Index: Cowan (Re)

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

IN THE MATTER OF a Hearing directed
by the Executive Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 36(1) of the ***Health Professional Procedural Code,***
being Schedule 2 to the ***Regulated Health Professions Act,***
1991, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and –

DR. JOHN BALFOUR COWAN

PANEL MEMBERS: DR. J. WATTS (CHAIR)
DR. P. CHART
P. BEECHAM
G. DEGROOT

PUBLICATION BAN

Hearing Dates: February 17 - 21, 2003
Decision/Release Date: February 21, 2003

DECISION AND REASON FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on February 17 to 21, 2003. At the conclusion of the hearing, the Committee made a finding that the member had committed acts of professional misconduct and was incompetent, and pronounced its penalty order, with written reasons to follow.

PUBLICATION BAN

Both the College and the member requested an order under subsection 45(3) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, (the "Code") prohibiting the publication or broadcast of the names of, or any information that could identify, the patients of Dr. Cowan, other than those patients who testified at the hearing. The Committee made such an order for reasons given on the record at the hearing.

ALLEGATIONS

The Notice of Hearing alleged that Dr. John Balfour Cowan committed acts of professional misconduct:

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

2. under subsection 51(1)(a) of the Code in that he has been found guilty of an offence that is relevant to his suitability to practise;

3. under subsection 1(1)(16) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he falsified a record relating to his practice;

4. under subsection 1(1)(18) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he signed or issued in his professional

capacity, a document that he knew or ought to have known was false or misleading;

5. under subsection 1(1)(28) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he contravened section 6.5 of the *Aeronautics Act* (Canada), a law whose purpose is to protect public health, the contravention of which is relevant to the member's suitability to practise medicine;

6. under subsection 1(1)(27) and (29) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he contravened sections 27 and 28 of the *Regulated Health Professions Act* in that he permitted untrained and uncertified persons to perform controlled acts as defined under the latter legislation.

7. under subsection 51(1)(b.1) of the Code in that he sexually abused a patient by making remarks of a sexual nature to the patient;

8. under subsection 1(1)(4) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he practised the profession while his ability was impaired;

9. under subsection 1(1)(20) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he charged a fee for services not performed;

10. under subsection 1(1)(5) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he had a conflict of interest in his dealings with a patient;

11. under subsection 1(1)(6) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he prescribed, dispensed or sold drugs for an improper purpose;

12. under subsection 1(1)33 of Ontario Regulation 856/93 for conduct or an act 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

13. under subsection 1(1)(34) of Ontario Regulation 856/93 made under the *Medicine Act, 1991,* in that he committed acts unbecoming a physician.

It was further alleged that Dr. Cowan is incompetent as defined by subsection 52(1) of the Code, in that his care of a patient displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates that he is unfit to continue practise or that his practise should be restricted.

RESPONSE TO ALLEGATIONS

Dr. Cowan admitted that he had committed acts of professional misconduct as set out in allegation Nos. 8, 12 and 13 of the Notice of Hearing. He denied the balance of the allegations. Counsel for the College withdrew allegation No. 6 before the conclusion of the hearing.

EVIDENCE

The College entered into evidence the following Agreed Statement of Facts, which was signed and consented to by counsel for both the College and Dr. Cowan.

BACKGROUND

1. Dr. Cowan is a family physician.

2. Since the early 1970's Dr. Cowan has established and conducted a family practice in a [small town] community [the "Town"], a significantly under-serviced area

3. During the period of time in which the matters under review occurred, Dr. Cowan was experiencing serious personal difficulties. In particular, as a result of a significant degenerative disc problem, Dr. Cowan developed an iatrogenic dependency on narcotic medication. Dr. Cowan's personal difficulties were exacerbated by those of his wife who

suffered and continues to suffer extremely debilitating rheumatoid arthritis which has rendered her significantly disabled on an ongoing basis.

DR. COWAN'S REHABILITATION

4. Dr. Cowan has since undergone surgery on his back on December 17 1997, which has to a large extent alleviated his pain and suffering.

5. Moreover, Dr. Cowan has also undergone [the OMA's] Physician Health Program [the "PHP"] entering into, and successfully completing a 12-month diagnostic monitoring contract.

6. The basis for the monitoring agreement was a diagnosis of substance abuse. Upon completion of the program, [the PHP] reported that Dr. Cowan showed consistent dedication to the goals of the program and successfully completed his monitoring contract. [The PHP] further confirmed Dr. Cowan's continued commitment to rehabilitation in that Dr. Cowan was maintaining a regular therapeutic relationship with his addiction medicine physician and his psychiatrist. (Attached and marked as Tab A to the Agreed Statement of Facts was a copy of [the PHP's] report regarding Dr. Cowan's completion of the Physician Health Program.)

7. While Dr. Cowan successfully completed the Physician Health Program as of March 22, 2000, he continued his contact with [his addiction medicine physician and his psychiatrist], on an ongoing basis thereafter.

THE CRIMINAL OFFENCE

8. On September 15, 1997, Dr. Cowan practised in his medical office in [the Town]

9. [Ms. A] started to work for Dr. Cowan as a receptionist in approximately 1995. On September 15, 1997, Dr. Cowan asked [Ms. A] to re-type a fax. Dr. Cowan removed a handgun out of a holster that he was wearing. He pointed the handgun at [Ms. A]. [Ms. A] told Dr. Cowan not to point it at her and she pushed it away. Dr. Cowan said something to the effect that [Ms. A] should do as she was told and not to give him a hard time. Dr. Cowan laughed as if it was a joke.

10. On June 10, 1998, Dr. Cowan pleaded guilty to the criminal offence of a careless use of a firearm. He received a conditional discharge. (Attached to the Agreed Statement of Facts and marked as Tab B was a copy of the transcript of the guilty plea.)

IMPROPER CERTIFICATION OF THE AVIATION CERTIFICATE

11. Dr. Cowan was a certified aviation examiner in 1997 and 1998. [Patient #1], a pilot, was a patient of Dr. Cowan at that time. Dr. Cowan had completed several Civil Aviation Medical Examination Reports of [Patient #1] from 1993 to 1997.

12. As an aviation examiner, Dr. Cowan examines pilot patients and writes a report to Transport Canada. Examiners are expected to report various health conditions as well as medications that may be prescribed to pilots. Transport Canada relies on these reports in deciding whether to renew a pilot's license or whether to suspend the license or place conditions on it. (Attached as Tab C to the Agreed Statement of Facts was the guide "The Physician and the Aeronautics Act" published by the Canadian Medical Association and the relevant provisions of the Aeronautics Act.)

13. As soon as the medical examination is completed and the examiner stamps the report, the pilot's license is valid for a further 90 days from the date of the stamp. The new licence is usually sent by Transport Canada out to the pilot within that 90 days.

14. On August 15, 1997, Dr. Cowan certified and stamped [Patient #1]'s report. He witnessed [Patient #1]'s declaration on August 19, 1997. (Attached to the Agreed Statement of Facts as Tab D was the said Civil Aviation Medical Examination Report.) This report was not received by Transport Canada until January 27, 1998.

15. [Patient #1] suffered from chronic back pain. In June of 1997 he re-injured his back. From June of 1997 until November of 1997, Dr. Cowan prescribed a number of drugs for [Patient #1] including Talwin, Morphine, and Demerol. Dr. Cowan was aware of his back condition and the prescribing of the drugs. (Attached at Tab E to the Agreed Statement of Facts was a schedule of dates and drugs prescribed by Dr. Cowan to [Patient #1].)

16. Dr. Cowan certified [Patient #1]'s report on August 15, 199[7] by stating he had no musculo-skeletal disorders and was not under any current medication and by certifying him fit to fly.

FALLING ASLEEP/PASSING OUT IN FRONT OF PATIENTS

17. During the year 1997, Dr. Cowan would pass out or fall asleep in front of his patients in his medical office when the patients came to see him for medical care and treatment. On occasion, the clinic staff was alerted to this by the patients.

PRESCRIBING ULTRADIOL AND NORFLEX ON MAY 11, 1996

18. (Attached to the Agreed Statement of Facts as Tab F were copies of documents regarding the prescriptions for Dr. Cowan.) [Dr. Z] of Barrie, Ontario, never had Dr. Cowan as a patient and never called in the prescription. (Attached as Tab G to the Agreed Statement of Facts were extracts for Ultradol and Norflex from the Compendium of Pharmaceuticals and Specialties 1997.)

WITNESSES FOR THE COLLEGE

Ms. C

Ms. C works as a medical secretary in a physician's office. She completed Grade 10 and took a medical secretary course in a community college in 1988-89. She started working for Dr. Cowan in 1990 or 1991 as a medical secretary where her duties included billings, typing letters and notes, and booking appointments. She was also required to perform immunizations, ECGs and veni-punctures. Ms. C testified that she may have done five veni-punctures a day, on average. She had no nursing background; her training consisted of observing the office manager, Ms. D, performing veni-punctures. She had taken no course in respect of the procedure. She was taught by Ms. D about sterile needles, clean

sites, disposal of needles and infection control, but she was not taught anything about complications. Ms. C was trained regarding immunizations by Dr. Y, a locum in Dr. Cowan's office in the early 1990s. She did not recall administering any medications by injection. Dr. Cowan himself never specifically trained her in respect of veni-puncture or immunization. She testified she drew blood from Dr. Cowan and he was able to observe her technique.

Ms. C worked in Dr. Cowan's office until 1996 or 1997. She testified that, for a several month period during her last year in Dr. Cowan's office, Dr. Cowan would stagger, bang into walls and seem confused almost every day. This behaviour occurred in front of patients. He also used abusive and foul language in front of patients and sometimes directed toward patients. This would occur almost every day.

Ms. C recalled that some prescriptions were made out "for office use" and some made out for Dr. Cowan including Demerol, MS Contin and Leritine. Ms. C also testified that the local pharmacy had called the office a couple of times about prescriptions written by Dr. Cowan that did not make sense or that might cause an adverse reaction for patients.

Ms. C witnessed the signatures of Dr. Cowan and a patient, Patient #2, on an agreement between them by which Dr. Cowan was to receive a percentage of the proceeds of settlement that Patient #2 might receive relating to an insurance claim concerning a motor vehicle accident. Ms. C gave evidence that, in respect of Patient #2, Dr. Cowan had from time-to-time provided information to insurance companies and lawyer without charging a fee.

Dr. X arrived to practice with Dr. Cowan in late 1995-96. Dr. X was acting as Dr. Cowan's physician and writing prescriptions for him. Ms. C observed a deterioration in Dr. Cowan's behaviour in 1996 and 1997, coinciding with Dr. X's treatment of him.

Ms. C observed that Dr. Cowan's patient population consisted in large part of socio-economically disadvantaged patients, many with multiple medical problems. A number of these patients were manipulative and drug seeking. During Dr. X's tenure, Dr. Cowan's level of prescribing narcotics to these patients increased.

The Committee found Ms. C to be a credible witness and accepted her testimony.

Ms. E

Ms. E worked for Dr. Cowan from 1995 to 1997 as a medical secretary. She had no nursing training. Her duties included greeting patients, doing preliminary set-up for physical examinations, taking blood pressures, ECGs and veni-punctures. She sometimes performed as many as six to eight veni-punctures daily for Drs. Cowan and Petts. She had never drawn blood before working for Dr. Cowan. Ms. D had shown her twice how to draw blood for training purposes. She had no other training in this respect and was not instructed in sterile technique or infection control. Ms. E drew blood from Dr. Cowan himself a couple of times. She stated that she did not experience any difficulties drawing blood.

Dr. Cowan's 16-year-old son also drew blood from patients. Ms. E trained Dr. Cowan's son how to draw blood. On one occasion Dr. Cowan's son while drawing blood hit a patient's nerve and was in a state of some panic.

Ms. E administered injections such as booster shots and allergy shots, and injected narcotics such as Demerol, Morphine and Gravol. Ms. C had taught her to give injections, but Ms. E had received no information on any complications that might occur. She gave narcotic injections when asked by Dr. Cowan, as often as ten times daily. She did not feel entirely comfortable giving some injections, especially for babies and children. For a period of time she went on house calls by herself and drew blood from patients, perhaps twice a week on average. Dr. Cowan never gave her any instruction on either drawing blood or giving injections for medications. She testified that, if she was not sure of the right location for the injection, she would ask Ms. C or Ms. D. She testified that Dr. Cowan once asked her if she would do a Pap smear. She refused.

From Ms. E's observations, Dr. Cowan displayed very erratic behaviour - like Dr. Jekyll and Mr. Hyde. One moment he would be happy and content and the next moment ugly and irrational. He acted as if he was inebriated at times, and seemed to fall asleep a lot while working. His language was loud, foul, and abusive to both staff and patients.

Ms. E thought Dr. Cowan's behaviour started to change before Dr. X arrived. After Dr. X began working in the office, there was a more liberal prescribing practice for narcotics.

Ms. E testified that there were many problems of narcotics going missing in the office. The office would get a large amount of narcotics from the pharmacy and the narcotics would be missing a few days later.

Ms. E agreed that a large portion of the patient population came from poor socio-economic circumstances with multiple medical problems and chronic pain and disability. A portion of the patient population was drug seeking and manipulative, and some patients were taking advantage of Dr. Cowan's prescribing practices.

The Committee found Ms. E's evidence to be consistent with that of Ms. C, and accepted her testimony as credible. The Committee did note that Ms. E showed some hostility to Dr. Cowan.

Patient #3

Patient #3 is currently on disability. She testified that in 1998 she attended Dr. Cowan's office with her (now) husband because she was experiencing migraine headaches when she had an orgasm. Dr. Cowan was not her regular physician. When she described her problem to Dr. Cowan, he laughed and said she should be so "f---ing" lucky because most women do not have orgasms. Dr. Cowan started talking to her husband and told a dirty joke, using words such as "f---" and "c--t". Patient #3 was stunned.

Patient #3 was offended by Dr. Cowan's inappropriate behaviour. She did not think Dr. Cowan was trying to put her at ease, although she acknowledged that that could have been his intention. Dr. Cowan provided no treatment or counselling to address the migraine problem, and performed no examination except for blood pressure. The appointment lasted about fifteen to twenty minutes. She saw Dr. Cowan perhaps another three or four times thereafter because she did not have another doctor. She felt uncomfortable seeing him. Dr. Cowan did give her advice and treatment during her subsequent visits with him, and acted appropriately.

Patient #3 testified that her husband was on narcotic medications for some time and that Dr. Cowan at a certain point confronted him about his narcotic use.

The Committee accepted Patient #3's testimony as credible.

Patient #3's Husband

Patient #3's husband has been on disability since 1986. In the summer of 1998 during his wife's first appointment with Dr. Cowan, she described her problem involving migraines. Dr. Cowan, who according to Patient #3's husband had "blurry" eyes at the time, used "the c word and the f word", and said that most women should be so "f---ing" lucky. His wife got no treatment for her problem, although Dr. Cowan wanted to take her off her high blood pressure pills. In Patient #3's husband's view, Dr. Cowan was not the same Dr. Cowan that he had seen before. Patient #3's husband also testified that, on another occasion, Dr. Cowan told him that he would like to wait until his office was full and then come in with a gas mask, grenades and an M16 and blow every one to bits. Patient #3's husband stated that Dr. Cowan was not laughing; Patient #3's husband thought he was serious.

Patient #3's husband had a long history of chronic back and hip pain and fibromyalgia. He had complained for a number of years of chronic stomach problems and a hernia, and chronic headaches. He was not aware that some doctors doubted his claims; however, certain medical reports appeared to suggest this. At one point in his testimony Patient #3's husband testified that one of the doctors treating him was lying in her description of his claims.

The Committee found Patient #3's husband to be a somewhat hostile and forgetful witness, at least as regards his own medical history. His description of the incident involving Patient #3 was, however, generally consistent with her version of events.

Patient #2

Patient #2 is on disability. He started to see Dr. Cowan in 1988 and stopped in August, 1998. He saw Dr. Cowan frequently, especially after motor vehicle accidents in 1992 and 1993. He testified that Dr. Cowan's behaviour started to deteriorate about one and a half to two years before Dr. X's arrival. Patient #2 observed Dr. Cowan in "pretty rough shape" — sucking on his stethoscope, slobbering, head nodding, falling asleep — on several occasions in his office. Dr. Cowan's language was "street level" language, with lots of swearing. He and Dr. Cowan talked like "buddies at the bar", and used the "f"

word frequently. Dr. Cowan made comments about female patients such as “nice ass” or “nice tits”. He also testified that Dr. Cowan would reveal personal information about himself, boasting about vacations, trips to Las Vegas and expensive call girls.

Patient #2 testified that he once saw Dr. Cowan with a gun. Dr. Cowan mentioned a patient who had slashed his tires over not being given certain prescriptions, and said “I can take care of myself” (opening his jacket to reveal a handgun in a holster). On another occasion, Patient #2 saw Dr. Cowan with a gun in the trunk of his car.

Patient #2 was involved in two lawsuits relating to his motor vehicle accidents. At a certain point, Dr. Cowan presented an agreement providing that Dr. Cowan would receive 10% of any settlement. Patient #2 signed the agreement because he feared that if he did not sign, Dr. Cowan would no longer provide his drug prescriptions. Patient #2 admitted he had a drug problem at that time. Dr. Cowan wrote reports and letters to the lawyers and got paid for them by the lawyers.

At that time, Dr. Cowan was prescribing several different narcotics to Patient #2. According to Patient #2, Dr. Cowan injected “cocktails” of liquid Valium, Demerol, Norflex, Stematil and another drug. Patient #2 testified that sometimes Dr. Cowan injected the narcotics and sometimes the “nurses” injected him.

OHIP billings by Dr. Cowan suggested at least twenty medical visits to Patient #2’s home. Patient #2 testified, however, that Dr. Cowan was at Patient #2’s home on no more than three occasions. He testified that Dr. Cowan asked if it was alright for him to bill for psychotherapy and the occasional home visit, although Dr. Cowan did not visit.

The relationship ended when Dr. Cowan gave Patient #2 a document to sign stating that Patient #2 was a drug addict. He was perturbed that the document described him as a drug addict (although he acknowledged that this was true). He signed the document on August 11, 1998, but Dr. Cowan would not give him a prescription or referrals. He went to a rehab clinic for drug addiction and is now treated by a doctor for pain management.

In cross-examination, Patient #2 acknowledged that he went to see an addiction specialist at the direction of Dr. Cowan. Dr. Cowan also referred him to other specialists. He testified that he recalled Dr. Cowan speaking to him about drug use. He had two criminal

convictions for marijuana use. Patient #2 had no complaints about the services Dr. Cowan provided. Dr. Cowan was prepared to assist with pain from the motor vehicle accident and counselled him for problems in his personal life. He considered Dr. Cowan a friend at the time. Dr. Cowan had cooperated fully by providing information to the insurance company and other specialists. Patient #2 acknowledged that Dr. Cowan spent a lot of time counselling, even going to his home to treat him.

In Exhibit 9, dated October 24, 1995, Dr. Cowan proposed to cut Patient #2 off narcotics cold turkey and asked the insurance company to help get Patient #2 into a rehab clinic. In Exhibit 10, dated December 19, 1995, Dr. Cowan reported that he would not be prescribing any more Percodan, Dalmane or Valium in the interim. Patient #2 testified that the prescriptions never stopped. He agreed, however, that Dr. Cowan was interested in arranging for addiction and psychiatric treatment. He had eliminated Percodan and Benzodiazepines for a period of time. In 1996 and 1997, the pain was such that Patient #2 required additional medications.

Patient #2 told the Committee that the contents of the drug contract somewhat reflected ongoing discussions and that he and Dr. Cowan had, and that Dr. Cowan did speak of getting help for him. He was angry with Dr. Cowan, but he denied that he had made threats in the community against Dr. Cowan. He started to see Dr. X after Dr. Cowan presented the drug contract.

The Committee was of the view that Patient #2 was somewhat prone to exaggeration in his description of Dr. Cowan's conduct, and was very defensive when confronted with inconsistent documentary evidence. While aspects of his evidence were of assistance, the Committee was reluctant to rely on other aspects of his testimony where they were uncorroborated.

The College's Expert

The Committee accepted the College's expert as qualified to give expert opinion evidence in family practice medicine. The College's expert had examined certain of Dr. Cowan's patient charts and prepared reports.

The College's expert expressed concern over the delegation of veni-puncture and injection to staff. Dr. Cowan did not supervise. The College's expert considered Dr. Cowan's medical care in this regard to be below the standard expected of a reasonably prudent general practitioner.

The College's expert testified that, of the twenty-eight patient charts he examined, he considered that thirteen cases met the standard of care and fifteen did not. He noted that there was no appreciation by Dr. Cowan of potential harm with ongoing narcotic treatment, and no referrals to specialist or psychiatric reviews. He outlined the deficiencies in respect of the 15 patient charts that he viewed as falling below the standard. The deficiencies included over-prescribing narcotics, a failure to substitute non-narcotic alternatives, a failure to fully document findings, a failure to confront certain patients about prescription narcotics addiction and to refer them to specialists, a failure to accurately or honestly complete a pilot's medical certification (in the case of Patient #1), and a failure to fully investigate the cause of certain symptoms. According to the College's expert, Dr. Cowan also failed to keep an accurate record of injectable narcotics ordered for office use.

The College's expert acknowledged that during a portion of the period under review, Dr. Cowan was experiencing personal difficulties and drug dependency. Dr. Cowan was working with a difficult patient population, many of whom were addicted to drugs and drug seeking.

The College's expert told the Committee that Dr. Cowan had completed the Physician Health Program and had been monitored for twelve months as being drug free. He had also severed relations with Dr. X. The College's expert indicated that Dr. X had prescribed quite inappropriately for Dr. Cowan. Dr. Cowan had admitted to the College's expert that he had been unusually liberal in his own dispensing of narcotics. The College's expert noted that, as of 2001, Dr. Cowan had referred patients with addiction problems to specialists, thus ridding his practice of the most manipulative and drug seeking patients. Dr. Cowan had confronted certain patients regarding the use of narcotic medications. Also, Dr. Cowan had cut back on prescribing narcotics to patients, kept much smaller amounts in his office and computerized the narcotics log.

Regarding the improper certification of the aviation certificate, the College's expert agreed that the document regarding Patient #1's medical examination was signed but not sent to Transport Canada until four months after the examination, at which time Patient #1 was thought to be off medication.

The College's expert also testified that, in Dr. Cowan's treatment of atrial fibrillation with anticoagulant therapy for certain patients, Dr. Cowan had displayed a lack of knowledge of beta-blockers and current treatment for atrial fibrillation. The College's expert acknowledged that Dr. Cowan has more recently taken steps to address issues raised by the College's expert and is now running a much more controlled practice.

The Committee found that the College's expert was a helpful and credible witness and accepted his evidence.

THE DEFENCE WITNESSES

Dr. John Cowan

Dr. Cowan is 62 years old. He was born in Glasgow, the son of a physician. He worked in Glasgow as a general practitioner for 5 years with his father, emigrated to Canada in 1971 and started a general practice in a larger town with privileges at the local hospital. In June of 1972, he moved his practice to the Town because many of his patients came from there. He has a restriction on his certificate of registration to practice only in the Town, an under-serviced area, as he passed only one part of the LMCC. He did not see himself moving from the Town; therefore, he did not take time from his practice to study and re-attempt the second part. He has worked at times in sole practice and at times in partnership with other physicians, the last being Dr. X.

Dr. Cowan is the medical officer at CFB Borden where he works two days a week. He has been a provincial Coroner since 1972 and attends conferences or refresher courses two or three times a year. He has also taken some psychiatric courses in Toronto.

Dr. Cowan's patient population is between 2,000 to 2,500 patients, with a large transient population. He sees 500-600 patients on a regular basis. He no longer does obstetrics or emergency, but performs pre and postnatal checkups. He has many geriatric patients and

still performs some paediatrics. The Town, according to Dr. Cowan, is a depressed socio-economic area with much welfare, retirement, disability and drug traffic.

Dr. Cowan testified that his staff are taught procedures to facilitate the practice such as blood pressures, BMI, urinalysis, veni-puncture, intra-muscular injections, allergy shots, pulmonary tests and ECGs. He personally trained staff in veni-puncture, infant immunisations, intra-muscular injections and allergy shots. He would have staff demonstrate their skill by taking his blood. Ms. D has been with him for 15 years and is certified by the Ministry of Health to perform veni-punctures.

Dr. Cowan testified that he was always on the premises when the staff performed injections or veni-punctures. He would show the staff appropriate sterile techniques such as cleansing the skin, the use of needles at the correct angle and so forth. Skin preparation was always emphasized. No one ever came to him with a problem. Nothing was to take place unless he was in the building.

Dr. Cowan suffered from chronic hypertension since 1984 that was controlled by medication. In 1985, he was diagnosed with chronic lymphatic leukemia. He has a longstanding history of chronic low back pain. The pain became worse and he had to take time off from his practice. He started on narcotics in the early 1990's. He was treated by two physicians, one of whom prescribed non-steroidal anti-inflammatory drugs and Tylenol No. 3. In 1995, he asked Dr. X to become his family doctor. In December, 1997, he had a laminectomy, relieving him of much of his pain. He suffered from depression and anxiety due to family stresses. His wife is extremely disabled with Rheumatoid Arthritis. He has suffered much stress, depression and pain and has sought psychiatric assistance from time to time.

Dr. Cowan told the Committee that he does not drink alcohol at all, and has never used street drugs. He stated that his back pain was severe at the time that Dr. X joined him in practice and began treating him. Dr. X prescribed Darvon, an analgesic that did not adequately control the pain. Dr. X then prescribed Demerol 28 mg, increasing to 50 mg and then 100 mg. The increasing strength of Demerol was not relieving his pain. Dr. X also prescribed Leritene starting at 25 mg, and increased to 50 mg. Dr. Cowan was getting relief from these narcotic injections, and he was increasingly empathetic with

patients who sought prescription narcotics to relieve pain. Dr. Cowan testified that the office staff told him at a certain point that his behaviour was erratic. When examining a patient, he once found his chin on his chest (meaning he had fallen asleep).

He acknowledged the use of inappropriate or foul language on his part, and that he was sometimes not as diplomatic as he should be. He said he was brought up to speak directly, but does not deliberately upset patients.

Dr. Cowan testified that he recognized his responsibility to bring a patient's narcotic addiction to the patient's attention, and attempted to do so. He referred certain patients to pain specialists and addiction specialists. He told the Committee that he now seeks to avoid treating addicts.

Dr. Cowan could not explain the discrepancy the College's expert found in the narcotics log. At the time in question, Dr. Cowan, Dr. X, Ms. C, Ms. E, Ms. D and Ms. F all had access to the store of narcotics.

Dr. Cowan was a federal Civil Aviation Examiner. Patient #1, a sometime pilot, came in for an examination for licensing when he was on prescription Talwin for a backache. Dr. Cowan performed an examination and signed the certificate but said he would hold it until he was convinced that Patient #1 was not using narcotics. He did not submit the certificate until he knew Patient #1 had not been on narcotics for two or three months. Dr. Cowan testified that Patient #1 had not flown for several years and wanted the pilot's licence for business purposes. When he realized that Patient #1 was still taking narcotics, he phoned a physician at the Civil Aviation Board, and told Patient #1 he no longer wanted to be his doctor.

Dr. Cowan testified that in 1972 he had purchased a handgun for home protection. In 1997 Dr. Cowan decided he did not want the gun any longer. He knew that a patient who was a registered arms dealer was coming in for an appointment. On September 15, 1997, the patient came in for his appointment, examined the gun and said he did not want it. Dr. Cowan testified the gun was not loaded and was rusty and not functioning. The patient told him to throw the gun in the waters of Georgian Bay. Dr. Cowan testified that on that same day he and his assistant [Ms. A] were discussing a report that Ms. E had

typed. He asked Ms. A to retype it. He took the gun out of the holster, pointed it at her and asked her to do the report, in a laughing manner. Ms. A put her hand on the barrel of the gun and said, "Jack, don't do that". He pointed the gun again. The police came the next day and laid charges. He later pleaded guilty and was convicted of careless use of a firearm, contrary to section 86(2)(b) of the *Criminal Code*. He was sentenced to a conditional discharge, with one-year probation. Dr. Cowan admitted that it was a very stupid act that backfired. Contrary to Patient #2's evidence, Dr. Cowan stated that at no other time did he wear the gun, or bring it to the office.

After the gun incident, Dr. Cowan quit taking narcotics cold turkey and has not had any other narcotics since that day (with the exception of morphine following his back surgery in 1997).

Dr. Cowan acknowledged that he made a mistake in treating patients while he was under the influence of narcotics. He accepted that he made a terrible error in judgment. He also acknowledged that the gun incident was abysmally stupid, but said it was not drug driven. He enrolled in the Physician Health Program in March of 1999. He gained insight into how to control narcotics treatment. Both the addiction medicine physician and the psychiatrist, whom Dr. Cowan was seeing as part of the PHP, have told Dr. Cowan he need not see them anymore.

Dr. Cowan testified that he has modified his practice. He is now much more restrictive in prescribing narcotics. He uses many specialists and addiction counsellors. He keeps only two vials of Demerol and two vials of morphine in the office for treatment of patients with acute pain. He only accepts patients with narcotic prescriptions in cases of terminal care. When new patients phone, the office staff questions them as to their narcotics use and if they say they are using narcotics, Dr. Cowan refuses to take them on as patients. Dr. Cowan stated that he has no drug-seeking patients now.

Regarding the prescriptions for Dr. Cowan prescribed by Dr. Z, Dr. Cowan testified he does not know Dr. Z and did not get prescriptions from him. He had no idea where those prescriptions came from. If he needed a prescription, at that time, he would go to his prescribing physician.

Dr. Cowan told the Committee that he does fourteen to fifteen house calls a month, often attending a second member of the family as well. He has many elderly patients with ongoing complaints. He testified that every house call to Patient #2 billed to OHIP was performed, and each was necessary due to Patient #2's ongoing back problems and general malaise. He provided all the services for which he billed. Patient #2 might have thought it was a friendly chat and not therapy. Regarding Patient #2's evidence concerning the alleged drug "cocktails", Dr. Cowan testified that he rarely puts more than one substance in one syringe, but that Patient #2 might have received more than one injection at a visit.

As to the agreement with Patient #2 to receive 10% of accident settlement proceeds, Dr. Cowan testified that he spent a lot of time doing services for Patient #2 (such as telephone calls) for which he could not bill OHIP. Patient #2 made the suggestion that he would be happy to pay for those services once he settled with the insurance company. As a result, Dr. Cowan had the agreement prepared. To date, he has not been paid and has not pursued payment.

In cross-examination, Dr. Cowan admitted that he may have fallen below the standard of care in prescribing for some of the patients referred to in the College's expert's report of 1998. He told the Committee that he had taken the College's prescribing course in September of 1996. Although his use of narcotics is very limited now, if he had to stop prescribing narcotics, it would prove a hardship for certain of his patients as he is a sole practitioner. He believes his prescribing habits now fall within acceptable standards.

Dr. Cowan testified that he was personally involved in staff training although he did not show them how to take blood, or how to do injections. There was no written protocol for veni-puncture or injections. He had Ms. D and Ms. C try their technique on him first. He was unaware that his son had hit a nerve in one procedure, as it had never been brought to his attention at the time. He acknowledged that Ms. E went to homes to take blood and give injections. He said he does allow staff to do veni-punctures when he is not present.

Dr. Cowan acknowledged that there was a period of time when he was abusing narcotics. In hindsight, he acknowledged that it was inappropriate to self-administer narcotics even though his partner was in the office at the time. He agreed that in that time frame, his

practice of medicine was impaired. Dr. Cowan could not explain the missing ampoules and testified that he only took what was dispensed and prescribed by Dr. X. He thought the missing ampoules might have been dropped on the floor but has no memory of this. He admitted that his memory and judgment may have been impaired, but he denied using the "missing" narcotics.

Dr. Cowan acknowledged that he had fallen asleep in front of patients at least three or four times. He does not remember staggering. He stated this behaviour was a result of the prescriptions given to him by Dr. X. Dr. Cowan agreed that he was putting patients at risk while practicing under the influence or narcotics. He stated that he was not taking narcotics during the day that he can recollect. He acknowledged that he could have stopped taking narcotics earlier, but made the choice not to do so.

Dr. Cowan agreed that he swore and used common, vulgar language both before and after his addiction. He understands how some people could take offence but he did not intend to be abusive. He agreed that Patient #3 was embarrassed about her problems, but he cannot remember having said what she testified to. If he did use such language, he acknowledged that it would be unprofessional and disgraceful. He told the Committee that he was trying to break the ice with her, not belittle her. Dr. Cowan testified that he is more guarded in his language today. As to the alleged statement to Patient #3's husband about blowing up the clinic, Dr. Cowan testified that it could have happened but that he does not remember saying that.

Dr. Cowan acknowledged that he certified that Patient #1 was able to fly legally for 90 days after the form has been stamped. The form was not accurate when he signed it and he held it back. When Patient #1 signed the attestation, Dr. Cowan knew it was not correct, yet he witnessed it. He concurred with the College's expert's statement that, legally, Patient #1 could have flown. He acknowledged that, in his letter to Transport Canada reporting Patient #1, he was still not candid.

Dr. Cowan testified that he does not remember showing Patient #2 the gun in the trunk of the car. He acknowledged that he was paid for medical reports for Patient #2 by OHIP, however, he had made phone calls to the insurance company and to various referral

physicians for Patient #2 without payment. Dr. Cowan did not think there was a conflict of interest with respect to the agreement he and Patient #2 signed.

The Committee found that Dr. Cowan generally gave his evidence in a forthright manner, but that his memory was vague on certain key events. There were a few occasions on which his evidence on cross-examination was not fully consistent with his evidence in chief. Some of the memory lapses appeared to be self-serving. In several respects, however, Dr. Cowan showed a degree of insight into his past problems, and demonstrated that he has changed his prescribing practices.

Patient #4

Patient #4 and his family are patients of Dr. Cowan. He testified that he is very happy with Dr. Cowan's treatment, has been a patient for over a decade, without difficulty.

He testified that the whole community knows that Patient #2 is a known drug abuser. Patient #4 testified that Patient #2 had approached him to buy medication and he had to call the OPP. Patient #4 testified that Patient #2 said of Dr. Cowan "I'm going to get the S.O.B." to Patient #4 on three occasions.

Patient #4 testified that he currently takes anti-inflammatories and takes Percocet off and on, sometimes two or three a day. He gets forty to sixty pills per prescription. He occasionally takes MS Contin, but never Demerol. He is treated by Dr. Cowan

The Committee found that Patient #4's evidence was of limited value; however, it did demonstrate that Dr. Cowan was still prescribing narcotics in certain instances to non-terminal patients.

Patient #1

Patient #1 held a pilot's licence from early 1990 to 1998. Dr. Cowan was not his regular family physician, but he saw him for the aviation examination. He had back pain in June 1997, and had to have his annual medical for aviation fitness. Dr. Cowan asked if he had flown recently and Patient #1 told him that he had not. Dr. Cowan told Patient #1 that he would perform the examination at that time and send the form in after he was off the medication for the back pain. Patient #1 said he had last flown in the spring of 1997. He

never flew while he was on medication. Transport Canada called and asked him about the medications but he explained and the issue was resolved. He testified that he was prescribed Talwin, Morphine and Demerol. Dr. Cowan had told him to take it easy on the medications. He stopped being a patient of Dr. Cowan's just after the incident. He said that he was very pleased with Dr. Cowan's treatment of him, that Dr. Cowan did home visits and was very professional. Patient #1 told the Committee that he was not aware of Dr. Cowan's letter dated April 16, 1998 reporting his narcotic usage.

The Committee found Patient #1 to be a generally credible witness and accepted his evidence.

The Pharmacist

The Pharmacist lives in the Town. She was the pharmacist owner of Shoppers Drug Mart in the Town from February 1997 until January 31, 2003. She would typically fill twenty to thirty of Dr. Cowan's prescriptions per day. In the first six to twelve months, she had concerns that Dr. Cowan's patients received more narcotics than other physicians' patients. More recently, Dr. Cowan's prescribing was much more controlled, with only a one-month supply at a time and no refills. The narcotics had decreased significantly. Dr. Cowan is now more controlled than the other doctors in the area. She has no concerns today about Dr. Cowan's prescribing practices.

The Pharmacist confirmed the prescriptions of Dr. Z for Dr. Cowan, but could not assist in explaining the underlying circumstances.

The Committee found the Pharmacist to be a credible witness and accepted her testimony.

FINDINGS AND REASONS THEREFOR

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. The Committee also carefully considered the additional evidence adduced by the College and Dr. Cowan, as summarized above but fully set out in the record.

The Committee concluded that Dr. Cowan did not adequately train, supervise and control members of his staff in respect of veni-puncture, inoculations and injections, and failed to ensure that only qualified persons were performing such procedures. Only one staff member had official certification. It was not sufficient for Dr. Cowan to leave training and supervision of these procedures to staff members without adequate training or qualification.

The Committee found that Dr. Cowan was plainly impaired by narcotics while practising during the time he was being treated by Dr. X. He was falling asleep while seeing patients, staggering, and clearly suffering the effects of the prescription narcotics to such an extent that he was not fit to be seeing patients. Dr. Cowan acknowledged his impairment.

The degree of supervision and control over narcotics supplies in Dr. Cowan's office was inadequate and did not meet the standards required of a reasonably prudent practitioner. There was evidence before the Committee to raise considerable concern about access to these narcotics supplies.

Dr. Cowan's use of language in his medical office, including with patients, was also clearly inappropriate. The incident involving Patient #3 was the most striking example. While Dr. Cowan viewed it as an "ice breaking" joke, the crude sexual content is entirely unacceptable for a physician. The Committee notes that the incident occurred on Patient #3's first visit to Dr. Cowan. Dr. Cowan acknowledged that his strong language was not the result of his narcotic impairment.

The Committee concluded that the firearms incident involving Ms. A was disgraceful and highly inappropriate. Ms. A would have had no idea that the gun was not loaded. The incident took place in Dr. Cowan's medical office and involved one of his staff members, arising out of clinic-related work. The Committee found that the incident related to Dr. Cowan's practice and was relevant to his suitability to practise.

The completion of the aviation certificate in respect of Patient #1 was dishonest and inappropriate, whatever Dr. Cowan's motives may have been. As a result of Dr. Cowan's completion of the certificate in an inaccurate manner, Patient #1 was certified to fly an

airplane in Canada, even though Dr. Cowan knew that Patient #1 was on prescription narcotics. Dr. Cowan's actions could have jeopardized the safety of Patient #1 and others.

Dr. Cowan's prescribing practices, as described by the College's expert, did not in certain cases meet the standard of practice. As detailed by the College's expert, whose evidence the Committee fully accepted, certain patients were over-prescribed, when they should have been confronted directly about their addiction and referred to specialists. Dr. Cowan has changed his practice in this regard, but Patient #4's evidence established that Dr. Cowan's more recent narcotic prescribing practice is not as restrictive as he claimed in his testimony before the Committee.

The Committee also accepted the College's expert's evidence and found that Dr. Cowan fell below the standard in respect of the course of treatment of certain patients with atrial fibrillation.

The agreement prepared and signed by Dr. Cowan relating to settlement proceeds to be received by Patient #2 put Dr. Cowan in a conflict of interest concerning his reporting of Patient #2's condition and prognosis. Such an agreement was not appropriate and Dr. Cowan should have known that. He appears to have later recognized this in that he did not seek to enforce the agreement.

The Committee did not find that there was sufficiently cogent and convincing evidence to establish that Dr. Cowan had billed OHIP for home visits that were not performed. Patient #2 acknowledged that there were some home visits, and Dr. Cowan testified that Patient #2 might not have distinguished between counselling and friendly social visits. Dr. Cowan insisted that he billed OHIP only for treatment actually performed. The Committee found that Patient #2's evidence in this respect was not sufficiently reliable to act upon.

FINDINGS ON THE ALLEGATIONS

The Committee considered each of the allegations against Dr. Cowan in turn, having regard to the evidence and to the findings of fact made by the Committee. The Committee found that the evidence established that Dr. Cowan had committed acts of

professional misconduct as described in allegation Nos. 1, 2, 3, 5, 7, 8, 10, 12, 13 of the Notice of Hearing, and also established the allegation of incompetence. Allegation No. 4 was also made out on the evidence but the Committee did not formally enter a finding on this allegation as it related to the identical transaction as allegation No. 3. The Committee found that the evidence did not establish allegation No. 9 relating to charging a fee for services not performed, and allegation No. 11 relating to prescribing, dispensing or selling drugs for an improper purpose, respectively. As stated above, the College withdrew allegation 6.

As to allegation No. 1, the failure to maintain the standard of practice, the Committee found that there were several instances of a failure to maintain the standard established on the evidence. The Committee concluded that the inappropriate prescribing of narcotics identified by the College's expert, the use of inappropriate language, the lack of monitoring of office narcotics supplies, falling asleep in front of patients, failure to fully investigate symptoms and manage patients as described by the College's expert, and the lack of training and supervision of staff in respect of veni-puncture, immunizations and injections, fell below the standard of practice.

The Committee found that Dr. Cowan's criminal conviction in respect of the gun incident involving his staff member, Ms. A, in his medical office was relevant to his suitability to practice, and that allegation No. 2 has been established.

Regarding allegation No. 3, the Committee found clear, cogent and convincing evidence that Dr. Cowan had falsified a record, specifically the Civil Aviation Medical Examination Report completed for Patient #1. The Committee also found similar proof for allegation No. 4, but as there is a precise overlap between the two allegations, the Committee did not enter a formal finding for allegation 4.

As to allegation No. 5, the Committee found that Dr. Cowan had indeed contravened section 6.5 of the *Aeronautics Act*, and that this contravention was relevant to his suitability to practice.

The Committee accepted the evidence of Patient #3 and found that Dr. Cowan had made inappropriate remarks of a sexual nature. The Committee therefore concluded that allegation No. 7 was established.

Dr. Cowan admitted that he had practised the profession while his ability was impaired, and the Committee found that the evidence established that allegation No. 8 was made out.

As to allegation No. 9, the Committee, as noted above, concluded that the evidence was not sufficiently convincing to make this serious finding.

Allegation No. 10 concerned the agreement with Patient #2. The Committee accepted the agreement and the generally uncontested facts surrounding it as establishing a clear conflict of interest in Dr. Cowan's dealings with a patient.

As to allegation No. 11, the Committee found that there was insufficient evidence to substantiate this allegation. While Dr. Cowan's prescribing of narcotics was too liberal, the evidence did not clearly establish that his prescribing was for an "improper purpose".

Dr. Cowan admitted allegation Nos. 12 and 13. The Committee finds that Allegation No. 12 was established on the evidence, having regard to the incident involving the gun, the inappropriate language, the inappropriate sexual remarks, the treatment of patients while impaired, the Patient #2 agreement and the false aviation certificate. Allegation No. 13 was made out on the basis of the gun incident.

As to the allegation of incompetence, the Committee found that the evidence clearly established that Dr. Cowan had in his care of patients displayed a lack of judgment, or disregarded the welfare of patients, to an extent that demonstrates that his practise should be restricted. Dr. Cowan displayed lack of judgment or disregard for the welfare of patients in many areas: in his over-prescription of narcotics; in the incident involving the civil aviation certificate; in his treatment of Patient #3; and most notably in his treatment of patients while he himself was obviously under the influence of narcotics. The Committee found that while Dr. Cowan has shown some insight into his problem, he still blames others (such as Dr. X) for his difficulties. The evidence of Patient #4 also

demonstrated that Dr. Cowan was not completely forthright in his description of his current narcotic prescribing practices.

PENALTY AND REASONS FOR PENALTY

Counsel for the College submitted that the appropriate penalty was revocation of Dr. Cowan's certificate of registration, together with an order that he pay costs to the College in the amount of $10,000.

Counsel for Dr. Cowan proposed a 12-month suspension subject to the conditions that Dr. Cowan submit to a peer review process and abide by any recommendations, complete courses that the Committee would consider appropriate and undergo periodic, random, inspection of his practice and random urine or blood tests.

The Committee carefully considered the arguments of both the College and the defence on penalty. The Committee was of the view that Dr. Cowan's conduct was very serious and unprofessional in several distinct respects. In considering penalty, the Committee took into account the principles of general and specific deterrence, rehabilitation, and the protection of the public and the reputation of the profession. The Committee also took into account Dr. Cowan's behaviour before, during and after his problems with narcotics abuse. The Committee had regard to all of the instances of professional misconduct, and the finding of incompetence. The Committee also had regard to the vulnerability of his patients (many of whom were disadvantaged and suffering from chronic pain and disabilities, with limited access to other medical treatment).

A message must be sent to the public and the profession that such conduct will not be tolerated. The Committee found that Dr. Cowan displayed dishonesty to an extent that he could not be put in a position of trust in such public positions as coroner, immigration examiner, or civil aviation examiner. Although Dr. Cowan has taken the prescribing course at the College and has completed the Physician Health Program, the Committee concluded that he has not been fully rehabilitated. The Committee concluded that Dr. Cowan should complete the current prescribing course because there are many aspects of the course that would be helpful to Dr. Cowan in pain and patient management.

Dr. Cowan is a solo practitioner with minimal continuing medical education in the last year. The Committee is of the opinion that a practice review in the form of a PREP assessment was needed to ensure that standards of care would be met in the interests of public safety. Also, in order to protect the public, the Committee is of the opinion that Dr. Cowan needs to complete a boundaries course given his disrespectful conduct leading to the allegation of sexual abuse.

The Committee continues to hold concerns regarding Dr. Cowan's integrity regarding narcotics prescriptions and his ability to accept responsibility regarding training of staff. The Committee concluded that monitoring of his practice and his own medication use was necessary and appropriate in this case.

While Dr. Cowan has shown a degree of insight and taken strides to improve his practice, his conduct has demonstrated that strict conditions must be placed on his certificate. The Committee believes that these conditions will protect the public while allowing Dr. Cowan an opportunity to continue his rehabilitation. The strict conditions also serve as a general deterrent to the profession and a specific deterrent to Dr. Cowan.

With regard to costs, the Committee accepts that Dr. Cowan did plead to several allegations of professional misconduct, but contested many others that were ultimately made out. The Committee concluded that partial costs of $5,000.00 were appropriate.

ORDER

At the conclusion of the hearing, the Committee ordered and directed that:

1. Dr. Cowan appear before the Committee to be reprimanded and the fact of such reprimand be recorded in the register.

2. The Registrar suspend Dr. Cowan's certificate of registration, effective April 1, 2003, for a period of twelve (12) months, with nine (9) months of this suspension to be suspended on the strict condition that Dr. Cowan comply with the following terms and conditions:

    (a) that Dr. Cowan successfully complete, at his own expense, a prescribing course offered by the College, or such other course acceptable to the

Registrar, at the earliest available date and not later than twelve (12) months from the date of this Order.

(b) that Dr. Cowan successfully complete, at his own expense, the physician-patient boundaries course offered by the College, at the earliest available date and not later than twelve (12) months from the date of this Order.

(c) that Dr. Cowan undertake as soon as possible, but not later than six months from the date of this Order, at his own expense, a PREP assessment under the auspices and supervision of the Quality Assurance Committee and successfully complete any remedial and assessment steps recommended by the PREP assessor or the Quality Assurance Committee. The PREP assessor and the Quality Assurance Committee shall be provided with the decision and reasons of this panel in advance of the assessment. The PREP assessor shall provide a full report to the Quality Assurance Committee following the assessment and any reassessment. In the event that Dr. Cowan scores level 1, 2, or 3, on the PREP assessment, he shall be permitted to continue in practise while undergoing any remedial steps recommended by the assessor or the Quality Assurance Committee. In the event that Dr. Cowan scores level 4 or 5, he will be required to withdraw completely from the practise of medicine until such time as he achieves level 3 or higher on a PREP reassessment.

(d) in the event that Dr. Cowan fails to comply with any of the conditions set out in paragraphs (a) – (c) above, the suspended nine months of his suspension will take operative effect immediately upon notice from the Registrar advising of such non-compliance.

3. The Registrar impose the following terms, conditions and limitations on Dr. Cowan's certificate of registration:

(a) the term specified in paragraph 2(c) above shall be a term, condition and limitation on Dr. Cowan's certificate of registration, in addition to forming a condition of the partial suspension of the twelve (12) month suspension.

(b) that Dr. Cowan be prohibited from prescribing any of the drugs listed in Schedule 1 to the *Controlled Drugs and Substances Act* with the exception of Codeine alone or in combination with non-narcotic analgesics.

(c) that Dr. Cowan is to immediately send a letter to the Director, Office of Controlled Substances, Health Canada, advising that the Discipline Committee of the College of Physicians and Surgeons of Ontario has imposed a condition on his certificate of registration prohibiting the prescribing of the drugs on Schedule 1 to the *Controlled Drugs and Substances Act* with the exception of Codeine alone or in combination with non-narcotic analgesics, and provide proof to the Registrar that he has sent such a letter.

(d) that Dr. Cowan cease to serve as an Ontario Provincial Coroner, a Federal Civil Aviation Examiner and a Federal Immigration Examiner.

(e) that commencing immediately and for a period of five (5) years from the date of this order,

(i) Dr. Cowan shall enter into a course of regular treatment with a physician specializing in addiction medicine, which physician shall be proposed by Dr. Cowan and subject to the written approval of the Registrar or an Associate Registrar. The approved physician shall enter into an undertaking with, and acceptable to, the Registrar or an Associate Registrar to serve in this capacity and to complete the steps set out below. The frequency of treatment visits shall be determined by the treating physician, but shall take place at least once every six (6) months. The treating physician shall undertake or supervise random urine testing of Dr. Cowan, the frequency of which shall be determined by the treating physician, but shall take place at least three times annually. The treating physician shall submit reports acceptable to the Registrar or an Associate Registrar, including the results of the random urine

testing, as appropriate and, in any event, not less than once every six (6) months.

(ii) Dr. Cowan shall be subject to random, unannounced inspections, carried out by inspector(s) selected by the Registrar or an Associate Registrar, which inspections may include clinical records reviews, inspection of infection control practices and procedures, staff training and delegation of controlled acts. Such inspections are to be carried out at least once and not more than three (3) times annually. The inspector(s) shall submit a detailed report to the Registrar or Associate Registrar within thirty (30) days after each inspection. The costs of such inspections shall be borne by Dr. Cowan.

(f) Dr. Cowan or the College may apply to the Discipline Committee after five (5) years for a variation of this Order.

COSTS

Dr. Cowan was ordered to pay costs in the amount of $5000.00 within six (6) months of the date of the Order.

The Committee administered the reprimand to Dr. Cowan following the conclusion of the hearing.

DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

DR. M. DAVIE (CHAIR)	)	**Hearing date:**
DR. E. ATTIA (Ph.D.)	)	July 3, 2009
DR. F. SLIWIN	)	

B E T W E E N:

DR. JOHN BALFOUR COWAN

(Applicant)

-and-

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

(Respondent)

ORDER AND REASONS FOR ORDER
(On a Motion to Vary the Order of the Discipline Committee of 2003)

INTRODUCTION

On Friday, July 3, 2009, the Discipline Committee (the "Committee") heard a motion brought by Dr. Cowan for an order seeking to vary the terms, conditions and limitations imposed on his certificate of registration pursuant to an order of the Committee made on February 21, 2003 (the "2003 Order"). At the conclusion of the hearing, the Committee allowed the motion and delivered its order varying the terms, conditions and limitations imposed on Dr. Cowan's certificate of registration in writing, with written reasons to follow.

THE MOTION

The member's Notice of Motion sought an order to vary the 2003 Order to enable Dr. Cowan to engage in specified employment activities within or related to the practise of medicine. Dr. Cowan's counsel advised that he was seeking, at this time, only to be

permitted to function as a surgical assistant (limited to assisting in the O.R. and not involving pre- or post-operative care).

BACKGROUND:

Dr. Cowan originally appeared before the Discipline Committee on February 17 through 23, 2003. The 2003 hearing related to incidents which occurred in the course of Dr. Cowan's family practice in Wasaga Beach in 1997, during which time Dr. Cowan was abusing narcotics. At that time, the Discipline Committee made the following findings:

- Dr. Cowan did not adequately train, supervise and control members of his staff in respect of veni-puncture, inoculations and injections, and failed to ensure that only qualified persons were performing such procedures.
- Dr. Cowan was impaired by narcotics while practising during the time he was being treated by another physician (Dr. X). Dr. Cowan acknowledged his impairment.
- The degree of supervision and control over narcotic supplies in Dr. Cowan's office was inadequate and did not meet the standards required of a reasonably prudent practitioner.
- Dr. Cowan's use of language in his medical office, including with patients, was clearly inappropriate.
- The Committee concluded that "the firearms incident" was disgraceful and highly inappropriate, and was relevant to his suitability to practise.
- The completion of an aviation certificate with respect to a patient was dishonest and inappropriate.
- Dr. Cowan's prescribing practices, in certain cases, did not meet the standard of practise.
- With respect to the course of treatment of certain patients with atrial fibrillation, Dr. Cowan fell below the standard of practise.
- A document prepared and signed by Dr. Cowan regarding proceeds to be received by a patient pursuant to a settlement agreement put Dr. Cowan in a conflict of interest concerning his reporting of the patient's condition and prognosis.

The 2003 Order of the Discipline Committee included the following provisions relevant to this application:

2. The Registrar suspend Dr. Cowan's certificate of registration, effective April 1, 2003, for a period of twelve (12) months, with nine (9) months of this suspension to be suspended on the strict condition that Dr. Cowan comply with the following terms and conditions…

   (c) that Dr. Cowan undertake as soon as possible, but not later than six months from the date of this Order, at his own expense, a PREP assessment under the auspices and supervision of the Quality Assurance Committee and successfully complete any remedial and assessment steps recommended by the PREP assessor or the Quality Assurance Committee. The PREP assessor and the Quality Assurance Committee shall be provided with the decision and reasons of this panel in advance of the assessment. The PREP assessor shall provide a full report to the Quality Assurance Committee following the assessment and any reassessment. In the event that Dr. Cowan scores level 1, 2, or 3, on the PREP assessment, he shall be permitted to continue in practice while undergoing any remedial steps recommended by the assessor or the Quality Assurance Committee. In the event that Dr. Cowan scores level 4 or 5, he will be required to withdraw completely from the practice of medicine until such time as he achieves level 3 or higher on a PREP reassessment.

Dr. Cowan successfully completed all of the terms and conditions except for the PREP assessment; he undertook the PREP assessment in September 2003, but did not achieve a level 1, 2 or 3 result. Therefore, Dr. Cowan has not practised medicine since that time.

Dr. Cowan is currently 65 years old and is not seeking to return to the practise of family medicine. He is seeking solely to practise as an O.R. assistant, providing no pre- or post-operative care.

EVIDENCE

Dr. Cowan has had many changes in his life since the decision of the Discipline Committee, rendered in 2003. He suffers from medical conditions including chronic hypertension and chronic Lymphocytic Leukemia, both of which are well-controlled. His chronic back pain was exacerbated by motor vehicle accidents but is now well-controlled by a pain management specialist in Barrie. His wife died of cancer in April 2004, after a prolonged chronic illness.

In 2005, Dr. Cowan appeared before another panel of the Discipline Committee to vary the 2003 Order. That Committee found that Dr. Cowan's knowledge deficiencies were not sufficiently addressed to enable him to practise the array of activities which he sought to engage in at that time.

Prior to appearing before the 2005 panel, Dr. Cowan voluntarily re-enrolled in the Physicians Health Program (PHP), after undergoing an intensive outpatient program in Kansas. A letter dated May 6, 2005 from the Professional Renewal Center in Kansas to Dr. A, Medical Director of the PHP, gives the diagnosis of "Opioid Dependence, In Sustained Full Remission."

Furthermore, the letter gave the following recommendation: "With a reasonable degree of psychological certainty, the treatment team finds Dr. Cowan fit to return to the practice of medicine with monitoring by the PHP…."

Dr. Cowan had continued to see an addiction specialist, Dr. B, until Dr. B died in 2008. He continued with the PHP until 2008, when he was suspended from the program.

A letter dated June 26, 2009 from Dr. A to Ms. C, counsel for the College, states:

> The basis for the suspension was that questions had arisen concerning Dr. Cowan's compliance with his agreement, mostly related to questionable approach (in my opinion) to the management of his chronic and recurrent pain, and, to a lesser extent because he had fallen behind in payments for ongoing lab work as required as part of the program….

> As we contemplated resumption of Dr. Cowan's PHP monitoring, Dr. Cowan asserted that he did not, and has never, in fact, genuinely accepted a diagnosis of substance dependence as appropriate and comfortable for him. I had no choice, therefore, but to advise Dr. Cowan and his counsel that owing to uncertainty about the specific appropriate diagnosis for Dr. Cowan, a precondition to Dr. Cowan possibly resuming participation in the PHP would be that he undergo a comprehensive diagnostic assessment…the cost of that kind of assessment would likely be somewhere in the range of $4000 to $7000. That said…I do not think that the PHP is necessarily the only choice for Dr. Cowan at this time.... I recommend Dr. D, an addiction medicine physician with experience treating health professionals…. Presuming Dr. D can arrive at a diagnostic understanding, a clear approach to clinical management and follow Dr. Cowan's progress on a regular basis incorporating random urine testing, then I believe there is an acceptable alternative to PHP monitoring in this instance.

Dr. Cowan has met with Dr. D on one occasion and has another appointment scheduled in July 2009. Dr. D has agreed to provide ongoing treatment and to act as a monitor for Dr. Cowan.

Dr. Cowan's personal financial circumstances at this time are desperate and he is at risk of losing his home. He has worked sporadically at various jobs including as a taxi driver and a call centre operator.

PRELIMINARY ISSUES:

1. Dr. Cowan's ability to practise as a surgical assistant without retraining.

2. The ability of Dr. Cowan to practise as a surgical assistant in Operating Rooms at hospitals in Collingwood and Barrie, given the geographical restrictions on his certificate.

1. Surgical Assisting:

The College would consent to Dr. Cowan acting as a surgical assistant in the Operating Room without providing pre- or post-operative care, even if the PREP level is not met, but only if Dr. Cowan resumes monitoring by the PHP.

The onus is on Dr. Cowan to show that a change of circumstances has occurred such that the terms, conditions and limitations of the 2003 Order be removed, as stated by the Committee in the decision in *CPSO v. Wesley* (2008):

> Counsel for both parties agreed that the onus was upon Dr. Wesley to show that a change in circumstances has occurred such that it is in the public interest for the terms, conditions and limitations to be removed. The burden of proof to be met is the civil standard or a balance of probabilities.

It is not the position of the College that an alternative would never be appropriate, but in this case, it is unknown if the proposed monitor, Dr. D, would meet the standard of the PHP. It is the College's position that a change of circumstances has not yet been established, as Dr. Cowan is at the beginning of establishing a relationship with Dr. D. Dr. Cowan and Dr. D have met only once and the assessment has not yet occurred. Thus, the College feels that the motion is premature and that Dr. Cowan has failed to meet the onus by showing that sufficient safeguards are in place, and that therefore there has been a change in circumstances such that it is in the public interest to vary the Order.

Dr. Cowan accepts that the onus is on him to show the sufficient change in circumstances has occurred.

Dr. Cowan has voluntarily sought treatment and monitoring, despite not being required by order to do so. It is often the case that a Committee will order as one of its terms and conditions that a physician undergo treatment and monitoring. When doing so, a Committee does not yet have a full diagnosis or treatment and monitoring plan. There is no difference in this case. The fact that the assessment of Dr. D has not yet occurred does not, in our view, make this motion premature.

It is Dr. Cowan's position that a full PHP contract, with all of its requirements, is not necessary in order to perform surgical assisting with no pre- or post-operative care. We agree. There are other mechanisms that can be used instead of the PHP contract to ensure protection of the public.

2. Geographical restrictions:

Dr. Cowan's certificate, which he has held since the early 1970s, restricts his practice to Wasaga Beach. Neither hospital (Collingwood or Barrie) are within this limited geographical area. Although Dr. Cowan has practised at both hospitals in the past, this does not mean that he did so within the bounds of the geographical restrictions on his practice. Counsel for the College and counsel for Dr. Cowan agree that the geographical location restriction should be an issue for the Registration Committee, rather than the Discipline Committee.

The Committee agrees with both parties that any geographical issue should be dealt with by the Registration Committee, and not by this Committee.

DECISION AND REASONS

The issue to be resolved in this hearing is whether Dr. Cowan has shown that a change in circumstances has occurred such that it is in the public interest to vary paragraph 2 (c) of the 2003 Order. Paragraph 2(c) of the existing Order states as follows:

> (c) that Dr. Cowan undertake as soon as possible, but not later than six months from the date of this Order, at his own expense, a PREP assessment under the auspices and supervision of the Quality Assurance Committee and successfully complete any remedial and assessment steps recommended by the PREP assessor or the Quality Assurance Committee. The PREP assessor and the Quality Assurance Committee shall be provided with the decision and reasons of this panel in advance of the assessment. The PREP assessor shall provide a full report to the Quality Assurance Committee following the assessment and any reassessment. In the event that Dr. Cowan scores level 1, 2, or 3, on the PREP assessment, he shall be permitted to continue in practise while undergoing any remedial steps recommended by the assessor or the Quality Assurance Committee. In the event that Dr. Cowan scores level 4 or 5, he will be

> required to withdraw completely from the practise of medicine until such time as he achieves level 3 or higher on a PREP reassessment.

Dr. Cowan has not asked the Committee to vary paragraph 3(e)(i) of the Order, which dealt with treatment and monitoring and had a five-year term, which has since expired.

We are satisfied that there has been a change in circumstances. Dr. Cowan's situation today is not as it was in 2003. However, before making any variation, the Committee's paramount consideration is and must be the protection of the public. Dr. Cowan is seeking to return only to surgical assisting, during which he would provide no pre- or post-operative care. Both parties agree that Dr. Cowan can practise as a surgical assistant without further retraining, but they differ as to appropriate ongoing monitoring to ensure public safety.

Dr. Cowan had been voluntarily registered with the PHP until 2008, and has now voluntarily made arrangements with Dr. D to act as his ongoing monitor. He was not under an order by the College to do so. Dr. D has agreed to provide ongoing treatment and to act as Dr. Cowan's monitor. In the past, the College had accepted Dr. B, an addiction specialist, as an appropriate monitor for Dr. Cowan. As well, Dr. A, Medical Director of the PHP, recommended that Dr. D provide ongoing treatment and monitoring for Dr. Cowan as a possible alternative to the PHP.

After hearing the submissions of counsel and considering all of the evidence presented, including reviewing the letters from the Professional Renewal Center and Dr. A, and the *curriculum vitae* of Dr. D, the Committee finds that Dr. D is a suitable alternative to the PHP and can provide ongoing treatment and act as a monitor for Dr. Cowan. The Committee therefore allows the motion, and varies paragraph 2(c) of the 2003 Order as indicated below. In order to ensure public safety, the Committee has included specific terms of monitoring, which shall be in place for at least one year.

ORDER

Therefore, the Discipline Committee ordered and directed that:

1. The Order of the Discipline Committee made February 21, 2003 is hereby varied by the addition of the following to the conclusion of subparagraph 2(c) thereof:

> … except that Dr. Cowan can act solely as a surgical assistant in a hospital. Dr. Cowan shall not provide pre-operative or post-operative care.

2. The Order of the Discipline Committee made February 21, 2003 is hereby varied by the addition of the following as subparagraph 2(c.1):

> (c.1) Dr. Cowan shall only act as a surgical assistant provided that he enter into a course of regular treatment with Dr. D in Newmarket, Ontario, or such other physician specializing in addiction medicine proposed by Dr. Cowan and approved in writing by the Registrar. Dr. D or the approved physician shall enter into an undertaking with, and acceptable to, the Registrar to serve in this capacity and to complete the steps set out below:
>
> (i) The frequency of treatment visits shall be determined by the treating physician but shall take place at least monthly for the first six months;
>
> (ii) The treating physician shall undertake or supervise random urine testing of Dr. Cowan, the frequency of which shall be at least every three months for the first year;
>
> (iii) The treating physician shall submit reports to the Registrar, including the results of the random urine testing, every three months for the first year and then every six months thereafter;

(iv) After the first year, this course of treatment shall continue until such time as the treating physician determines that the course of treatment is no longer required by Dr. Cowan.