NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Michael Varenbut, this is notice that the Discipline Committee that no person shall publish or broadcast the name and any information that could disclose the identity of the complainant 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: Varenbut, M. (Re)

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. MICHAEL VARENBUT

PANEL MEMBERS:

DR. P. TADROS
DR. P. POLDRE
M. FORGET
DR. R. SHEPPARD

Hearing Date:	October 17, 2012 (Motion) February 19, 2013 (Hearing)
Decision Date:	February 19, 2013
Release of Written Reasons:	May 31, 2013

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 October 17, 2012 (Motion), and February 19, 2013 (Hearing). At the conclusion of the hearing, the Committee delivered a written order stating its finding that the member committed an act of professional misconduct and penalty and costs order, with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Michael Varenbut 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. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

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

The Notice of Hearing also alleged that Dr. Varenbut is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the Regulated Health Professions Act, 1991, ("the Code"), in that his care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practise should be restricted.

RESPONSE TO THE ALLEGATIONS

Dr. Varenbut admitted the first allegation of professional misconduct in the Notice of Hearing, that he failed to maintain the standard of practice of the profession. Counsel for the College withdrew the second allegation of professional misconduct and the allegation of incompetence.

THE FACTS

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

Part I – Facts

Background

a) Dr. Varenbut and the Treatment Model at the Ontario Addiction Treatment Centre Clinics

1. Dr. Varenbut obtained his medical degree from the University of Toronto in 1991 and completed his residency in Family Medicine in 1993. For the past 17 years he has specialized in the field of Addiction Medicine and is a co-founder of the Ontario Addiction Treatment Centres (OATC), the country's largest network of Methadone clinics.

2. In addition to being a Fellow of the College of Family Physicians of Canada, Dr. Varenbut is also a Fellow of the American Society of Addiction Medicine (ASAM) and a board member of the Canadian Society of Addiction Medicine (CSAM). He also holds a Specialty Certification from both the American and Canadian Societies of Addiction Medicine and in 2009 was inducted as a Diplomate of the American Board of Medicine (ABAM).

3. OATC uses a multi-disciplinary approach to treat patients living with drug addiction. It provides a range of harm reduction treatment modalities, including Methadone Maintenance Treatment (MMT) programs. MMT is recognized as a highly effective approach to the treatment of opiate addiction. Methadone itself is a long-acting synthetic opioid which affects opiate receptors in the body by substituting methadone for other opiates. OATC's MMT program is supported by a multidisciplinary team and services which include addiction counselling, crisis intervention, and various other clinical services. Clinical case managers ("CCM's") are assigned to each OATC patient in order to help them navigate through the treatment program, and a variety of other community resources. The overall objective is to stabilize patients dependent on opiates.

The OATC has been accredited by Accreditation Canada and is a fully accredited provider on the OTN network. The Ontario Telehealth Network (OTN) is used to deliver care to patients in remote and under-serviced communities.

b) The Disease of Addiction

4. Drug addiction is a pervasive medical disease characterized by chronic relapses resulting in compulsive drug seeking and use. It impacts body organs but, more fundamentally, prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking drugs. The impact of drug use on the brain also leads to a constellation of unwanted behavioural, psychological and cognitive consequences. For this reason, effective treatment for drug addiction addresses not only physiological, but also the behavioural, psychological and social functioning components that are part and parcel of the disease. Drug addiction, particularly for high-risk injecting users, is characterized by high rates of morbidity and mortality. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Patient A's Treatment at OATC Between March 2005 and May 2008

5. Patient A was a woman in her early 20's who, in 2005, sought out the OATC for help with her drug addiction. She opted to start a MMT program to assist her in achieving this goal.

6. In order to be accepted into the MMT program Patient A was required to provide urine samples to confirm her opiate use and to check for other drug use. She was then immediately started on the program at a dose of 30mg of methadone per day. Although Patient A was asked to provide a blood sample prior to initiation on MMT, the physicians and clinic staff started her on methadone without the lab work being completed until two months later. She was not asked to obtain an ECG prior to, nor during, the treatment.

7. Patient A was a patient of OATC from March 2005 to May 2008. During this time, Patient A relocated a number of times between the OATC clinics in Town B, Town

C, and Town D, primarily to attend university programs. OATC accommodated these relocations.

8. As is often characteristic of a patient dealing with the disease of drug addiction, Patient A's sometimes chaotic lifestyle meant that her compliance with the MMT program was erratic and her demeanour with the clinic staff was often challenging and demanding. The clinic staff felt Patient A's non-compliance and the hostile conduct of her partner presented more challenges than most of their patients and caused them greater difficulties within their clinic structure. Her non-attendance for her regular urine samples, supervised methadone doses, and clinic appointments was exacerbated by financial difficulties and the substantial travel barriers she faced in getting to the clinic.

9. As of mid-2006, Dr. Varenbut became the Most Responsible Physician with respect to Patient A's care.

10. At the end of May 2008, Patient A travelled to Town E, Ontario to obtain a medical procedure. Although she arranged to have her methadone dose transferred so that she could continue on the program, there were delays in obtaining the medical procedure and ultimately she stopped taking her dose.

Patient A's Attempts to Return to Treatment at OATC in 2008-2009

11. In August, 2008, Patient A attended an appointment she had scheduled at OATC in Town B to re-start on the methadone program. At the time, Patient A was using cocaine and other opiates, including by injection. She met with a CCM who advised her that in order to see a physician and be restarted on MMT she was required to leave urine samples twice a week and have blood work and an ECG done. She was advised that, if this was completed, she could see the doctor in September, 2008. The OATC clinic indicated that these preconditions were now required for all patients seeking to be initiated on the methadone program.

12. Patient A provided two urine samples, but had not obtained blood work or an ECG. As a result, the CCM did not book the appointment with a doctor for September

2008 as originally anticipated. Patient A's appointment with a CCM for early September 2008 was cancelled and another CCM appointment was scheduled for ten days later, which Patient A missed.

13. Between August and December 2008, Patient A attended at the OATC clinic on nine occasions to provide witnessed urine samples.

14. By letter dated January 6, 2009, Patient A wrote to Dr. Varenbut indicating that she had been advised by the clinic that there was a problem with her health card version code that she needed to rectify. She also indicated in her letter that she had been told by a CCM that, once her health card was updated, she would have to redo all her urine samples before they would schedule a doctor's appointment for her. Patient A requested that Dr. Varenbut waive this condition and provide her with the earliest possible appointment with him. Although the clinic staff reiterated the intake requirements prior to re-admission, Patient A never received a response to her letter from Dr. Varenbut himself. In Dr. Varenbut's view, her failure to do the blood work and ECG showed a lack of commitment to the program and he was unwilling to waive these requirements. Patient A's letter of January 6, 2009 to Dr. Varenbut is attached at Tab 1 [to the Agreed Statement of Facts and Admission].

15. Patient A attended at the clinic in early February 2009 asking to meet with a doctor. Again, she was told that she would need to continue providing urine samples, obtain blood work and an ECG prior to re-entry and she was given a CCM appointment three days later. Following this attendance, Patient A wrote to the OATC expressing her frustration that the next appointment would be with a CCM rather than with a physician. Patient A further indicated that she would be willing to travel to Toronto if that would expedite the situation. Patient A never received a response to her letter from Dr. Varenbut himself. Patient A's letter of February 9, 2009 to the OATC is attached at Tab 2 [to the Agreed Statement of Facts and Admission].

16. Patient A attended for her scheduled appointment with a CCM on her scheduled appointment day in mid-February at which time she discussed her upcoming holiday

plans to go out of the country for two weeks in March and her desire to be initiated on methadone prior to her departure date and with a request for two weeks of carries (take home doses) to be used while on vacation.

17. Patient A wrote another letter to the clinic on February 20, 2009 asking again that she be given an appointment to see a doctor prior to her arranged travel plans and reiterating the fact that she had not received any contact from a doctor. Patient A's February 20, 2009 letter to the OATC is attached at Tab 3 [to the Agreed Statement of Facts and Admission].

18. Patient A met with a CCM in early March 2009, when she again advised about her upcoming trip and her desire to start methadone prior to leaving.

19. Six days later, Patient A attended at the clinic for her scheduled appointment with Dr. Varenbut, which she had confirmed the previous day. She was told by the clinic staff that Dr. Varenbut had cancelled the appointment because Patient A had not completed her blood work.

20. Following this cancellation, Patient A's partner wrote to the clinic that day on her behalf expressing his frustration and dissatisfaction with the further cancellation of her doctor's appointment, particularly in light of her upcoming departure from the country.

21. The next day, Patient A had her blood work done but not her ECG.

22. Between January and March 2009, Patient A attended at the OATC clinic on 15 occasions to provide witnessed urine samples.

Patient A's Termination From Care by OATC

23. After returning from her trip, Patient A attended the clinic in early April 2009 to leave a urine sample. At that time, she was advised by a CCM for the first time that Dr. Varenbut was terminating her care and that the OATC would no longer provide her service. She was referred to a psychiatric hospital in Town B for methadone treatment.

However, the hospital clinic had a waiting list and could not provide immediate treatment.

24. At the time of termination, Dr. Varenbut had concluded that there had been an irreparable breakdown in the physician-patient relationship with Patient A.

Part II – Admission

25. In all the circumstances, Dr. Varenbut failed to maintain the standard of care with respect to Patient A in the following ways:

(a) by failing to provide Patient A with a physician appointment within a reasonable time after she sought to be re-admitted to the MMT program in August 2008;

(b) by failing to make a timely decision about whether or not to accept Patient A back into the MMT program; and

(c) by unreasonably delaying Patient A's access to methadone treatment, of which she was in urgent need.

FINDING

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

AGREED STATEMENT OF FACTS ON PENALTY

Additional facts were established in an Agreed Statement of Facts on Penalty that was filed as an exhibit as follows:

1. Dr. Varenbut intends to stop his methadone practice and to focus his attention on other administrative and professional responsibilities. He has already started to transfer his Methadone Maintenance Treatment ("MMT") patients to other physicians.

2. Since the time of Patient A's involvement with Dr. Varenbut and the Ontario Addiction Treatment Centre ("OATC") clinics, the following changes have been implemented:

i) An Involuntary Discharge Policy which details the protocol to be followed when terminating a MMT patient has been implemented at all OATC clinics. A copy of this policy is attached at Tab 1 [to the Agreed Statement of Facts on Penalty]; and

ii) The OATC has a "Best Practice Committee" comprised of five OATC physicians, a Clinical Case Manager, clinic nurses and other ad hoc members of the team. A dedicated subcommittee of the Best Practice Committee, the "Involuntary Discharge Committee", has been formed which collaborates on any decision to discharge a patient involuntarily from OATC. The Terms of Reference for the OATC Best Practice Committee are attached at Tab 2 [to the Agreed Statement of Facts on Penalty].

3. Since September 2011, the Ontario Ministry of Health has implemented a policy that prohibits billing for urine testing where a patient has not been seen by a physician at least once per month. A description of the changes in the OHIP Schedule of Benefits is attached at Tab 3 [to the Agreed Statement of Facts on Penalty].

4. In 2008, an assessment of Dr. Varenbut's MMT practice based on a review of his care of 15 patients was conducted for the College's Methadone Committee. The Committee concluded that his care of these patients complied with the MMT Guidelines.

PENALTY AND COSTS ORDER AND REASONS

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. It was jointly proposed that Dr. Varenbut be reprimanded by the Committee and that he pay costs in the amount of $14,600.00, which is the tariff cost of four hearing days.

The Committee carefully considered the joint submission on penalty. The Committee is aware that a joint submission must be accepted, unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

The Committee accepts the joint position of the parties in this matter. The order sought, in the view of the Committee, is fair and reasonable under the circumstances. It will address issues of specific and general deterrence, the denunciation of wrongful conduct, and the protection of the public, which are the primary goals of a penalty order.

The Committee accepts that Dr. Varenbut failed to maintain the standard of practice of the profession with respect to his handling of the complainant's case. The patient was a high risk and vulnerable patient needing urgent care, which would have been recognized by Dr. Varenbut, an experienced clinician in the area of addictions medicine. Notwithstanding the patient's challenging behaviours, and her failure to completely follow through with the OATC's requirements for resumption of Methadone maintenance treatment, Dr. Varenbut should have responded in a more timely fashion to her multiple requests to see a physician. Because of the delay in making a decision on the patient's status with respect to the resumption of Methadone maintenance, the patient was left without treatment, and was thus exposed to potential harm. This was a lapse in judgment on the part of Dr. Varenbut, and does not meet the requisite standard of care.

The Committee acknowledges that Dr. Varenbut's credentials in the area of addictions medicine are impressive. He is clearly a knowledgeable and skilled practitioner in this area. Moreover, he has contributed in a very significant fashion to the advancement of this specialized area of medical practice. The Committee reviewed the character reference letters provided in evidence by counsel for Dr. Varenbut (Exhibit 4), which confirm that he is held in high regard by his peers. The Committee notes also that a 2008 assessment of Dr. Varenbut's Methadone maintenance practice, conducted by the College's Methadone Committee, concluded that his care of the 15 patients reviewed complied with Methadone maintenance treatment guidelines.

The Committee, furthermore, is encouraged by Dr. Varenbut's response to these proceedings. He has admitted responsibility for his misconduct, obviating the need for a lengthy hearing. He has assisted also with the implementation of systemic changes within the OATC, for the purpose of addressing some of the issues raised by this case, notably the often difficult decisions involved in the involuntary discharge of patients from Methadone maintenance treatment. As indicated earlier in this decision, an Involuntary Discharge Policy has been implemented at all OATC clinics, and an Involuntary Discharge Committee, a sub-committee of the OATC Best Practice Committee, has been formed to assist with decision-making in these challenging cases.

For the information of the profession, the OATC Involuntary Discharge Policy and the Terms of Reference for the OATC Best Practice Committee are attached to this decision. It is hoped that College members will find these informative, and that they may be of assistance in other areas of practice. The issue of the involuntary discharge from medical practice of difficult and non-compliant patients is not confined to Methadone maintenance treatment.

The particulars of this case are concerning, and the exposure of the complainant to potential harm cannot be excused. There is however no evidence before this Committee that Dr. Varenbut's failure to maintain the standard of care in this case was anything but an isolated episode in the context of Dr. Varenbut's otherwise impressive contributions to addiction medicine. This is a single patient case and there is no prior discipline history. The Committee considers this to be a mitigating factor with respect to penalty.

The Committee reviewed the precedent cases which were filed by counsel, which had some similarities to the facts of the current proceedings. While the Committee is not bound by these earlier decisions, similar facts should generally attract similar penalties. The Committee is satisfied that the order proposed for Dr. Varenbut is within the range of previous penalties for similar findings.

A finding of failure to maintain the standard of practice of the profession is a serious matter, and a public reprimand is a serious sanction. As stated by the Court in the case of *The College of Physicians v. Boodoosingh (1990)*, "a reprimand by one's governing body is a devastating event in the life of a professional."

ORDER

Therefore, having stated the finding of professional misconduct in paragraph 1 of its written order of February 19, 2013, on the matter of penalty and costs, the Committee ordered and directed that:

1. Dr. Varenbut appear before the panel to be reprimanded.

2. Dr. Varenbut pay to the College costs in the amount of $14,600 within 60 days of the date of this Order.

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