed urine drug screens;
- The pharmacists advised that they monitored patients for missed or withheld doses and would communicate with Dr. Schwarz regarding missed or withheld doses;
- Pharmacist A advised that his pharmacy did complete clinical assessments to determine if dosing was appropriate. However, Pharmacist A assumed that Dr. Schwarz was also completing clinical assessments. He assumed that Dr. Schwarz was reassessing patients over the course of a prescription to ensure that the medication and dosing were appropriate for the patient;
- Pharmacist B advised that his pharmacy did not clinically assess patients. He assumed that Dr. Schwarz was completing clinical assessments, including over the duration of a prescription. He stated that it was his understanding that Dr. Schwarz was responsible for the patient;

22. With respect to dosing adjustments:

- Pharmacist A advised that if he had concerns regarding the patient's dose, he may provide recommendations to Dr. Schwarz. He would not make dosing adjustments himself, as he is not allowed to do so as a pharmacist;

- Pharmacist B advised that he did not make any dosing adjustments or recommendations for dosing changes. If the patient had concerns with their doses, he would advise the patient to follow-up directly with Dr. Schwarz.

ICRC's Interim Order and Cessation of Prescribing

23. On November 28, 2017, after receiving an interim report from Dr. Giorshev and a response from Dr. Schwarz, the ICRC imposed an interim order pursuant to s. 25.4 of the Health Professions Procedural Code, prohibiting Dr. Schwarz from prescribing narcotics and other controlled or monitored substances, unless under the guidance of a clinical supervisor. A copy of the Order made under s. 25.4 is attached at Tab 4 to the Agreed Statement of Facts and Admission.

24. Dr. Schwarz did not obtain a clinical supervisor. Consequently, on January 13, 2018, he ceased prescribing narcotics and other controlled or monitored substances.

25. On January 30, 2018, Dr. Schwarz advised the College, through counsel, that he did not wish to maintain or seek reinstatement of his prescribing privileges.

PART II – ADMISSION

26. Dr. Schwarz admits the facts set out above and admits that, based on these facts, he:

a) committed an act of professional misconduct 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

b) is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code.

WITHDRAWAL

The College withdrew allegations (2) and (3) in the Notice of Hearing, i.e., that Dr. Schwarz had 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; and that Dr. Schwarz had contravened a term, condition or limitation on his certificate of registration.

FINDING

The Committee accepted as correct all the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Schwarz's admission and found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession, and that he is incompetent.

PENALTY AND REASONS FOR PENALTY

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

Discipline Committee History

1 . On March 8, 2019, the Discipline Committee found that Dr. Schwarz had engaged in professional misconduct, in that he engaged in sexual abuse of a patient and engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be considered by members as disgraceful, dishonourable or unprofessional. A copy of the decision of the Discipline Committee on liability is attached at Tab 1 to the Agreed Statement of Facts Regarding Penalty.

2. On December 2, 2019, the Discipline Committee imposed a penalty including the immediate revocation of Dr. Schwarz's certificate of registration, requiring Dr. Schwarz to reimburse the College for costs related to the patient under program required by section 85.7 of the Code and to appear at the College for a reprimand, and the payment of costs to the College. A copy of the decision of the Discipline Committee on penalty is attached at Tab 2 to the Agreed Statement of Facts Regarding Penalty.

Public Complaints Resulting in Cautions and SCERPs

3. On November 14, 2013, the Inquiries, Complaints and Reports Committee of the College ("ICRC") decided to issue a written caution to Dr. Schwarz regarding his care of a patient and, in particular, regarding his follow-up when symptoms change; conducting an examination when indicated; ensuring a prompt referral; and having a process in place to track referrals. The Committee also directed Dr. Schwarz to complete a Specified Continuing Education or Remediation Program ("SCERP"), whereby it required him to complete a Record-Keeping Course and to undergo a reassessment. A copy of the ICRC Decision and Reasons dated November 14, 2013 is attached at Tab 3 to the Agreed Statement of Facts Regarding Penalty.

4. In November 2009, the ICRC decided to require Dr. Schwarz to attend at the College to be cautioned regarding his care of a patient and, in particular, regarding the presentation of laryngeal cancer and the steps necessary to achieve a timely diagnosis and referral for patients presenting with this condition. A copy of the ICRC Decision and Reasons dated November 2009 is attached at Tab 4 to the Agreed Statement of Facts Regarding Penalty.

Record-Keeping Course

5. Dr. Schwarz completed a course on medical record-keeping at the University of Toronto on June 23, 2014. A certificate of completion is attached at Tab 5 to the Agreed Statement of Facts Regarding Penalty.

JOINT SUBMISSION

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

Although the Committee has discretion to accept or reject a joint submission on penalty, the law provides that the Committee should not depart from a joint submission, unless the proposed penalty would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R. v. Anthony-Cook,* 2016 SCC 43).

Penalty Principles

When considering an appropriate penalty order, the Discipline Committee is guided by the following principles: public protection; maintaining the reputation and integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest; deterrence of the member; general deterrence of the profession; and the opportunity for member rehabilitation. The Committee also considers the principles of proportionality and denunciation of the misconduct.

Aggravating Factors

Dr. Schwarz has a history with the Discipline Committee. In March 2019, the Committee found he had engaged in professional misconduct, in that he engaged in sexual abuse of a patient and engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be considered by members as disgraceful, dishonourable or unprofessional. Dr. Schwarz's certificate of registration was revoked as a result of that finding.

In November 2013, the College's Inquiries, Complaints and Reports Committee issued a written caution to Dr. Schwarz and he was directed to complete a SCERP that included a Record-Keeping Course. Dr. Schwarz completed the course in June 2014. Despite his

taking this course, it is clear that Dr. Schwarz continued to have significant difficulties with record keeping. The fact that he was either unwilling or unable to improve his record keeping, despite prior intervention by the College on this very issue, is an aggravating factor.

Turning to the nature of the misconduct, Dr. Schwarz's actions demonstrated unsafe prescribing practices and incompetent record-keeping practice. Both deficiencies threaten public safety directly and indirectly. Failure to obtain a proper history and medical screening before prescribing any drug puts a patient at risk of medical harm. When prescribing narcotics and controlled drugs, there is additional risk of patient addiction and community harm. Given the vulnerability of this patient population and the societal concerns regarding the prescription of narcotics and controlled substances, the Committee found the nature of the misconduct to be an aggravating factor.

Further concerning to the Committee is Dr. Giorchev's opinion that Dr. Schwarz did not lack knowledge to make changes to his practice. Rather, Dr. Schwarz exhibited lack of care, judgment and insight. While lack of insight is not an aggravating factor, the Committee was concerned that the misconduct in this case exhibited a cavalier and reckless approach to the prescription of narcotics and controlled substances. This mindset risks the health of all patients and particularly those with addictions. It is a frightening reflection on the profession, and constitutes another aggravating factor.

Mitigating Factors

The Committee finds that Dr. Schwarz's admission that he committed an act of professional misconduct is the only mitigating factor. This meant that witness and expert testimony were not needed at a hearing and avoided the time and cost of a contested hearing.

Prior Cases

In *Ontario (College of Physicians and Surgeons of Ontario)* v. *Kingstone*, 2006 ONCPSD 11, the Committee found that Dr. Kingstone had committed an act of professional misconduct in that he failed to maintain the standard of the profession regarding his prescribing of narcotics, controlled drugs and substances, and with respect to record-keeping. Dr. Kingstone had pleaded no contest to the allegation and the parties made a joint submission with respect to penalty The Committee ordered that Dr. Kingstone be permanently prohibited from prescribing narcotics and that he not prescribe other Schedule I to IV drugs, except when such prescription was co-signed by a physician acceptable to the College. Further, Dr. Kingstone was required to keep a log for all such prescriptions. It was ordered that Dr. Kingstone would be suspended from practice for six months, with three months suspended if he successfully completes the College's prescribing course. A clinical supervisor was also required to oversee his practice for a minimum of one year. The Committee took note of the mitigating factor of Dr. Kingstone's long years of honourable service to the profession and to his speciality. It also noted the evidence of Dr. Kingstone's kindness and genuine caring for his patients. Thus, his skills and value were recognized in allowing him a path back to independent practice.

In the more recent case of *Ontario (College of Physicians and Surgeons of Ontario)* v. *Syed*, 2018 ONCPSD 23, the Committee found that Dr. Syed had failed to maintain the standard of practice of the profession, in that he inappropriately prescribed opiates in combination with other potent drugs. Dr. Syed admitted the allegation and the parties made a joint proposal with respect to penalty. The Committee ordered: i) a reprimand, ii) a suspension of Dr. Syed's certificate of registration for two months, and iii) several terms and conditions following Dr. Syed's return to practice. These included monitoring of his narcotic practice by a clinical supervisor, and a separate clinical supervision of his general practice for a period of several months. A reassessment of Dr. Syed's practice was also ordered to occur approximately three months following the completion of

each clinical supervision period. Although Dr. Syed's suspension from practice was only for two months, the expert opinion viewed Dr. Syed as having the capacity to improve and motivation to do so. There was no expert evidence to this effect in Dr. Schwarz's case.

The Committee accepts the proposed penalty. While Dr. Schwarz's actions were abhorrent, the proposed penalty protects the public by prohibiting Dr. Schwarz from prescribing narcotics, controlled drugs, targeted substances and other monitored drugs, should he return to practice. This restriction is necessary as Dr. Schwarz has exhibited a persistent disregard for his prescribing responsibilities. He appears to lack insight into his deficits and has not accepted responsibility for prescribing, wrongly assigning that duty to pharmacists. The removal of prescribing privileges protects the public and should send a message of general deterrence to the profession. The imposition of clinical supervision, a reassessment and ongoing monitoring (if Dr. Schwarz returns to practice) will also protect the public and should serve as a specific deterrent with respect to future misconduct. This is essential, given that Dr. Giorchev opined that Dr. Schwarz did not lack knowledge but rather failed to alter his practice; this conveys lack of insight, lack of caring, or both. The education courses also served to protect the public and should drive home the responsibilities associated with record keeping and proper patient care.

The Committee finds that the three-month suspension is appropriate. Given that Dr. Schwarz' certificate of registration has already been revoked, a three month suspension will have no impact on Dr. Schwarz but it should still act as a deterrent to the profession, and conveys that these clinical failures will not be tolerated.

The Committee is satisfied that the proposed penalty falls into the reasonable range of prior decisions of the Committee taking into account the aggravating circumstances in this case and the mitigating circumstances in the cases that were provided to the Committee.

The reprimand is appropriate as it allows the Committee the opportunity to specifically denounce the misconduct. It should also serve to specifically deter Dr. Schwarz (should he ever return to practice) and send a message of general deterrence to the profession.

The Committee finds that costs in the amount of $6,000, is appropriate given that this was jointly submitted by the parties.

ORDER

The Committee stated its findings in paragraphs 1 and 2 of its written order of February 19, 2020. In that order, the Committee ordered and directed on the matter of penalty and costs that:

3. The Registrar suspend Dr. Schwarz's certificate of registration for a period of three (3) months, commencing from February 20, 2020 at 12:01 a.m.

4. The Registrar place the following terms, conditions and limitations on Dr. Schwarz's certificate of registration effective immediately:

Restriction on Prescribing

(i) Dr. Schwarz shall not issue new prescriptions or renew existing prescriptions for or administer any of the following substances:

(a) Narcotic Drugs (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
(b) Narcotic Preparations (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*; S.C., 1996, c. 19);
(c) Controlled Drugs (from Part G of the Food and Drug Regulations under the *Food and Drugs Act*, S.C., 1985, c. F-27);

(d) Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19; (A summary of the above-named drugs and links to the current regulatory lists are attached as schedules to the Order);
(e) Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act,* 2010, S.O. 2010, c. 22, with a link to the current regulatory list in a schedule to the Order);

(ii) Dr. Schwarz shall post a sign in all waiting rooms, examination rooms and consulting rooms, in all his practice locations, in a clearly visible and secure location, in the form set out at Schedule "D" to the Order. For further clarity, this sign shall state as follows:

IMPORTANT NOTICE

Dr. Schwarz must not prescribe or administer any of the following:
- Narcotic Drugs
- Narcotic Preparations
- Controlled Drugs
- Benzodiazepines and Other Targeted Substances
- Monitored Drugs

Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca

(iii) Dr. Schwarz shall post a certified translation(s) in any language(s) in which he provide services, of the sign described in paragraph 4(ii) above in all waiting rooms, examination rooms and consulting rooms, in all his Practice Locations, in a clearly visible and secure location.

(iv) Dr. Schwarz shall provide the certified translation(s) described in paragraph 4(iii) above, to the College within thirty (30) days of this Order.

(v) Should Dr. Schwarz elect to provide services in any other language(s), he must notify the College prior to providing any such services.

(vi) Dr. Schwarz shall provide to the College the certified translations) described in paragraph 4(iv) prior to beginning to provide services in the languages) described in paragraph 4(v).

Clinical Supervision

(vii) Prior to the expiry of the period of suspension and/or the reinstatement of Dr. Schwarz's certificate of registration, Dr. Schwarz shall retain a clinical supervisor acceptable to the College (the "Clinical Supervisor"), who has signed an undertaking in the form attached to the Order as Schedule "E".

(viii) For a period of four (4) months commencing on the date Dr. Schwarz resumes practice, Dr. Schwarz may practice medicine only under the supervision of the Clinical Supervisor (the "Clinical Supervision"), who shall facilitate the education program set out in the Individualized Education Plan attached to the Order .

(ix) After an initial meeting, Dr. Schwarz shall meet with the Clinical Supervisor every month for four (4) months. At each meeting the Clinical Supervisor shall:

(a) Review a minimum of fifteen (15) patient charts, to be selected at the sole discretion of the Clinical Supervisor.

(b) Discuss with Dr. Schwarz any concerns the Clinical Supervisor may have arising from the chart reviews;
(c) Make recommendations to Dr. Schwarz for practice improvements and inquire into Dr. Schwarz's compliance with the recommendations.
(d) Keep a log of all patient charts reviewed along with patient identifiers; and
(e) Perform any other duties, such as reviewing other documents or conducting interviews with staff or colleagues, that the Clinical Supervisor deems necessary to the Clinical Supervision.

(x) The Clinical Supervisor shall submit written reports to the College after two (2) and four (4) months of Clinical Supervision, or more frequently if the Clinical Supervisor has concerns about Dr. Schwarz's standard of practice.

(xi) Throughout the period of Clinical Supervision, Dr. Schwarz shall cooperate fully with the Clinical Supervision and abide by all recommendations of his Clinical Supervisor with respect to practice improvement and ongoing professional development.

(xii) If the Clinical Supervisor who has given an undertaking in Schedule "E" to the Order is unable to unwilling to continue to fulfill its terms, Dr. Schwarz shall, within seven (7) days of receiving notice of same, obtain an executed undertaking in the -same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time.

(xiii) If Dr. Schwarz is unable to obtain a Clinical Supervisor as set out in the Order, he shall cease practising medicine until he has obtained a Clinical Supervisor acceptable to the College.

(xiv) If Dr. Schwarz is required to cease to practise medicine as a result of section (4)(vii) above, this will constitute a term, condition or limitation on his certificate of registration and that term, condition or limitation will be included on the public register.

Professional Education

(xv) Dr. Schwarz shall participate in and successfully complete all aspects of the detailed IEP, attached to the Order as Schedule “F”, including all the following professional education (the “Professional Education”):

(a) Completion of two (2) CMPA e-modules on record-keeping.
(b) Review and discussion with the Clinical Supervisor of:
1) College Prescribing Drugs Policy.
2) College Medical Records Policy.
3) Canadian Guideline for Opioid Use in Non-Cancer Pain.

(xvi) Dr. Schwarz shall provide proof to the College of his successful completion of the Professional Education, including proof of registration and attendance and participant assessment reports, if applicable, within one (1) month of completing it.

Reassessment of Practice

(xvii) Approximately three (3) months after the completion of the Clinical Supervision and Professional Education, Dr. Schwarz shall undergo a reassessment of his practice by a College-appointed assessor (the “Reassessment”; the “Assessor”)

(xviii) The Reassessment may include a review of Dr. Schwarz's patient charts, direct observations, and interviews with staff and/or patients and any other tools deemed necessary by the College. Dr. Schwarz shall abide by all recommendations made by the Assessor(s), and the results of the Reassessment will be reported to the College and may form the basis of further action by the College.

(xix) Dr. Schwarz shall consent to such sharing of information among the Assessor, the Clinical Supervisor, and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

Monitoring

(xx) Dr. Schwarz shall inform the College of each and every location where he practices or has privileges, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of commencing practice at that location.

(xxi) Dr. Schwarz shall cooperate with unannounced inspections of his practice by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of the Order.

(xxii) Dr. Schwarz shall consent to the College's making appropriate enquiries of the Ontario Health Insurance Plan, the Narcotics Monitoring System and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.

(xxiii) Dr. Schwarz shall be responsible for any and all costs associated with implementing the terms of this Order.

5. Dr. Schwarz shall attend before the panel to be reprimanded.

6. Dr. Schwarz shall pay costs to the College in the amount of $6,000 within 30 days of the date of the Order.

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

TEXT of PUBLIC REPRIMAND

Delivered February 19, 2020

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

DR. PETER ROBERT SCHWARZ

Dr. Schwarz:

This Panel wishes to express its strong disapproval of your misconduct.

Your obligation when prescribing drugs including narcotics is to perform a clinical and risk assessment of the patient. You failed to do this.

Your misconduct put patients and the public at significant risk of harm. In one instance, an elderly patient had a high risk of death.

What is most disconcerting is Dr. Giorshev found you to be lacking in judgment even though he found you to have adequate knowledge. You appear to not care about the well-being of your patients.

You should remember that being a member of this profession is a privilege not a right. The public relies on you. Your misconduct cannot and will not be tolerated by the public or the profession.