NOTICE OF PUBLICATION BAN

In the matter of College of Physicians and Surgeons of Ontario and Dr. Matheson this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names or any information that could disclose the identity of the patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

> Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:
>
> > Every person who contravenes an order made under … section 45… is guilty of an offence and on conviction is liable,
> >
> > > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Matheson, 2017 ONCPSD 32

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. JEFFREY RICE HOLMES MATHESON

PANEL MEMBERS: **DR. E. STANTON (Chair)**
MR. P. GIROUX
DR. B. LENT
MR. J. LANGS
DR. C. LEVITT

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MR. PETER WARDLE

COUNSEL FOR DR. MATHESON:

MR. NEIL ABRAMSON

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. GIDEON FORREST

Hearing Date: May 1, 2017
Decision Date: May 1, 2017
Release of Written Reasons: June 28, 2017

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 May 1, 2017. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

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

RESPONSE TO THE ALLEGATIONS

Dr. Matheson admitted allegations 1 and 2 in the Notice of Hearing, in that he has failed to maintain the standard of practice of the profession and in that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional with respect to the manner and circumstances of his opioid prescribing and in failing to comply with the

College's Out of Hospital Premises requirements. The College withdrew the allegation of incompetence, the allegation of disgraceful, dishonourable and unprofessional conduct in respect of prescribing opioids after agreeing not to do so, and the allegation of disgraceful, dishonourable and unprofessional conduct in failing to respond to the Out of Hospital Premises program as requested.

THE FACTS

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

PART I – THE FACTS

Background

1. Dr. Matheson is a 52 year-old family medicine physician with a practice in Ajax, Ontario who beginning in 2002 developed a specialty in Chronic Pain Management.

2. On July 30, 2013, the College Public and Physician Advisory Service received a telephone call from a pharmacist raising concerns with Dr. Matheson's prescribing practices. The pharmacist was concerned about Dr. Matheson prescribing large amounts of medication, particularly the narcotic medications to a particular patient, and had contacted Dr. Matheson to discuss the prescription and the reason for the large amounts being ordered. Dr. Matheson provided a letter to the pharmacist outlining the unique circumstances of this patient and confirming the amount of medications to be dispensed.

3. The College received a call from another pharmacist on February 28, 2014, expressing concerns about Dr. Matheson's prescribing.

4. On August 15, 2014, another pharmacist called the College with concern about a prescription written by Dr. Matheson.

5. A copy of that prescription was also provided to the College through the College of Pharmacists, who had alerted the Ministry of Health, after which the Ministry of Health sent out an advisory.

6. On October 1, 2014, another concerned pharmacist called the College about Dr. Matheson's prescribing practices.

Interim Undertaking Restricting Prescribing

7. As a result of concerns raised by the College and its expert during its investigation, on March 16, 2015 Dr. Matheson voluntarily ceased prescribing narcotics or controlled substances.

8. On May 28, 2015, Dr. Matheson signed a formal interim Undertaking to cease prescribing narcotic and controlled substances. The Undertaking dated May 28, 2015 is attached at Schedule "A" [to the Agreed Statement of Facts and Plea].

Expert Opinion

9. The College retained the services of Dr. MacLeod to review the standard of care provided by Dr. Matheson. Dr. MacLeod is a family physician in Thunder Bay whose practice is focussed on chronic pain management. Dr. MacLeod reviewed 25 charts randomly sampled from Dr. Matheson's opioid prescribing practice and interviewed Dr. Matheson on June 9, 2015. Dr. MacLeod opined in part, as follows:

> *Dr. Matheson did not meet the expected standard of practice as outlined in the Canadian Guidelines, not at the level of primary care physicians, and certainly not at what would be a reasonably higher standard of physicians, like Dr. Matheson, holding themselves out as specialist in the field.*
> *…*
> *Dr. Matheson consistently demonstrated a lack of understanding of the expectations of the Canadian guidelines in instituting opioid therapy,*

following up, changing from one opioid to another, and the medical implications of high-dosage opioids …

Dr. Matheson consistently demonstrated an almost cavalier approach to switching opioids, most often increasing the total daily morphine equivalent, by as much as 30% rather than allowing for incomplete tolerance and decreasing by 30 – 50%. All the time with no documentation of discussion around the driving or fall risk …

…Dr. Matheson's greatest failure of judgment, is perhaps his complete lack of adherence to and recognition of the importance of the fundamental importance of the Canadian guidelines to an opioid practice. That he would initiate a specialty pain practice in October 2013, 3 years after the Canadian guidelines were published in large volumes without adequately tracing this process, all shows a significant lack of judgment to the point of negligence causing harm."

…

"Does Dr. Matheson's clinical practice, behaviour or conduct expose or is it likely to expose patients to harm or injury?"

Yes, Dr. Matheson's prescribing of opioids and failure to follow any standards of care beyond opioid agreements is nothing short of reckless.

…His failure to adhere to standards of care, as noted above there is a risk to both his clients health and that of the public at large.

A copy of Dr. MacLeod's report received July 24, 2015 is attached at Schedule "B" [to the Agreed Statement of Facts and Plea].

10. Dr. Matheson was the medical director of premises that were subject to the inspection/assessment regime at the College under Part XI of O. Reg. 114/94. No person may perform procedures as defined in that Part, in a premises, unless the College "passes" the premises or passes it with conditions that allow procedures to be performed.

11. On September 9, 2014, the College's Out of Hospital Premises Inspection Program received notice that Dr. Matheson's premises was intending to move in December 2014 and advised Dr. Matheson that the premises must be assessed prior to becoming operational.

12. The new premises were inspected on February 2, 2015. Dr. Matheson was provided with the Inspection-Assessment Report which noted some deficiencies, and was twice asked for feedback in submissions that would be considered by the Premises Inspection Committee. He was given deadlines on both of those occasions. Dr. Matheson did not respond.

13. On June 11, 2015, Dr. Matheson's premises were subject to an unannounced visit by the Premises Inspection Program. During the inspection Dr. Matheson acknowledged that he had been performing "Level 2" procedures at the premises since February.

14. On June 19, 2015, Dr. Matheson's premises received a grade of "Fail". The Committee noted that "Upon reviewing the summary, the Committee is concerned that there was a risk to patient health and safety as you have been performing procedures at this premises without the approval of the Committee. The Committee is also of the opinion that you failed, by act or omission, to comply with any duty or requirement" under Part XI of O. Reg. 114/94.

PART II – [ADMISSION]

15. Dr. Matheson admits the facts set out above and admits that based on these facts he engaged in professional misconduct in that:

    (a) he failed to maintain the standard of practice in the profession under paragraph 1(1)(33) of Ontario Regulation 856/93 ("O. Reg. 856/93") in his care and treatment of patients;
    (b) he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as

disgraceful, dishonourable, or unprofessional under paragraph 1(1)(2) of O. Reg. 856/93 in the manner and circumstances of his opioid prescribing and in failing to comply with the College's Out of Hospital Premises requirements.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statements of Fact and Plea. Having regard to these facts, the Committee accepted Dr. Matheson's admission and found that he committed an act of professional misconduct in that has failed to maintain the standard of practice of the profession and that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

SUBMISSIONS ON PENALTY

College counsel reviewed the foundational principles to be considered when determining an appropriate penalty. These include public protection, general and specific deterrence, the need to maintain public confidence in the integrity of the profession and in the College's ability to govern the profession in the public interest, and rehabilitation of the member to the extent possible. In addition, counsel for the College reiterated the legal principle that a joint submission on penalty should be accepted, unless to do so would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

The Committee was provided with three professional misconduct cases for guidance on the range of penalties imposed in similar circumstances. In *CPSO v Redekopp* (2011), the penalty for deficiencies in the prescribing of opioids and benzodiazepines included a prohibition on prescribing narcotics and other controlled substances; a requirement for a waiting room sign informing the public of this prohibition; successful completion of the medical record-keeping course, but no suspension. In *CPSO v Wu* (2013), the penalty for deficiencies in opioid prescribing and for breaching an undertaking with the College included a six-month suspension; a prohibition on prescribing narcotics and other controlled substances; and a requirement for a waiting room sign informing the public of this prohibition (in English and Chinese). In *CPSO v*

Esmond (2016), the penalty for deficiencies in narcotic prescribing and record-keeping and for failing to comply with the College's policy on Treating Self and Family Members included a four-month suspension; a prohibition prescribing narcotics and other controlled substances; and a requirement for a waiting room sign informing the public of this prohibition (in English and Spanish).

In this case, the parties agreed on most elements of the penalty, but made submissions with respect to certain aspects of the penalty. The parties asked the Discipline Committee to treat the agreed aspects of the penalty as a joint submission on penalty and to make a determination on the areas where there was a disagreement. The Committee was prepared to do so in this case.

College counsel submitted that the appropriate penalty and costs order would include the following components:

1. A reprimand;
2. A four-month suspension, effective immediately;
3. A restriction on Dr. Matheson's prescribing of narcotics and other controlled substances;
4. A requirement to post a sign informing patients of Dr. Matheson's inability to prescribe narcotics and other controlled substances in English and in any other language in which he provides clinical care;
5. A requirement that Dr. Matheson successfully complete the medical record keeping course, the opioid prescribing course and an individual program in ethics;
6. A requirement that Dr. Matheson cooperate with unannounced College inspections of his practice and/or with any other measures the College deems necessary to monitor his compliance;
7. A requirement that Dr. Matheson consent to the College seeking information from various provincial databases including OHIP and the Narcotics Monitoring System;
8. A requirement that Dr. Matheson acknowledge that the College can provide relevant information about the Order to other individuals or any health care organizations which he is considering as a practice location; and,
9. Costs in the amount of $6,630.30.

Counsel for Dr. Matheson agreed with most, but not all, of the College's submission on penalty and costs. In particular, counsel for Dr. Matheson argued that no waiting room sign was necessary, given that all Ontario pharmacies would be made aware of the prohibition on his privileges to prescribe narcotics and other controlled substances. Counsel for Dr. Matheson further submitted that, if the Committee did require a sign, the wording be the same as is on the sign currently posted in his office waiting room, specifically that Dr. Matheson "*had relinquished*" his privileges to prescribe narcotics and other controlled substances, rather than the language proposed by the College that "Dr. Matheson *shall* not prescribe". Counsel also argued that reference to the CPSO website on the sign was unnecessary.

Counsel for Dr. Matheson also submitted that taking the course on opioid prescribing would be a drain on Dr. Matheson's time and money, and would not help him to improve his clinical care as he would no longer be prescribing opioids, given the prohibition being ordered. College counsel replied that a full knowledge of the opioid pharmacology is required for Dr. Matheson to assess and manage patients who might be taking opioids prescribed by other physicians.

Counsel for Dr. Matheson accepted the need to co-operate with unannounced College inspections, but submitted that the expansion of the requirement to co-operate to include "any other activity the College deems necessary in order to monitor compliance with the terms of this Order" broadened the College's powers unnecessarily.

Similarly, while Dr. Matheson's counsel agreed that the College could provide information about this Order to hospitals and/or individuals, he submitted that expanding the list to include "other person or individual as necessary for the implementation of this Order" was unnecessary.

PENALTY AND REASONS FOR PENALTY

In deciding on the appropriate penalty, the Committee reviewed the draft penalty and costs order provided by the College counsel, considered the aspects of the penalty agreed upon and the modifications suggested by Dr. Matheson's counsel, and carefully considered how each element of the proposed order would address the fundamental penalty principles. The Committee recognizes that public safety is paramount, but that a penalty must also address the need to

maintain public confidence in the College's ability to govern the profession in the public interest, general and specific deterrence, and, where appropriate, the rehabilitation of the member. The Committee is aware that these principles must be balanced with consideration of aggravating and mitigating factors. In addition, the Committee understands that a joint submission on penalty should be accepted, unless to do so would bring the administration of justice into disrepute, or would otherwise be contrary to the public interest.

The Committee was quite alarmed by the glaring deficiencies from the accepted standard of practice in Dr. Matheson's patient care with respect to the use of opioids, as documented in detail by the expert who reviewed 25 of his patients' charts. The expert further noted that Dr. Matheson's "complete lack of respect for the implicit risks involved in opioid prescribing" increased the risk of adverse effects and/or addiction for his own patients and put the public in harm's way from the possible diversion of the medications, especially given the large number of tablets and patches he prescribed to individual patients at any one time. Removal of Dr. Matheson's privileges to prescribe narcotics and other controlled substances is unquestionably required to protect the public.

In considering the proposed requirement to post a waiting room sign, the Committee reviewed the three cases provided by College counsel and noted that a sign was required in each case. The Committee accepts that informing patients of the restriction on Dr. Matheson's prescribing at each visit contributes to public protection and should be a term of the Order. The Committee is persuaded that the wording proposed in the College's draft order ("Dr. Matheson *shall* not prescribe") is more appropriate than the wording of the sign adopted as part of his undertaking ("Dr. Matheson *had relinquished*"), because it reflects that the restriction emanates from an order of the Committee.

The requirement that Dr. Matheson successfully complete courses in medical record-keeping, opioid prescribing, and professional ethics will also contribute to protection of the public and to Dr. Matheson's rehabilitation. Even though Dr. Matheson will no longer be prescribing narcotics, the course on opioid prescribing will provide him with the knowledge required to appropriately assess and manage patients who may be taking opioids prescribed by another physician. The medical record-keeping course will highlight the processes and tools required to

ensure that Dr. Matheson's assessments of clinical problems and management plans are robust and consistent with widely-held expectations for appropriate medical records.

The Committee recognizes that the College's ability to govern the profession effectively in the public interest requires that members take College processes seriously. Notwithstanding Dr. Matheson's counsel's assurances that Dr. Matheson accepts the terms, conditions and limitations being imposed on his certificate, the Committee notes his previous failure to respond to repeated College directives. The Committee accepts that allowing the College to use "any other activity the College deems necessary" to monitor compliance is appropriate in this case. Similarly, the Committee accepts as appropriate that the College can provide information about this Order to "any Chief of Staff, or colleague with similar responsibilities at any practice location", including "other person or individual as necessary for the implementation of this Order". The Committee believes that it is essential that Dr. Matheson consent to the College being able to share information relevant to this Order and/or to the monitoring of his compliance with this order with any person in a leadership position in any clinical setting in which he chooses to practise. The Committee notes that in the March 2015 and February 2016 undertakings Dr. Matheson consented to the Collage providing such information to any Chief of Staff, or colleague with similar responsibilities, at any Practice Location.

The Committee believes that the proposed penalty will send a clear message to the public and to other members of the profession of the Committee's abhorrence of the lack of knowledge, skill and judgment that Dr. Matheson displayed in his opioid prescribing and will thus address general deterrence and the need to maintain public trust in the integrity of the profession and in the College's ability to govern its members effectively.

The Committee considered several aggravating factors. The Committee notes that despite Dr. Matheson's characterization of his clinical practice as "specializing in chronic pain management", he displayed a reckless and cavalier approach to opioid prescribing, which occurred in the context of caring for many patients over an extended period of time. In doing so, he increased the risk of adverse effects and/or addiction for his own patients, and put the public in harm's way from the possible diversion of the medication.

With respect to mitigating factors, the Committee notes that Dr. Matheson has acknowledged that his patient care failed to maintain expected standards, promptly entered into (and has complied with) the May 2015 Undertaking and has cooperated with the College investigation. He has no previous history with the Discipline Committee. His decision to proceed with an Agreed Statement of Facts and a Joint Submission on Penalty with respect to most aspects of the penalty and costs order saves the College the time and resources of a contested hearing.

ORDER

Therefore, having stated its findings of professional misconduct as set out in paragraphs 1 and 2 of its written order of May 1, 2017, the Committee ordered and directed that:

3. Dr. Matheson appear before the panel to be reprimanded.

4. The Registrar suspend Dr. Matheson's certificate of registration for four (4) months commencing May 1, 2017.

5. The Registrar impose the following terms, conditions and limitations on Dr. Matheson's Certificate of Registration:

Prescribing Privileges

(1) Dr. Matheson shall not issue new prescriptions or renew existing prescriptions for any of the following substances:

(a) Narcotic Drugs (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);

(b) Narcotic Preparations (from the *Narcotic Control Regulations* made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);

(c) Controlled Drugs (from Part G of the *Food and Drug Regulations* under the *Food and Drugs Act*, S.C., 1985, c. F-27);

(d) Benzodiazepines and Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act.*, S.C., 1996, c. 19); or (A

summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached to the Order as Schedule "A"; and the current regulatory lists are attached to the Order as Schedule "B"); and

(e) All other Monitored Drugs (as defined under the *Narcotics Safety and Awareness Act*, 2010, S.O. 2010, c. 22 as noted in Schedule "C" to the Order); and as amended from time to time.

Posting a Sign

(2) Dr. Matheson shall post a sign in the waiting room(s) of his office, in a clearly visible and secure location, in the form set out at Schedule "D" to the Order. For further clarity, this sign shall state as follows: "Dr. Matheson shall not prescribe Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and Other Targeted Substances, or any other Monitored Drugs. Further information may be found on the College of Physicians and Surgeons of Ontario website at www.cpso.on.ca".

(3) Dr. Matheson shall post a certified translation in any language in which he provides services, of the sign described in paragraph 5.(2) above, in the waiting room(s) of his office.

(4) Dr. Matheson shall provide the certified translation(s) described in paragraph 5.(3), to the College within thirty (30) days of this Order.

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

(6) Dr. Matheson shall provide to the College the certified translation(s) described in paragraph 5.(4) prior to beginning to provide services in the language(s) described in paragraph 5.(5).

Coursework

(7) At his own expense, Dr. Matheson shall participate in and successfully complete, within 6 months of the date of this Order, the following programs:

a) Medical Record Keeping;

b) Opioid Prescribing; and

c) Individualized instruction in medical ethics satisfactory to the College, with an instructor selected by the College.

Compliance

(8) Dr. Matheson must inform the College of each and every location in which he practises or has privileges, including, but not limited to, hospital(s), clinic(s) and office(s), in any jurisdiction (collectively the "Practice Location(s)"), within five (5) days of commencing practice at that location.

(9) Dr. Matheson shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the terms of this Order.

(10) Dr. Matheson shall co-operate with unannounced inspections of his Practice Location(s) and patient charts by the College and to any other activity the College deems necessary in order to monitor his compliance with the terms of this Order.

(11) Dr. Matheson shall provide his irrevocable consent to the College to make appropriate enquiries of the Ontario Health Insurance Plan ("OHIP"), the Drug Program Services Branch, the Narcotics Monitoring System ("NMS") implemented under the Narcotics Safety and Awareness Act, 2010 and any person or institution that may have relevant information, in order for the College to monitor his compliance with the terms of this Order.

(12) Dr. Matheson acknowledges that the College may provide this Order to any Chief(s) of Staff, or a colleague with similar responsibilities, at any Practice Location where he practices or has privileges ("Chief(s) of Staff"), or other person or individual as necessary for the implementation of this Order and shall consent to the College providing to said Chief(s) of Staff, person or organization with any information the College has that led to this Order and/or any information arising from the monitoring of his compliance with this Order.

6. Dr. Matheson pay costs to the College in the amount of $6,663.60 within thirty (30) days of the date this Order becomes final.

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

TEXT of PUBLIC REPRIMAND
Delivered May 1, 2017
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. JEFFREY RICE HOLMES MATHESON

Dr. Matheson, it is always unfortunate when a member of our profession appears before this Committee. Your responsibility as a physician was to have proper knowledge of all the medication you prescribed and to document your care accurately.

It is unusual that this Committee has been presented an expert opinion that documents such alarming deficiencies in opioid prescribing, which falls far short of the expected standard of practice. Despite having ascribed to using the PDF version of the Canadian Guidelines for Safe and Effective Use of Opioids for chronic non-cancer pain, you consistently and repeatedly demonstrated not only a lack of understanding, but also a flagrant disregard for those guidelines.

Your cavalier and reckless approach to opioid prescribing not only put your patients in harm's way, but also potentially members of the public that could result from the possible diversion of opioids you prescribed to your patients. This is particularly egregious in view of the fact that you held yourself out as a physician specializing in chronic pain management.

This cannot, and indeed will not, be tolerated by the public or the profession. Your actions have not only brought disgrace to yourself, but the profession as a whole. The public expects and puts their trust in their physician they will provide care at the prerequisite standard. You violated that trust.

In addition, you admitted to failing to comply with the out-of-hospital premises requirements. Maintaining the ability of the College to govern the profession effectively in the public interest, is an important principle which demands that each member of the profession complies with the College requirements. You failed to do so, which has the potential for eroding public trust.

We trust that you have learned from this experience, and when you return to practice your care and documentation of that care will meet the standard that the public deserves.

Finally, we sincerely hope that you will never appear before this Committee again.