

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Fenton this is notice that the Discipline Committee ordered that no person shall publish or broadcast the name or any information that could disclose the identity of 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. Fenton,
2017 ONCPSD 16**

**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. PETER MICHAEL FENTON

PANEL MEMBERS:

**DR. WILLIAM KING (Chair)
MS DEBBIE GIAMPIETRI
DR. ANDREW TURNER
MR. SUDERSHEN BERI
DR. PAMELA CHART**

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

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MR. GIDEON FORREST

PUBLICATION BAN

**Hearing Date: March 20, 2017
Decision Date: March 20, 2017
Release of Written Reasons: April 21, 2017**

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 March 20, 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 is incompetent and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Peter Michael Fenton committed an act of professional misconduct:

1. under paragraph 1(1)2 of 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 Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“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. Fenton is incompetent as defined by subsection 52(1) of the Code.

RESPONSE TO THE ALLEGATIONS

Dr. Fenton admitted the allegations in the Notice of Hearing.

THE FACTS

The following Agreed Statement of Facts and Admissions was filed as an exhibit and presented to the Committee:

1. Dr. Peter Michael Fenton (“Dr. Fenton”) is 50 year old family physician practising in Toronto, Ontario. Dr. Fenton received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the “College”) in June 1992. At all relevant times, Dr. Fenton practised in a solo family medicine practice.

Section 75(1)(a) Investigation Regarding Prescribing

2. In June 2013, the College received a public complaint from a parent regarding Dr. Fenton’s prescribing and treatment of their daughter. In July 2014, the College received information from a physician expressing concern that Dr. Fenton was prescribing Percocet to a patient that is also in receipt of methadone from the physician. The physician had attempted to contact Dr. Fenton to discuss the prescribing, however, Dr. Fenton did not respond.
3. On the basis of this information, the Inquiries, Complaints and Reports Committee (“ICRC”) approved the appointment of investigators under section 75(1)(a) of the Health Professions Procedural Code (the “Code”) in order to conduct a broader investigation into Dr. Fenton’s prescribing practices.
4. The College retained Dr. Kimberley Morrison, a family physician, to opine on Dr. Fenton’s care and treatment of patients. After reviewing 26 patient charts and conducting an interview with Dr. Fenton, Dr. Morrison opined that Dr. Fenton’s care and treatment displayed a lack of knowledge, skill and judgment and that he failed to meet the standard of practice in the following respects:

- His charting is completely inadequate in terms of lack of substantive content for patient encounters, lack of useful cumulative patient profiles, including current medication lists, and when screening for controlled substances is begun in the fall of 2014, there is evidence of lack of insightful enquiry. Referral letters to consultants are consistently insufficient in content;
- There is a widespread lack of preventative care and chronic disease management;
- His acute presentation management as presented in his charts is generally superficial and treatment is not evidence based. Referrals are made at patient's request with little documentation of thought of possible differential diagnoses;
- His failure to acknowledge and appropriately document follow up concerns such as systolic blood pressure greater than 200 mm Hg and a neck mass growing in size could be considered as risks to the patient;
- His EMR is not used effectively for medication management, cumulative patient profiles, or lab result management. In the interview, it is clear that he does not have the knowledge to use his Electronic Medical Record ("EMR") effectively for these functions. After more than a year, both paper and electronic charts are maintained. Evidence of follow up of abnormal results or consultants recommendations is absent;
- He prescribes controlled substances in excess quantities in many charts and there is lack of knowledge of guidelines for safe prescribing as outlined in the CPSO Policy #8-12 regarding prescribing of medications and the Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non Cancer Pain. He does not have a solid understanding of the use of urine toxicology screening for controlled substances.
- There is evidence that he continues prescribing controlled substances for patients with possible adverse events, which may be directly related to the medication prescribed. Poly-pharmacy is often seen, and may be causing adverse effects such as decreased cognitive functioning in the elderly or insomnia in the case of excessive stimulant doses; and

- He appears to lack the professionalism to practice evidence based medicine, which he appears to have knowledge of, opting instead to prescribe as per the wishes of his “difficult” “demanding” patients, as he describes them.

A copy of Dr. Morrison’s report, dated July 24, 2015, is attached at Tab 1 to the Agreed Statement of Facts and Admissions.

5. Dr. Fenton responded to Dr. Morrison’s report, however, her opinion regarding his care and treatment remained unchanged.
6. In the course of this investigation, Dr. Fenton obtained a copy of Dr. Morrison’s report. This report contained the initials, date of birth and sex for 26 of Dr. Fenton’s patients together with a detailed review of the treatment and care received. Dr. Fenton showed Dr. Morrison’s report to at least one of his patients, including a patient who was not the subject of Dr. Morrison’s review.
7. Dr. Fenton is incompetent and failed to maintain the standard of practice of the profession with respect to his prescribing of narcotic drugs, narcotic preparations, controlled drugs, Benzodiazepines and other targeted substances and all other monitored drugs (“Controlled Substances”), as described above.
8. Dr. Fenton also failed to maintain the standard of practice of the profession as described above, including by:
 - Failing to follow appropriate practices related to chronic disease management and preventative care; and
 - Failing to maintain appropriate clinical notes and records.
9. Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in failing to preserve and maintain patient confidentiality during the College’s investigation as set out in paragraph 6 above.

Investigation Regarding Patient A

10. On December 8, 2014, the College received a public complaint from Patient A, who had been a patient of Dr. Fenton's for approximately five years. The care provided to Patient A included treatment for chronic pain and anxiety. Dr. Fenton dismissed Patient A from his practice in late November 2014.

11. The College retained Dr. Kimberly Morrison to opine on the care and treatment provided by Dr. Fenton to Patient A. After reviewing the patient's medical record and the relevant Narcotic Monitoring System ("NMS") data, Dr. Morrison opined that Dr. Fenton's medical records demonstrate a significant lack of knowledge, skill and judgment in medical record keeping and controlled substance prescribing, and do not meet the standard of care of the profession for a family physician as follows:
 - Dr. Fenton's recorded histories are often non-existent and lack detail to understand the patient's story. His documented physical examinations are either lacking entirely or insufficient for the complex chronic pain condition this patient reports. No investigations are done with respect to her physical pain or anxiety conditions. Impressions and management plans are not outlined regularly. Not all prescriptions given are recorded in the EMR. Rational for the prescription of medications (choice of drug, dose or quantity) including many controlled substances is not found in the medical record. CPP was not completed until after the patient was discharged from the practice.
 - Dr. Fenton's prescribing of controlled substances including narcotics, benzodiazepines and stimulants is excessive and without documented justification.
 - Prescription information from the NMS database and Dr. Fenton's chart calculate over 1000 morphine equivalents daily well in excess of "watchful dose" limits. There is a lack of evidence of application of recognized controlled substance prescribing guidelines. There is no adequate discussion of side effects, risks and alternative analgesic options. There are no clear treatment goals documented.

There is no documented indication for either stimulant or sedative medication, or discussion about the use [of] both categories of medication being prescribed concurrently. There is no supporting documentation of underlying diagnoses to support the use of these medications. There is no supporting evidence of favourable clinical outcomes as a result of these treatments.

- Dr. Fenton appropriately advised the patient that because of repeated breaches of their opiate treatment agreement, he would no longer continue to prescribe controlled substances for her. This would be partially considered to be within the standard of care for termination of a physician patient relationship as per CPSO Policy, however the policy also indicates a copy of this letter should be sent by registered mail to the patient and a copy be in the patient record. There is no documentation in the chart or in the patient complaint that the patient received such a letter. In addition, in considering termination of the patient physician relationship, there is no evidence that arrangement for any consultations with a pain clinic or alternate provider were made which would also be within the standard of care in family medicine. More importantly there is no evidence that strategies of tapering doses of her various medications or dispensing smaller quantities at one time, which would have potentially mitigated some of her risk having been taking such high doses of narcotics and sedatives prior to her dismissal.

A copy of Dr. Morrison's report, dated May 5, 2016, is attached at Tab 2 to the Agreed Statement of Facts and Admissions.

12. Dr. Fenton responded to Dr. Morrison's report, however, her opinion regarding his care and treatment remained unchanged.
13. Dr. Fenton is incompetent and failed to maintain the standard of practice in his care and treatment of Patient A, as described above, including his failure to follow the College's Policy regarding Ending the Physician-Patient Relationship.

Investigation Regarding Patient B

14. On January 22, 2015, the College received a public complaint from Patient B who had been a patient of Dr. Fenton's from approximately July 2008 until November 2014. Patient B's medical history includes hypertension, hypercholesterolemia, diabetes and chronic pain.
15. The physician-patient relationship ended in November 2014. At that time, Patient B requested that his patient chart be provided to his new family physician. There is no record in Dr. Fenton's chart of the new family physician's request for Patient B's chart, of the two occasions that Patient B attended Dr. Fenton's office to obtain his chart or of his transfer of the chart. Dr. Fenton did transfer Patient B's chart and, in his response to the complaint, apologized for not providing it in a more timely manner at the time it was requested.
16. The College retained Dr. Kimberley Morrison to opine on Dr. Fenton's care and treatment of Patient B. Dr. Morrison reviewed Dr. Fenton's paper chart and EMR for Patient B, as well as the complaint and response, and opined that Dr. Fenton's care of Patient B did not meet the standard of care, including in his record keeping, his chronic disease management and his follow up on abnormal test results and suggestions of consultants. Specifically, Dr. Morrison noted the following deficiencies:
 - There is evidence that medications are prescribed but not recorded within the EMR. A large gap exists in that there is no evidence of chronic disease management between the periods June 2013 to May 2014. There is evidence that abnormal test results and suggestions of consultant (in this case the ER doctor) are not followed up.
 - Dr. Fenton's treatment of [Patient B's] hypertension is not clear from the documentation found in the chart in that a complete list of medications being prescribed is not found in the record provided. It is unclear as to when or why hydrochlorothiazide appears to have been added. There is no documented risk

stratification. There is no assessment of possible end organ damage. The management of hypertension and its risks as documented does not meet the standard of care as expected of a competent practitioner in Family Medicine and demonstrates a lack of skill and judgment in the management of this chronic disease.

- The diagnosis and management of diabetes by Dr. Fenton does not follow the current guidelines of the Canadian Diabetic Association. Dr. Fenton appears from the chart to have made the diagnosis of diabetes based on a single laboratory reading of HbA1c equaling 0.065. There is no discussion of repeating this test on a different day as recommended. Once diagnosed, appropriate treatment based on the information provided would begin with discussion of lifestyle management of weight loss, exercise, and dietary habits including referral to allied health professionals for education would be the expected standard of care. The only documentation in this regard is “weight loss discussed” following the visit where metformin therapy was instituted.
- There is mention in the chart provided of discussion of lipid management, however targets were not identified. Again there is no evidence of risk stratification to guide treatment decisions as outlined in current guidelines. The patient appears to have been put on sub therapeutic doses of atorvastatin and had Ezetrol added in 2012, with no follow up to document response to treatment, or potential side effects until 2014. There is no discussion documented regarding maximizing the dose of the statin, or reasons why this would not be appropriate, before starting another class of medication which is considered standard of care by current guidelines. There is no discussion of lipid management following the lab work done in May 2014, which included a lipid profile and Dr. Fenton’s diagnosis of diabetes.

Dr. Morrison’s report, dated April 10, 2016 is attached at Tab 3 to the Agreed Statement of Facts and Admissions.

17. Dr. Fenton responded to Dr. Morrison's report, however, her opinion regarding his care and treatment remained unchanged.
18. On December 17, 2015, the College's investigator received a call from Patient B who described that he had run into Dr. Fenton recently at a Tim Horton's in their neighbourhood. During that encounter, Dr. Fenton asked Patient B to call the College and drop his investigation regarding Dr. Fenton. Patient B asked the College investigator to contact Dr. Fenton on his behalf and request that Dr. Fenton not approach him in the future if they see each other in the community.
19. Dr. Fenton failed to maintain the standard of practice of the profession in his care and treatment of Patient B, as described above, including his failure to follow the College's Policy regarding Test Results Management.
20. Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in:
 - His failure to transfer Patient B's medical chart in a timely manner; and
 - His communications with Patient B regarding his complaint to the College and his request for Patient B to withdraw his complaint.

Investigation Regarding Patient C

21. On July 28, 2015, the College received a public complaint from Patient C's lawyer who was representing Patient C with respect to an insurance claim and accident benefits arising out of a motor vehicle accident in 2010. Patient C was a patient of Dr. Fenton's since approximately 2009. Between August 2011 and July 2015, Patient C's lawyer made several attempts to obtain Patient C's medical chart from Dr. Fenton. Copies of the complaint, dated July 23, 2015, with the supporting documentation are attached at Tab 4 to the Agreed Statement of Facts and Admissions.

22. The College notified Dr. Fenton of the complaint in August 2015. On October 21, 2015, the College requested Dr. Fenton's response to the complaint as well as a copy of Patient C's medical records. The College sent follow up letters to Dr. Fenton requesting his response and his medical records in December 2015, January 2016, May 2016 and June 2016.
23. In July 2016, the College's investigator called Dr. Fenton to request Patient C's medical records. Following that call, Dr. Fenton provided an eight-page EMR covering the period from December 2013 to March 2016.
24. During the call in July 2016, Dr. Fenton was asked to provide the chart directly to Patient C. On September 30, 2016, shortly before this investigation was to be considered by the ICRC, the College's investigator contacted Dr. Fenton to confirm that he had provided the chart to Patient C and that the eight-page chart received was the entire chart for this patient. Dr. Fenton advised that the chart had not been sent to Patient C and agreed to do so. He also undertook to locate the rest of the chart and to provide it to Patient C and to the College. Additional records were not located at that time and the chart was not provided to Patient C.
25. Shortly before this Discipline Committee proceeding, and upon request from the College, Dr. Fenton located some additional, paper charts for Patient C which covered the period from April 2012 to October 2013. The EMR and the paper charts covering the periods specified above were provided to Patient C's lawyer for the first time in March 2017.
26. In January 2016, Patient C had an appointment with Dr. Fenton. During that appointment, Dr. Fenton asked Patient C to contact the College and tell them that he had no problem with Dr. Fenton as a doctor. Dr. Fenton told Patient C that it would be helpful if Patient C could call the College and tell them he had no concerns.
27. Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in:

- His failure to transfer Patient C's medical chart in a timely manner;
- His failure to respond to inquiries from the College within a reasonable time; and
- His communications with Patient C regarding his complaint to the College and his request for Patient C to call the College and tell them he had no concerns with Dr. Fenton as a doctor.

Investigation Regarding Patient D

28. On February 19, 2016, the College received a public complaint from a family member of Patient D expressing concern regarding the care provided by Dr. Fenton to Patient D, who had been a patient of Dr. Fenton's since approximately April 2010.
29. The College retained Dr. Nancy Merrow, a family physician, to opine on Dr. Fenton's care and treatment of Patient D. After reviewing the EMR and paper medical records, Dr. Merrow opined as follows:
 - Dr. Fenton's practice does not meet the standard for record keeping. The basics of effective record keeping are lacking in this chart. This includes the lack of an up to date Cumulative Patient Profile, lack of documentation to demonstrate physical findings, differential diagnoses and well thought out treatment plans. His referral notes to specialists were incomplete.
 - Dr. Fenton's practice does not meet the standard for the safe and effective use of opioids in the management of chronic non cancer pain. He documented risk factors for addiction and adverse events (alcohol abuse, lorazepam abuse) and did not apply harm reduction strategies such as:
 - tapering Benzodiazepines;
 - weekly prescribing;
 - referral to a pain specialist.
 - Dr. Fenton's practice does not meet the standard of care for the safe and effective use of Benzodiazepines in the management of anxiety and insomnia. This patient became dependent on lorazepam. She was falling, complaining of general

malaise, dizziness, and tremor. Medication adverse effects were never documented as a possible contributing factor to her progressive debility.

30. Dr. Merrow further opined that Dr. Fenton's care and treatment of Patient D displayed a lack of knowledge, skill and judgment as follows:

- Lack of knowledge: Dr. Fenton knew [Patient D] had a history of alcohol abuse. He documented her dependence and abuse of lorazepam. He continued to prescribe for her as she became older and frailer (21 Dec 2015- "needs more help now every 2 weeks"), experiencing episodes of dizziness, poor balance, low appetite and multiple falls. There is no evidence that he has a comprehensive and organized approach to managing chronic non-malignant pain with resources other than controlled drugs.
- Lack of skill: Dr. Fenton continued to prescribe opioids and benzodiazepines for [Patient D] without taking any extra precautions to manage the risk of potential abuse. He did not refer her to a pain or addiction specialist. He did not reduce her prescribed doses in an attempt to safely wean her from these drugs. There is no evidence that he had a thoughtful approach to the overall health risk management of this frail elderly woman with multiple chronic conditions.
- Lack of judgment: Dr. Fenton acceded to [Patient D's] demands for stronger pain medication without establishing any safeguards against increasing dependence and adverse effects. He cautioned her about her drug and alcohol use but he took no effective steps to treat these conditions or reduce harm from his part, which was the prescribing. Dr. Fenton put the responsibility for managing dependence and abuse of controlled drugs onto his patient despite her clear ongoing indications that she was not taking the best care of herself.

A copy of Dr. Merrow's report, dated September 3, 2016, is attached at Tab 5 to the Agreed Statement of Facts and Admissions.

31. Dr. Merrow concludes that “it is reasonably foreseeable that if [Patient D’s] prescribed medications and alcohol use continue she will experience serious adverse health outcomes from some kind of in home accident, a fall or an overdose.” She also opines that Dr. Fenton’s care is likely to expose other patients to harm or injury as well if it is conducted similarly to his care of Patient D.
32. Dr. Fenton responded to Dr. Merrow’s report, however, her opinion regarding his care and treatment remained unchanged.
33. In order to investigate this complaint, the College requested Dr. Fenton’s medical records for Patient D on March 16, 2016. Subsequent requests from the College, including from the Chair of the ICRC, were sent to Dr. Fenton on April 28 and May 16, 2016. No records were received in response to these written requests.
34. On July 13, 2016, the College’s investigator contacted Dr. Fenton by telephone and requested that he provide his medical records for Patient D. These records were ultimately received by the College on July 18, 2016.
35. Dr. Fenton is incompetent and failed to maintain the standard of practice in his care and treatment of Patient D, as described above.
36. Dr. Fenton engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in his failure to respond to inquiries from the College within a reasonable time.

ADMISSION

Dr. Fenton admits the facts in paragraphs 1 to 36 above and admits that, based on these facts he failed to maintain the standards of practice of the profession contrary to paragraph 1(1)2 of Ontario Regulation 856/93, is incompetent as defined by subsection 52(1) of the Code with

respect to his prescribing of Controlled Substances and engaged in acts or omissions relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional contrary to paragraph 1(1)(33) of O. Reg. 856/93.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admissions. Having regard to these facts, the Committee accepted Dr. Fenton's admissions and found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession and 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 Committee also found Dr. Fenton incompetent under subsection 52(1) of 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 practice should be restricted.

FACTS ON PENALTY

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

Dr. Fenton's Status Pending This Hearing

1. The Inquiries, Complaints and Reports Committee of the College ("ICRC") made an interim order on April 28, 2016 under section 37 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*. Pending resolution of the allegations against him, Dr. Fenton was required, among other things, to practise under the supervision of a clinical supervisor acceptable to the College. The

interim order specified that for the first three months supervision would be at a high level, such that Dr. Fenton would not be the most responsible physician for any patients being seen. The interim order also prohibited Dr. Fenton from prescribing Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines, Other Targeted Substances and All Other Monitored Drugs pending resolution of the allegations by the Discipline Committee of the College.

2. Dr. Fenton did not obtain a clinical supervisor, as required by the interim order. As a result, he ceased practising medicine on May 30, 2016. Dr. Fenton has not practised medicine since that date.

Dr. Fenton's Undertaking to the College

3. Dr. Fenton entered into an undertaking to the College, dated March 3, 2017, which is attached at Tab 1. Through this undertaking, Dr. Fenton has agreed that he shall no longer prescribe or renew any and all Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines, Other Targeted Substances and all other Monitored Drugs.
4. In this regard, Dr. Fenton has executed the Prescribing Resignation Letter to Health Canada, and has also executed the Consent and Direction for the Release of Information from the Ministry of Health and Long-Term Care Drug Services Program, which enables the College to monitor his compliance with his undertaking.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The proposed order included a six month suspension, extensive terms, limitations and conditions to be imposed before and after Dr. Fenton returns to practice, a reprimand, and costs in the amount of \$5,500.00 payable to the College within 30 days of the date the Order becomes final.

In considering the proposed penalty order, the Committee was mindful of the well established principles applicable to the administration of penalty.

In this matter, the principles which are of a particular importance include denunciation of the misconduct, maintenance of public confidence in the profession, and the ability of the College to govern effectively the profession in the public interest. Specific and general deterrence and rehabilitation of the member play a role in this matter as well. The overarching principle and primary consideration is protection of the public.

The Committee was also aware of the court's direction that a joint submission should be accepted by the Committee, unless the penalty proposed by the joint submission would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

Dr. Fenton exhibited professional misconduct in a number of different ways. He demonstrated contempt for the College, colleagues and others in his delay in producing records. He failed to maintain the standard of practice in his record keeping and in his clinical care of a number of patients, including in his prescribing practices. He prescribed narcotics dangerously and inappropriately. He engaged in unprofessional behavior with patients and failed to maintain confidentiality.

Such behavior requires a serious sanction and the penalty proposed by the parties is just that. The Committee accepted the proposed penalty as an appropriate sanction and proportional to the misconduct as found in this matter.

The reasons for the Committee's decision are set out below.

Unprofessional behavior

Dr. Fenton exhibited unprofessional behavior with patients, other physicians, the College and with other professionals.

He was asked to produce patient records and ignored these requests. One request came from a lawyer seeking insurance relief for his client, another from a physician requesting transfer of records and, lastly, he ignored the numerous letters from the College to produce medical records of his patients. This type of behavior is not acceptable.

Dr. Fenton also failed to maintain adequate patient charts. In the interest of the public, it is necessary that a physician maintains accurate medical record. Failing to do so puts the public at risk and this should have been amply clear to Dr. Fenton.

Dr. Fenton's neglect of his professional responsibility in maintaining and producing patient charts is addressed by the requirements to complete individualized instruction in medical ethics and the Medical Record Keeping Course offered through the University of Toronto. Both the individualized instruction and the course requirement are to be satisfactorily completed prior to a return to practice.

Further, Dr. Fenton engaged in inappropriate communication with patients when he:

- asked a patient (Patient C) to contact the College and say that he had no problem with Dr. Fenton as a doctor;
- showed Dr. Morrison's report containing a review of personal information of 26 patients to at least one of his patients, including a patient who was not the subject of Dr. Morrison's review. This is a clear example of a failure to protect and maintain patient confidentiality; and
- asked Patient B, whom he had run into at Tim Horton's, to call the College and ask them to drop the investigation regarding Dr. Fenton.

These examples illustrate the need for instruction in communicating appropriately with patients, including the need to address boundary issues. Therefore, the requirements to complete the individualized instruction in communications and Understanding Boundaries Course form an integral part of the order and are tailored to Dr. Fenton's deficiencies. As with the remedial

training in ethics and record-keeping, the communication and boundaries training must be satisfactorily completed prior to a return to practice.

Practice Deficiencies

The expert report of Dr. Morrison highlights that Dr. Fenton's charting was completely inadequate, that his management of preventive care and chronic disease was lacking and he failed to document legitimate concerns. There was no evidence of follow up of abnormal results or consultants recommendations.

As illustrated by Dr. Morrison's comments regarding Patient A, Dr. Fenton was profoundly lacking:

“Dr. Fenton's histories are often non-existent and lack the detail to understand the patient's story. His documented physical examinations are either lacking entirely or insufficient...”

Polypharmacy, prescribing controlled substances in excess quantities, incompetence and failure to maintain the standard of practice in narcotics prescribing is clear and supported in the Agreed Statement of Fact and Admissions.

With respect to Dr. Fenton's care and treatment of Patient B, there is a profound neglect of the management of hypertension and diabetes according to the expected standard. There is discussion of lipid management, however, targets were not identified.

As a result of a complaint in 2016, the College retained another expert, Dr. N. Merrow, to review Dr. Fenton's care of Patient D. Again, there is noted a woeful lack in record keeping and unsafe use of opioids and Benzodiazepines. There was no evidence of a thoughtful approach. This is particularly disturbing to the Committee as Dr. Fenton was aware at the time he provided care to Patient D that his practice was under scrutiny and there appears to have been no steps taken to remediate the situation.

It is anticipated that the upcoming course in primary care will address some of these issues. However, Dr. Fenton's Clinical Supervisor should also address the deficiencies noted by Dr. Morrison and Dr. Merrow in their respective reports. The Committee notes that Dr. Fenton has agreed to no longer prescribe narcotics or other controlled substances and finds this as an encouraging first step.

It is clear from the breadth of the findings, the number of patients involved, and the number of deficiencies in Dr. Fenton's practice, that a substantial suspension is indicated. There is simply no other way that the Committee can adequately denounce this type of behavior and achieve the required specific and general deterrence.

The terms of the order tailored to address Dr. Fenton's deficiencies must achieve protection of the public and the Committee is comforted that this will be achieved by ordering the program of supervision, education and a comprehensive practice assessment.

The Committee recognizes that this penalty constitutes a sizable commitment on Dr. Fenton's behalf. However, anything less would leave the public at risk.

The Committee accepts that Dr. Fenton may have gained an insight from acknowledging his misconduct and settling the matter outside a contested hearing and that he has no prior disciplinary history. However, faced with the breadth and seriousness of the professional misconduct, such mitigating factors do not carry significant weight.

The Committee reviewed the case law referred to by counsel, which covers the issue of a physician's deficiencies in a number of areas. None of the cases are completely analogous to Dr. Fenton's case. The penalties imposed in those cases embrace features, which are incorporated into Dr. Fenton's penalty and the Committee is of the view that the penalty imposed in this case is consistent with the penalties imposed in prior cases.

ORDER

The Committee stated its findings in paragraphs 1, 2 and 3 of its written order of March 13, 2017. In that order, the Committee ordered and directed on the matter of penalty and costs that:

4. Dr. Fenton appear before the panel to be reprimanded.
5. The Registrar suspend Dr. Fenton's certificate of registration for a period of six (6) months commencing on March 21, 2017, at 12:01 a.m.
6. The Registrar impose the following terms, conditions and limitations on Dr. Fenton's certificate of registration:

Education

- (a) Dr. Fenton shall, at his own expense, participate in and successfully complete the following educational courses within six (6) months of the date of this Order:
 - (i) the Medical Record Keeping Course offered through the University of Toronto;
 - (ii) the Pri-Med Canada Course (formerly Primary Care Today Course) scheduled for May 10-13, 2017;
 - (iii) the Understanding Boundaries Course offered through the University of Western Ontario;
 - (iv) individualized instruction in ethics, satisfactory to the College, with an instructor satisfactory to the College; and
 - (v) individualized instruction in communications, satisfactory to the College, with an instructor satisfactory to the College.
- (b) Further to paragraphs 6(a)(iv) and 6(a)(v), the instructor(s) shall provide a summative report to the College including his or her conclusion about whether the instruction was completed successfully by Dr. Fenton, including information regarding Dr. Fenton's progress and compliance.

Clinical Supervision

- (c) Dr. Fenton shall, by September 21, 2017, retain a clinical supervisor or supervisors

(the “Clinical Supervisor”) acceptable to the College, who will sign an undertaking in the form attached to the order as Schedule “A”. For a period of twelve (12) months thereafter, Dr. Fenton may practise only under the supervision of the Clinical Supervisor. Clinical Supervision of Dr. Fenton’s practice shall contain the following elements:

- (i) The Clinical Supervision shall be at a moderate level for a minimum of six (6) months, commencing on the date Dr. Fenton returns to work following the expiry of the suspension of his certificate of registration. The Clinical Supervisor will meet with Dr. Fenton weekly and review ten to fifteen (10-15) of Dr. Fenton’s patient charts, discuss Dr. Fenton’s patient care, treatment plan and follow-up, identify any concerns regarding the care, treatment plan and follow-up and make recommendations for improvement;
- (ii) Dr. Fenton shall permit the Clinical Supervisor to directly observe him in practice for one half-day per week or, at minimum, five (5) patients per visit, with the Clinical Supervisor providing a report every month to the College;
- (iii) After three (3) months, and only upon recommendation by the Clinical Supervisor and approval of the College, the frequency of the meetings with and observation by the Clinical Supervisor may be reduced to biweekly;
- (iv) After six (6) months of moderate level supervision, at minimum, and only upon recommendation by the Clinical Supervisor and approval of the College, the Clinical Supervision may be reduced to low level supervision for six (6) months. During the period of low level supervision, the frequency of the Clinical Supervisor’ meetings with and, if required, observation of Dr. Fenton shall be reduced to monthly;
- (v) Dr. Fenton shall fully cooperate with, and shall abide by any recommendations of his Clinical Supervisor, including but not limited to any recommended practice improvements and ongoing professional development;
- (vi) If a Clinical Supervisor who has given an undertaking in the form attached at Schedule “A” to the Order is unwilling or unable to continue to fulfill its terms, Dr. Fenton shall, within twenty (20) days of receiving notice of same,

obtain an executed undertaking in the same form from a similarly qualified person who is acceptable to the College and ensure that it is delivered to the College within that time; and

- (vii) If Dr. Fenton is unable to obtain a Clinical Supervisor in accordance with paragraph 6(c) or paragraph 6(c)(vi) of this Order, he shall cease practising medicine immediately until such time as he has done so, and the fact that he has ceased practising medicine will constitute a term, condition or limitation on his certificate of registration until that time.

Reassessment

- (d) Approximately six (6) months after the completion of Clinical Supervision, Dr. Fenton shall undergo a reassessment of his practice by a College-appointed assessor (the “Assessor”). The assessment may include a review of Dr. Fenton’s patient charts, direct observation, interviews with staff and/or patients, one or more interviews with Dr. Fenton, and/or a formalized evaluation. The results of the assessment shall be reported to the College after which Dr. Fenton shall abide by any recommendations made by the Assessor by which the College has requested Dr. Fenton to abide.
- (e) Dr. Fenton shall consent to such sharing of information among the Assessor, the Clinical Supervisor, and the College as any of them deem necessary or desirable in order to fulfill their respective obligations and in order to monitor Dr. Fenton’s compliance with this Order and with any terms, conditions or limitations on his certificate of registration.

Monitoring

- (f) Dr. Fenton shall consent to the College providing any Chief(s) of Staff or a colleague with similar responsibilities, such as a medical director, at any location where he practises (“Chief(s) of Staff”) 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.
- (g) Dr. Fenton shall inform the College of each and every location where he practises, in any jurisdiction (his “Practice Location(s)”) within five (5) days of this Order and shall inform the College of any and all new Practice Locations within five (5) days

of commencing practice at that location.

- (h) Dr. Fenton shall cooperate with unannounced inspections of his Practice Location(s) and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of the Order.
 - (i) Dr. Fenton shall consent to the College making enquiries of the Ontario Health Insurance Plan (“OHIP”), the Drug Program Services Branch, the Narcotics Monitoring System implemented under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010, c. 22, as amended (“NMS”), and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of the Order and any terms, conditions or limitations on Dr. Fenton’s certificate of registration.
 - (j) Dr. Fenton shall be responsible for any and all costs associated with implementing the terms of the Order.
7. Dr. Fenton pay costs to the College in the amount of \$ 5,500.00 within thirty (30) days of the date the Order becomes final.

TEXT of PUBLIC REPRIMAND
Delivered March 20, 2017
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. PETER MICHAEL FENTON

Dr. Fenton, the Committee is dismayed by the breadth and depth of your failings which go well beyond competent care of chronic pain to include widespread inadequacy in basic primary care, disregard for or misunderstanding of the vital importance of adequate medical records and the necessity of sharing or transferring them when requested, contempt for the fundamental principles of medical ethics, and disdain for necessity of compliance with the College in its role of requesting or guiding the profession.

You have been granted considerable space for reflection and rehabilitation. You might do well to search some of it, searching your soul and decide whether you genuinely want to become a competent and ethical family physician, or whether you would be better off finding another profession.