

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Fenton,
2019 ONCPSD 34**

**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. E. STANTON
MS. G. SPARROW
DR. P. HENDRY
MR. J. LANGS**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF
ONTARIO:**

**MS. E. GRAHAM
MS. C. SILVER**

COUNSEL FOR DR. FENTON:

SELF-REPRESENTED

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

Hearing Dates:	April 22 to 26, 2019
Decision Date:	July 29, 2019
Written Decision Date:	July 29, 2019

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto from April 22 to 26, 2019. At the conclusion of the hearing, the Committee reserved its decision on finding.

THE ALLEGATION

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

1. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), 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.

RESPONSE TO THE ALLEGATION

Dr. Fenton denied the allegation in the Notice of Hearing.

BACKGROUND

Dr. Fenton is a 52 year old family physician, who received his certificate of registration in June, 1992. He established a walk-in clinic in Toronto in 1997 and managed it for fifteen years. He ceased practising on May 30, 2016.

Dr. Fenton entered into a health monitoring undertaking with the College (the “Undertaking”), executed July 3, 2016. The Undertaking provided, in part, as follows:

(5) Psychiatric Treatment

- (a) I, Dr. Fenton, undertake to continue psychiatric treatment with Dr. Wood Hill or another psychiatrist certified by the Royal College of Physicians and Surgeons and approved by the College (the “Psychiatrist”) at a minimum once every month for the first twelve (12) months, and more frequently if recommended by my Psychiatrist.

(b) After twelve (12) months, and only upon the recommendation of my psychiatrist and the approval of the College, I, Dr. Fenton, undertake to continue psychiatric treatment with the Psychiatrist at a minimum once every (3) months.

The Undertaking also provided:

(6) I, Dr. Fenton, undertake to comply with the provisions of this Undertaking and acknowledge that a breach by me of any provisions of this Undertaking may lead to an inquiry regarding my capacity to practice medicine, may constitute an act of professional misconduct and / or incompetence, and may result in a referral of specified allegations to the Discipline Committee of the College and/ or the Fitness to Practise Committee of the College.

In 2017, Dr. Fenton was subject to Discipline Committee proceedings (*CPSO v. Fenton*, 2017 ONCPSD 16). Those proceedings resulted in an Order, dated March 20, 2017, which provided, in part, that:

(6)(a) Dr. Fenton shall, at his own expense, participate in and successfully complete the following education courses within six (6) months of the date of this Order:

[...]

(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.

It is alleged that Dr. Fenton failed to comply with his obligations as set out in the Undertaking, and the 2017 Order.

THE ISSUES

This case raises the following issues. Did Dr. Fenton engage in disgraceful, dishonourable or unprofessional conduct by:

- a) failing to attend regular appointments with his treating psychiatrist contrary to the terms of the Undertaking; and
- b) failing to complete the Understanding Boundaries Course; individualized instruction in ethics, and individualized instruction in communications within six months, contrary to the terms of the 2017 Order.

SELF-REPRESENTATION

Dr. Fenton advised the Committee that he would be acting on his own behalf. Since Dr. Fenton was not represented by legal counsel, the Discipline Committee Chair detailed the process by which the hearing would be conducted. Dr. Fenton was advised several times throughout the hearing by the Chair and Independent Legal Counsel (ILC) of his right to be represented by legal counsel. Each time that Dr. Fenton was advised of this, he advised that it was his intention to continue to act on his own behalf.

THE EVIDENCE

The College called five witnesses in support of the allegations. The Committee heard testimony from two College compliance case managers who were tasked with monitoring the Undertaking and Order, two educators who provided training in communications and ethics, and Dr. Fenton's psychiatrist.

Dr. Fenton called the Manager of the Compliance Monitoring and Supervision Department at the College, the College investigator involved in negotiating the Undertaking, and his mother, Ms. Eva Fenton. Dr. Fenton also testified on his own behalf.

i. Testimony of Ms. Rita van der Heiden

Ms. Rita van der Heiden is a case compliance manager who has worked for the CPSO since 1994. It is Ms. van der Heiden's role to ensure that physicians are aware of their obligations

with respect to the College and that they comply with any applicable undertakings. Dr. Fenton's Undertaking required him to meet with his psychiatrist monthly for twelve months. Ms. van der Heiden stated that it was Dr. Fenton's responsibility to attend those meetings and both Dr. Fenton and his psychiatrist (Dr. Wood Hill) had to inform her if there were any missed appointments.

Dr. Hill signed an undertaking to provide treatment for Dr. Fenton on August 11, 2016. Ms. van der Heiden sent a letter to Dr. Hill on September 1, 2016 outlining his responsibilities, specifically that he report to the College regularly with respect to his appointments with Dr. Fenton.

Dr. Hill sent his first report to Ms. van der Heiden on January 19, 2017, which stated that Dr. Fenton had regular appointments from August 11, 2017 until December 1, 2017. After that date, the report indicated that Dr. Hill had not heard from Dr. Fenton despite several calls.

Ms. van der Heiden sent a letter to Dr. Fenton on February 2, 2017 indicating that his failure to attend appointments with Dr. Hill would be considered a breach of his Undertaking and the matter would be forwarded to the Inquiries, Complaints and Reports Committee (ICRC). A memo dated February 21, 2017 stated that Ms. van der Heiden received a voicemail from Dr. Fenton indicating that because he had been away from Toronto in December, it was Christmas-time, and that he was away from his practice, he had not attended any appointments with Dr. Hill. Dr. Fenton indicated that he would start seeing Dr. Hill on a weekly basis. Dr. Fenton saw Dr. Hill twice in February. Ms. van der Heiden sent Dr. Fenton a letter on February 23, 2017 acknowledging his February appointments with Dr. Hill, reminding him of the requirements of the Undertaking, and informing him that any future breaches would be referred to the ICRC. Dr. Fenton continued appointments with Dr. Hill in March but stopped after March 23, 2017.

Ms. van der Heiden sent a letter to Dr. Fenton on July 26, 2017 informing him that he was in breach of the Undertaking and that it might be brought to the attention of ICRC. Ms. van der Heiden received confirmation from Dr. Hill on August 24, 2017 that Dr. Fenton had not been seen since June 6, 2017. Ms. van der Heiden issued a letter to Dr. Fenton on January 11, 2018

which stated that his breaches would be discussed at ICRC on February 21, 2018. Dr. Fenton was invited to make submissions to ICRC but none were received.

The Committee found Ms. van der Heiden to be credible and reliable. Her evidence was consistent with the documentary evidence. Although it was suggested to her in cross-examination that she was more “aggressive” in monitoring Dr. Fenton’s compliance with the Undertaking than necessary, given that Dr. Fenton was not practising at the time, we do not find this to be the case. The Committee finds that Ms. van der Heiden approached her responsibility to monitor compliance with the Undertaking professionally.

ii. **Testimony of Dr. Robert Wood Hill**

The College called Dr. Hill, Dr. Fenton’s treating psychiatrist, to testify. Dr. Hill obtained his medical degree in 1970, trained in psychiatry from 1970 to 1974, after which he became a Fellow of the Royal College of Physicians and Surgeons of Canada. Dr. Hill currently practises forensic psychiatry but also works as an individual psychiatrist.

Dr. Hill has been Dr. Fenton’s psychiatrist since 2005.

On August 11, 2016, Dr. Hill signed an undertaking with the College to treat Dr. Fenton and provide regular reports to the College. In accordance with the terms of the undertaking, Dr. Hill was meant to see Dr. Fenton once every month for the first 12 months and more frequently if indicated. After one year, the psychiatric treatments could be reduced to once every three months, upon Dr. Hill’s recommendation and with College approval. When asked whether this step-down had occurred, Dr. Hill stated that he still has contact with Dr. Fenton a minimum of once every month.

Dr. Hill testified that he was treating Dr. Fenton for a personality disorder. In explaining the specific nature of Dr. Fenton’s personality disorder, Dr. Hill said the following:

“...showing evidence of what is, I think, now colloquially called “Asperger’s syndrome” or more technically “autistic spectrum syndrome” difficulties. And, at times, his functioning in the community saw his personality being disordered such

that he was having troubles with people around him, organizations around him, and having troubles functioning in his professional life.”

When asked if Dr. Fenton ever indicated that he did not consent to Dr. Hill treating him, Dr. Hill said that that Dr. Fenton had not.

Dr. Hill reviewed the timelines of appointments with Dr. Fenton and confirmed that Dr. Fenton failed to appear for ten appointments as stated by Ms. van der Heiden in her testimony. Further to Ms. van der Heiden’s testimony, Dr. Hill indicated that according to his office notes, he had not seen Dr. Fenton from June 6, 2017 to February 13, 2018 and he had informed Ms. van der Heiden of this on February 13, 2018.

Under cross-examination, Dr. Hill stated that Dr. Fenton did not have a major psychiatric illness such as schizophrenia or a mood disorder, nor any significant problems with depression or anxiety. While Dr. Hill didn’t believe that Dr. Fenton had a severe mental illness, he stated he was trying to treat the difficulties Dr. Fenton was experiencing in his professional and personal lives. He also indicated that Dr. Fenton’s failure to meet his obligations with the College was something he was trying to work on during his appointments.

The Committee found Dr. Hill to be a reliable and credible witness. Despite the fact that he has a treating relationship with Dr. Fenton, he provided his evidence in a fair and objective manner.

iii. Testimony of Ms. Lee-Ann Siu

The College called Ms. Lee-Ann Siu to testify. Ms. Siu was a compliance case manager with the College from September 2016 to June 2018 and now works as a case manager for the College of Psychologists. Her role at the College was to monitor physicians’ compliance with various orders, undertakings or specified continuing education or remediation programs that are imposed by the College’s statutory committees.

In her capacity as a compliance case manager, Ms. Siu monitored Dr. Fenton’s compliance with the 2017 Order. The 2017 Order imposed certain terms, conditions and limitations on Dr.

Fenton's certificate of registration, part of which required him to complete courses including an Understanding Boundaries Course and individualized instruction in ethics and communications.

Ms. Siu testified that she first identified herself to Dr. Fenton with a letter to his counsel dated March 21, 2017, which informed him of the 2017 Order's requirements, including the courses and individualized instruction that had to be completed within six months. Dr. Fenton was advised how to comply with the 2017 Order including the completion of both a "communications and ethics program" and an "Understanding Boundaries Course". Ms. Siu provided the name and contact information of Dr. Dawn Martin who would provide the individualized instruction in ethics and communications.

On April 6, 2017, Ms. Siu sent a letter to Dr. Martin, copied to Dr. Fenton via his counsel, requesting that she provide instruction in communications, and repeating her request that Dr. Fenton contact Dr. Martin. Despite what had been stated in Ms. Siu's letter to Dr. Fenton's counsel of March 21, 2017, Ms. Martin was only retained to provide individualized instruction in communications (not communications and ethics).

Ms. Siu was informed by Dr. Martin on July 23, 2017 that she had not heard from Dr. Fenton. Dr. Fenton's counsel sent Dr. Fenton an email on September 1, 2017 reminding him that he needed to contact Dr. Martin to arrange the individualized instruction. Dr. Martin sent Dr. Fenton an email on October 9, 2017 to arrange the individualized instruction.

Dr. Fenton contacted Dr. Martin by email on October 12, 2017. Dr. Martin emailed Dr. Fenton and his counsel on November 16, 2017 informing them that she called Dr. Fenton, had left messages, and that email worked better for her than phone calls. Dr. Martin sent an email to Ms. Siu on November 21, 2017 indicating that she had not connected with Dr. Fenton, and again on January 15, 2018.

On April 6, 2017, Ms. Siu sent a letter to Ms. Gail Siskind regarding providing Dr. Fenton with individualized instruction in ethics and professionalism. Although Ms. Siu had copied Dr. Fenton's counsel on her April 6, 2017 letter to Dr. Martin, she had not copied him on her April 6, 2017 letter to Ms. Siskind. On September 11, 2017, Ms. Siu emailed Dr. Fenton's

counsel requesting an update on Dr. Fenton's participation in the educational courses. In that email, Ms. Siu specifically advised that the one-on-one education in ethics would be provided by Ms. Siskind.

On October 19, 2017, Ms. Siu clarified to Dr. Fenton via his counsel that Ms. Siskind would provide individualized instruction in ethics, while Dr. Martin would provide individualized instruction in communications.

Ms. Siu received emails from Ms. Siskind on June 23, 2017, July 10, 2017, August 25, 2017 and September 25, 2017 indicating that Dr. Fenton had not contacted her. On October 16, 2017, Ms. Siu received an email from Dr. Fenton's counsel indicating that Dr. Fenton had exchanged correspondence with Ms. Siskind regarding the required ethics instruction.

On October 17, 2017, Dr. Fenton's counsel notified Ms. Siu that Dr. Fenton had registered for the boundaries course on October 20 and 21, 2017, upon notification by Ms. Siu that a spot had opened due to late cancellation.

Under cross-examination, Ms. Siu admitted that she had initially indicated to Dr. Fenton that both the communications and ethics instruction would be provided by the same educator, Dr. Dawn Martin. Ms. Siu testified that in her letter to Dr. Fenton's counsel on March 21, 2017, she stated that it was up to Dr. Fenton to contact the instructor, and if he had done so, the educator would have indicated who was instructing which course. Ms. Siu testified that it was her role to monitor, not to enforce the Order.

Ms. Siu testified that between March and September, 2017, the miscommunication with respect to the individualized instruction was identified. Ms. Siu testified that although there had been miscommunication regarding who was to instruct Dr. Fenton on the ethics component, this did not infringe upon Dr. Fenton's ability to comply with the other aspects of the 2017 Order including the communications instruction and Boundaries course.

Dr. Fenton was quite critical of Ms. Siu and her admitted error in her letter of March 21, 2017 whereby she erroneously stated that Dr. Martin would be providing the instruction in both communications and ethics. It is clear that Ms. Siu was mistaken in her March 21, 2017 letter, and in her failure to copy Dr. Fenton's counsel on her April 6, 2017 letter to Ms. Siskind. This

likely led to the error not being identified sooner. It would appear that the first time Dr. Fenton was informed (through communication to his counsel) that Ms. Siskind was to provide the instruction in ethics was September 11, 2017.

The Committee found Ms. Siu to be a credible and reliable witness. She admitted the error in her March 21, 2017 letter and her oversight in failing to copy Dr. Fenton's lawyer on her April 6, 2017 letter to Ms. Siskind. Her testimony with respect to her work in monitoring Dr. Fenton's compliance with the 2017 Order was consistent with the documentary evidence. Despite Dr. Fenton's suggestions, the Committee finds that Ms. Siu's decision to leave the College was completely unrelated to her work on Dr. Fenton's matter.

iv. Testimony of Dr. Dawn Martin

The College called Dr. Dawn Martin to testify about the communications instruction that was to be provided to Dr. Fenton. Dr. Martin has a MEd and PhD in Curriculum Teaching and Learning, is in private practice, and provides assessment consultation and coaching for physicians and health care professionals. She testified that she was asked to provide communications instruction to Dr. Fenton and reached out to him by email on June 19, 2017. Dr. Martin testified that she did not hear back from Dr. Fenton until he was contacted by his counsel about his failure to comply with the Order.

Dr. Martin confirmed the email communications between herself and Ms. Siu indicating that Dr. Fenton had not contacted her until October 9, 2017, after which potential dates for meetings were provided to Dr. Fenton. Despite several phone calls and messages, and an email in November, 2017, Dr. Fenton did not respond until January 22, 2018. Dr. Fenton completed the communications instruction on February 24, 2018.

Under cross-examination, Dr. Martin stated that she can provide instruction in communications and ethics but Ms. Siu had instructed her only to do the communications portion of the instruction, which is reflected in her agreement with the College. Dr. Martin indicated that it was usually the physician's responsibility to reach out to the instructor to initiate the education.

The Committee found Dr. Martin to be credible and her evidence reliable. Under cross-examination she appeared to be sincerely doing her best to recall whether or not she had a telephone conversation with Ms. Siu in addition to their email exchange, and to recall the details of her conversations with Dr. Fenton about his obligation to complete both a communications and ethics course. Dr. Martin agreed that she did advise Dr. Fenton that she would reach out to Ms. Siu to see if they could continue their work together to cover the ethics component of the Order, but was informed by Ms. Siu that Ms. Siskind had already been assigned to provide the instruction in ethics. She denied that she ever told Dr. Fenton that she would ask the College if the work they had done together could count for both the communications and ethics course.

v. Testimony of Ms. Gail Siskind

The College then called Ms. Gail Siskind to testify. Ms. Siskind has a Bachelor of Arts in Psychology and English, a diploma in nursing, and a Master of Arts in which her thesis topic was Mentors in Nursing. Ms. Siskind has provided instruction in ethics to physicians on behalf of the CPSO since 2013.

On April 6, 2017, Ms. Siskind was contacted by Ms. Siu with respect to providing ethics training to Dr. Fenton. Ms. Siskind testified that on June 23, 2017, she sent an email to Ms. Siu indicating that she had not heard from Dr. Fenton and was waiting for him to contact her. On July 10, 2017, Ms. Siskind was informed by Ms. Siu that it was the physician who was required to contact them to arrange instruction.

Ms. Siskind contacted the College on August 25, 2017, September 25, 2017, and January 15, 2018 indicating she had not heard from Dr. Fenton. Ms. Siskind had not been provided with Dr. Fenton's contact information by the College. After Ms. Siskind was copied on an email from Dr. Martin to Dr. Fenton, she emailed Dr. Fenton directly on March 18, 2018, but did not receive a response. Ms. Siskind sent a follow-up email on April 16, 2018 to arrange meetings without any response.

On June 20, 2018, Ms. Siskind sent an email to Ms. Siu indicating that Dr. Fenton had not been in touch with her. On July 4, 2018, as Ms. Siu had left the CPSO for another position,

Ms. Siskind contacted Ms. Gillian Slaughter (Manager of the College's Compliance Monitoring Department) to inform her that Dr. Fenton had not been in contact.

Dr. Fenton contacted Ms. Siskind sometime between July 4 and August 27, 2018. On August 27, 2018, Ms. Siskind sent emails to College Case Compliance Manager, Ms. van der Heiden, indicating that Dr. Fenton had contacted her and the instruction was to begin on September 7, 2018. The ethics instruction was completed on September 28, 2018. Ms. Siskind sent her report to the College regarding Dr. Fenton on October 21, 2018.

Under cross-examination, Ms. Siskind stated that she had reached out to both Ms. Siu and Dr. Martin about the ethics instruction to be provided, however, was told that it was the physician's responsibility to be in touch with her. Ms. Siskind stated that she does not usually receive the contact information for those who she is asked to instruct.

The Committee found Ms. Siskind's evidence to be credible and reliable. Again, her evidence was consistent with the documentary evidence. Dr. Fenton did not challenge any of the facts to which she testified with respect to their interactions.

vi. **Testimony of Ms. Gillian Slaughter**

Dr. Fenton called Ms. Gillian Slaughter to testify. Ms. Slaughter is the Manager of the Compliance Monitoring and Supervision Department at the College. She testified that Ms. Siu had notified her that she had initially informed Dr. Fenton to seek both communications and ethics instruction from Dr. Martin, and then later sent a letter to Dr. Fenton's counsel informing him that the ethics instruction was to be provided by Ms. Siskind. Ms. Slaughter explained that Ms. Siu was a diligent and prompt compliance manager and that she left the College for a position at another regulatory College and confirmed that she had not been terminated.

The Committee found Ms. Slaughter to be credible and reliable. Her testimony was consistent with the evidence from Ms. Siu that Ms. Siu left her position at the College voluntarily and that Ms. Siu's departure had nothing to do with her handling of Dr. Fenton's matter.

vii. Testimony of Ms. Fenton

Dr. Fenton called on his mother, Ms. Fenton, to testify. Ms. Fenton is an 81 year old widow who lives alone. She had a hip replacement on May 6, 2017. After her discharge from a rehabilitation hospital on May 29, 2017, Dr. Fenton cared for her at her home for three weeks after which time she has lived alone. The Committee found Ms. Fenton to be credible and reliable. The Committee does not doubt that Ms. Fenton was in need of assistance following her surgery and that her son, Dr. Fenton, cared for her as she testified.

viii. Testimony of Ms. Elizabeth Adamson

Dr. Fenton called Ms. Adamson to testify. Ms. Adamson has been an investigator at the College for 14 years. Ms. Adamson was present at the ICRC Incapacity Inquiry Panel meeting where the panel set out the terms of the Undertaking to be negotiated with Dr. Fenton.

Ms. Adamson testified that she called Dr. Fenton on March 28, 2016 to discuss the terms of the Undertaking and then sent the Undertaking for his consideration March 31, 2016.

Under cross-examination by the College, Ms. Adamson testified that she called Dr. Fenton on May 5, 2016. During that call, Dr. Fenton indicated that he was prepared to sign the Undertaking, and he did not express any concerns or reservations about its contents. Ms. Adamson indicated that she did not tell Dr. Fenton that he had to sign the Undertaking.

Ms. Adamson indicated that she spoke to Dr. Fenton by phone on June 22, 2016. This call is documented in a written memo. Ms. Adamson testified that during the June 22, 2016 call, she referenced their previous phone conversation in which Dr. Fenton had indicated that he would sign the Undertaking and return it to her. Dr. Fenton's response was that because he wasn't practising, he thought it didn't matter. Ms. Adamson said that she explained to Dr. Fenton that the Undertaking was still relevant, and if it was not returned, that it would have to be brought back to the ICRC for an alternate disposition. Dr. Fenton returned the signed Undertaking to the College on July 3, 2016.

During his re-examination of Ms. Adamson, Dr. Fenton asked whether she was concerned about his capacity to sign the Undertaking. Ms. Adamson stated that it was not her role in this situation to determine his capacity.

The Committee found Ms. Adamson to be credible and reliable. Much of Dr. Fenton's examination of Ms. Adamson was directed to the manner in which the Undertaking was prepared and how direction was given by the ICRC to Ms. Adamson regarding the preparation of the Undertaking. Those issues are not relevant to this proceeding. The issue in this proceeding is whether or not Dr. Fenton complied with the Undertaking that he signed.

ix. **Testimony of Dr. Fenton**

Dr. Fenton testified on his own behalf.

Dr. Fenton stated that he did not dispute the breaches of both the Undertaking and Order but that these breaches did not amount to "disgraceful, dishonourable and unprofessional" conduct.

Dr. Fenton stated that the confusion around who was to provide instruction in communications and ethics was one of the reasons why he couldn't comply with the 2017 Order. Dr. Fenton suggested that Dr. Martin's preference for emails rather than phone calls was another reason why he could not start the instruction.

Regarding the Boundaries course, Dr. Fenton provided an email from the Schulich School of Medicine, dated April 17, 2019, that provided the dates of the Boundaries courses that had been offered in 2017. There was a session scheduled for June, 2017 but Dr. Fenton stated that he could not attend due to his mother's illness.

Regarding the Undertaking, Dr. Fenton indicated that he was upset and angry when the College issued an interim suspension of his license on May 31, 2016. He suggested that this might have had an impact on his dealing with the terms of the Undertaking. He stated that at the time of signing the Undertaking, he was angry and upset and did not feel the psychiatric therapy was helping him so he thought it was optional.

During cross-examination, Dr. Fenton stated that he did not recall many of the communications presented as evidence between himself and the College and between himself and his counsel. He indicated that he may have signed documents without reading them. In addition, he indicated that he did not always open or respond to communications from the College. He stated that between May 31, 2016 and August 2016, he was upset and would not have opened letters from the College.

Dr. Fenton stated that Ms. Adamson informed him that if he didn't sign the Undertaking, his case may be referred to the Fitness to Practise Committee. Dr. Fenton did not make further inquiries as to what this meant, nor did he consult with the Canadian Medical Protective Association about the Undertaking, or his then legal counsel who he indicated was only representing him on the matter pertaining to the 2017 Order. Dr. Fenton stated that when he was informed that his breaches would be brought forward to either the ICRC or Discipline Committees, he thought there was a low probability that this would happen.

The Discipline Committee's decision in *CPSO v. Fenton*, 2017 ONCPSD 16 was reviewed and Dr. Fenton admitted that he agreed with the findings. However, he stated he didn't agree with the reasons why he had to take the instruction in communications, ethics and boundaries. He testified that he knew he had to complete the courses by September 20, 2017 and knew that it was his responsibility to arrange for the courses.

The Committee found Dr. Fenton's testimony challenging in that it was often vague and evasive. His recollection of events was variable depending on whether they were critical to his case.

ONUS AND STANDARD OF PROOF

The College has the onus to prove the allegations against Dr. Fenton on the civil standard of a balance of probabilities (*F.H. v. McDougall*, 2008 SCC 53). The evidence must be clear, cogent, and convincing to satisfy the balance of probabilities standard.

The Committee's findings are based exclusively on the evidence admitted, including both oral testimony and exhibits. The Committee assessed the evidence in its totality and did not assess individual items of evidence in isolation.

ANALYSIS AND FINDINGS

The issues before this Committee are whether or not Dr. Fenton failed to comply with the terms of the Undertaking and Order, and if he did not comply, whether this constitutes disgraceful, dishonourable or unprofessional conduct.

It would not be appropriate, nor is it the role of the Committee, to review the original decision of either the ICRC in 2016 to request Dr. Fenton's Undertaking, or the Discipline Committee in 2017 to make the Order that it did. In considering whether Dr. Fenton failed to comply with the Undertaking and 2017 Order, and if so whether this constitutes professional misconduct, the Committee considered all of the evidence before it, and the written and oral submissions.

While Dr. Fenton acknowledged the breaches he made, he did not feel that his behaviour was disgraceful, dishonourable or unprofessional.

In *Cartier v. College of Nurses of Ontario*, 2019 ONSC 2289, it states that “the determination of whether conduct is dishonourable and/or unprofessional must be made on the basis of the evidence before the Discipline Committee, and the Discipline Committee's assessment as to whether members of the profession would reasonably regard that conduct to be dishonourable and/or unprofessional”.

(i) Breach of Undertaking

Whether Dr. Fenton consented to treatment with Dr. Hill

Dr. Fenton submitted that the College failed to ensure that he had consented to treatment by Dr. Hill.

The Undertaking of July 3, 2016 clearly states that Dr. Fenton had to attend monthly appointments for at least one year with either his treating psychiatrist or a new psychiatrist approved by the College. The evidence indicates that Dr. Fenton's treatment with Dr. Hill had started years before due to a previous Undertaking with the College. Dr. Hill had been Dr. Fenton's treating psychiatrist since 2005.

The Committee finds that Dr. Fenton signed the Undertaking agreeing to see a psychiatrist on a monthly basis and that Dr. Fenton elected to seek that treatment from Dr. Hill. Since Dr. Fenton chose to continue treatment with his treating psychiatrist, no new consent was required. Therefore, the Committee rejects Dr. Fenton's submission that he did not consent to treatment by Dr. Hill.

Whether Dr. Fenton had capacity at the time of signing the Undertaking

Dr. Fenton also submitted that at the time of signing the Undertaking, he did not have capacity to understand its terms due to his mental state. The Undertaking states in paragraph 2: "I, Dr. Fenton, acknowledge that I am suffering from a mental health condition and as a consequence, that monitoring is desirable (as hereafter provided.)."

A person who is eighteen years of age or more is presumed in law to have the capacity to contract, by virtue of s. 2(1) of the *Substitute Decisions Act, 1992*, S.O. 1992, c. 30. Under s.2 (3) of that Act, a person is entitled to rely on this presumption unless there are reasonable grounds to believe that the other person is incapable of entering into the contract. The Committee is not persuaded that there are reasonable grounds to believe that Dr. Fenton was incapable of entering into the Undertaking.

The evidence before the Committee did not support Dr. Fenton's claim that he did not have the capacity to understand the terms of the Undertaking or to enter into the agreement. Dr. Fenton recalled being upset and angry prior to signing the Undertaking, but this is not indicative of his lack of capacity to understand the terms of the undertaking or to contract.

Ms. Adamson, the investigator, testified that she discussed the terms of the Undertaking with Dr. Fenton on March 28, 2016 and sent it to him on March 31, 2016. She testified that she called Dr. Fenton again on May 5, 2016 and on that date, he indicated that he was prepared to sign the Undertaking and had no concerns regarding its contents. She made a further phone call to Dr. Fenton on June 22, 2016 and testified that on that date, Dr. Fenton said he would sign the undertaking and return it to her. Ms. Adamson documented this call in a memo to file. The College received the signed Undertaking from Dr. Fenton on July 3, 2016. This

indicates to the Committee that Dr. Fenton was engaging with the College investigator with respect to the Undertaking and did not indicate any difficulty in comprehending it.

Dr. Fenton's psychiatrist, Dr. Hill, testified that he was treating Dr. Fenton for a personality disorder and the ensuing difficulties in his professional and personal lives. Dr. Hill testified that Dr. Fenton did not have a major psychiatric illness.

The Committee finds that the evidence does not support that Dr. Fenton was incapable of understanding the terms of the Undertaking when he signed it and returned it to the College on July 3, 2016.

Whether Dr. Fenton breached the Undertaking

Pursuant to the Undertaking, signed July 3, 2016, Dr. Fenton was required to attend monthly appointments for at least one year with his psychiatrist. After one year, the treatment could be reduced to attendance once every three months, but only upon the recommendation of the psychiatrist and approval of the College.

Dr. Hill testified that he never made the recommendation to reduce treatment. Further, approval to reduce treatment to once every three months was never provided by the College. Dr. Hill testified that Dr. Fenton attended monthly sessions from August to December 2016, but that he failed to attend in January of 2017. Dr. Fenton did attend for sessions on February 16 and 23, and on March 9, 16 and 23, but did not attend in April or May of 2017. Dr. Fenton did attend for his appointment on June 6, 2017, but then Dr. Hill testified that he did not see Dr. Fenton from June 6, 2017 to February 13, 2018.

The Committee finds that Dr. Fenton breached the Undertaking by failing to meet with his psychiatrist on a monthly basis as he was required to do so.

(ii) Breach of 2017 Order of the Discipline Committee

The 2017 Order, dated March 20, 2017, provided that the education courses had to be completed within six months from the date of the Order, i.e., by September 20, 2017.

Dr. Fenton provided a number of reasons for not completing the instruction in ethics and communications as required under the 2017 Order, although he testified that he knew he had to complete the instruction in a timely fashion. Dr. Fenton also said that he did not agree with the reasons of the Discipline Committee as to why he had to take the courses. He eventually started the instruction when he was informed these breaches may be forwarded to either the ICRC or the Discipline Committee.

Individualized Instruction in Communications

Dr. Fenton provided no reasonable explanation for his failure to complete the individualized instruction in communications within the six months as required by the 2017 Order. He did not complete this instruction until February 2018, several months after the deadline.

Despite having had Dr. Martin's email address since March 21, 2017, the day after the Order was made, and despite Dr. Martin's attempt to contact him in June 2017, Dr. Fenton failed to contact her until October 2017. Dr. Martin then made repeated attempts to contact Dr. Fenton on October 12, 26 and November 16, 2017. Once Dr. Fenton finally requested a meeting with Dr. Martin, on January 22, 2018, Dr. Martin scheduled their first session within six days.

Individualized Instruction in Ethics

Dr. Fenton testified that he was misled by communications from the College into believing that Dr. Martin would be providing both the individualized instruction in communications and ethics. However, by his own admission, Dr. Fenton failed to contact Dr. Martin, the person who he understood to be providing the instruction in both communications and ethics, at any time prior to October 2017. In the Committee's view, had Dr. Fenton made inquiries by contacting the College or Dr. Martin, he would have learned that the ethics and communications instruction would be provided by two separate instructors.

The compliance case manager, Ms. Siu, informed Dr. Fenton's counsel on September 11, 2017 that Ms. Gail Siskind would be providing the ethics instruction. On October 16, 2017,

Ms. Siu received an email from Dr. Fenton's counsel indicating that Dr. Fenton had exchanged correspondence with Ms. Siskind regarding the required ethics instruction.

Ms. Siskind emailed Dr. Fenton directly on March 18, 2018. She did not receive a response and followed up again by email to Dr. Fenton on April 16, 2018. Again, she received no response from Dr. Fenton. On August 27, 2018, Ms. Siskind reported to the College that Dr. Fenton had contacted her and that they had set up their first session for September 7, 2018. The ethics instruction was then completed on September 7 and 28, 2018.

The Committee is not persuaded that Dr. Fenton would have complied with the Order and seen Ms. Siskind for ethics instruction by September 20, 2017 (i.e., within the six-month compliance period) had he had her name or contact information prior to September 11, 2017. Even when he was provided with her name, he ignored numerous follow-up communications and did not complete the required course until over a year later, which was more than a year after the time provided in the 2017 Order.

Boundaries Course

Dr. Fenton's evidence was that the only time the Boundaries Course was offered within the six-month compliance period was June of 2017. Dr. Fenton testified that he was unable to attend the June session due to his obligation to care for his mother, who had undergone hip replacement surgery on May 6, 2017. However, Dr. Fenton did not advise the College at that time that he would be unable to complete the Boundaries Course during the time allotted by the Order because he had to care for his mother. Dr. Fenton did not advise the College until shortly before this hearing that he had been prevented from attending the June 2017 course because he had been attending to his mother. There was no evidence before the Committee that Dr. Fenton had sought to register for or had any intention of attending the June 2017 course prior to his mother's surgery.

Dr. Fenton was informed by the College on October 16, 2017 that a spot had opened up for the October 20-21, 2017 session. Dr. Fenton then registered and completed the course. Although Dr. Fenton completed the course in October of 2017, this was again beyond the time frame provided for in the 2017 Order.

The Committee finds that Dr. Fenton breached the terms of the 2017 Order in failing to complete the individualized instruction in communications and ethics and the boundaries course within the required time period.

(iii) Disgraceful, Dishonourable or Unprofessional Conduct

In the Committee's view, Dr. Fenton did not provide any credible rationale for failing to comply with the Undertaking or the 2017 Order. His delay in completing the Boundaries Course as required by the 2017 Order may have been adequately explained by the need to care for his mother. However, he failed to communicate this to the College at the time and not until just before this hearing.

The Committee finds that Dr. Fenton's conduct in breaching the Undertaking and 2017 Order was unprofessional. Dr. Fenton demonstrated a blatant disregard for College correspondence. Dr. Fenton admitted to not opening, keeping or responding to emails, phone calls/messages and letters from the College and instructors acting on the College's behalf. Further, despite the clear requirements of the terms of the Order and Undertaking, Dr. Fenton erroneously and irresponsibly concluded that certain terms did not matter or were no longer relevant. In the Committee's view, Dr. Fenton demonstrated a clear lack of respect for and cooperation with the College as his governing body.

Given the College's regulatory role, strict compliance by physicians with orders made by or undertakings provided to any College committee is of utmost importance. Dr. Fenton did not fulfill his professional responsibility in this regard.

In the Committee's view, Dr. Fenton's breaches of both the Undertaking and the 2017 Order demonstrate a serious disregard of his professional responsibility and obligations as a member of the College. The College is tasked with regulating the profession in the public interest and members of the College must make every effort to strictly abide by the undertakings they provide to the College and the orders made by the committees of the College. While every breach of any order or undertaking might not necessarily result in a finding of disgraceful, dishonourable or unprofessional conduct, the Committee notes that in his authoritative work, *"A Complete Guide to the Health Professions Act"*, Richard Steinecke states at 6:60.20(5)

that, "A serious or persistent disregard for one's professional obligations is sufficient" to base a finding of disgraceful, dishonourable or unprofessional conduct. The Committee agrees.

As stated above, there was no evidence of any good reason for failure to comply with the Undertaking. The Committee did not accept Dr. Fenton's arguments that he did not consent to treatment or that he failed to have the requisite capacity to enter into the Undertaking. Further, the Committee finds that Dr. Fenton's multiple breaches of the 2017 Order, cumulatively, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional. Although Dr. Fenton ultimately completed all of the education required by the 2017 Order, he did not do so in a timely manner, contrary to the express terms of the Order.

CONCLUSION

For the above reasons, the Committee finds that the allegation that Dr. Fenton engaged in disgraceful, dishonourable or unprofessional conduct, by breaching the terms of the Undertaking and Discipline Committee's 2017 Order, is proven.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest opportunity.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Fenton, 2020 ONCPSD 11

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

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

B E T W E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PETER MICHAEL FENTON

PANEL MEMBERS:

**DR. E. STANTON
MS. G. SPARROW
DR. P. HENDRY
MR. J. LANGS**

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

**MS. E. GRAHAM
MS. C. SILVER**

COUNSEL FOR DR. FENTON:

SELF-REPRESENTED

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS. J. MCALEER

Hearing Date: December 13, 2019
Decision Date and Release of Reasons Date: March 10, 2020

PENALTY DECISION AND REASONS FOR DECISION

On July 29, 2019, the Discipline Committee (the “Committee”) found that Dr. Fenton committed an act of professional misconduct, in that he engaged in an act relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

On December 13, 2019, the Committee heard evidence and submissions on penalty and costs, and reserved its decision.

SELF-REPRESENTATION

Dr. Fenton chose not to be represented at the hearing. Since Dr. Fenton was not represented by legal counsel, the Chair detailed the process by which the hearing would be conducted. Dr. Fenton was repeatedly advised by the Chair and Independent Legal Counsel (ILC) of his right to be represented by legal counsel.

SUMMARY OF FINDINGS OF MISCONDUCT

The finding of professional misconduct was the result of Dr. Fenton’s breaches of:

- 1) A health monitoring undertaking (“the 2016 Undertaking”) executed on July 3, 2016, which required him to continue psychiatric treatment every month for a minimum of twelve months, after which he would continue to see a psychiatrist every three months and;
- 2) An order from the Discipline Committee (“the 2017 Order”) dated March 20, 2017, which required him to complete five courses including a course on “Understanding Boundaries” (the Boundaries Course), and individualized

instruction in ethics and communications within six months of the date of the Order (i.e. by September 20, 2017).

Dr. Fenton failed to comply with the 2016 Undertaking in that he missed ten appointments with his psychiatrist, including one period in which he did not see his psychiatrist for seven months. He failed to comply with the 2017 Order in that he did not complete the Understanding Boundaries Course offered through the University of Western Ontario, the individualized instruction in ethics or the individualized instruction in communications within the specified timeframe.

SUBMISSIONS ON PENALTY

The positions of the parties on penalty were quite different. The College submitted that the Discipline Committee should make an order to revoke Dr. Fenton's certificate of registration on the basis that he had demonstrated that he was ungovernable in that he breached his 2016 Undertaking with the College, failed to meet deadlines to complete education courses required by the 2017 Order and had shown contempt for the College as his regulatory body. In addition, the College submitted that he should receive a reprimand and pay costs to the College in the amount of \$62,220 within 30 days.

Dr. Fenton submitted that a one-month suspension, a reprimand and payment to the College of \$62,220 in costs over a period of 90 days is appropriate.

EVIDENCE ON PENALTY

The College submitted no additional evidence on the penalty hearing.

Motion to Adjourn to call Evidence from Dr. Fenton's Former Lawyer

On December 6, 2019, the Committee heard an application by Dr. Fenton to have summonses issued to five witnesses, one of whom was Dr. Fenton's former lawyer, Mr. Jeff Freedlander. The Committee dismissed the application with respect to four of the proposed witnesses, but agreed to issue a summons to Mr. Freedlander. The summons was issued and provided to Dr. Fenton to serve on Mr. Freedlander. At the outset of the penalty hearing, Dr. Fenton advised that he had not understood that it was his responsibility to serve Mr. Freedlander and had not done so. ILC made attempts to contact Mr. Freedlander by email. Mr. Freedlander promptly called ILC in response to her email. The matter was held down to allow ILC to speak with Mr. Freedlander. ILC then advised the Committee and the parties that she had spoken with Mr. Freedlander and he had advised that he was out of the country with his family and would not be back in Ontario until the middle of February. Mr. Freedlander is now retired from legal practice and confirmed that he had not received a summons to attend the penalty hearing. Since he was out of the country, Mr. Freedlander was not available to attend at the penalty hearing.

Upon further discussion with Dr. Fenton, it became clear that he wanted to cross-examine Mr. Freedlander with respect to emails between Dr. Fenton and Mr. Freedlander which had not been previously admitted into evidence. It was explained to Dr. Fenton that he did not need Mr. Freedlander as a witness to have those emails admitted into evidence, but could enter those emails as exhibits through his own testimony, which he did. Dr. Fenton further advised that he wanted to cross-examine Mr. Freedlander with respect to the content of phone conversations the two had had. Dr. Fenton was advised that he could provide evidence on what had been communicated to him during those calls and his understanding in the result through his own testimony. In other words, he did not need Mr. Freedlander to testify as to what had been said, as he could advise the Committee himself. Dr. Fenton

maintained his position, however, that he wanted an adjournment in order to have Mr. Freedlander attend to provide evidence at the penalty hearing.

The College took the position that none of the evidence that Dr Fenton sought to call from Mr. Freedlander was relevant to penalty. In particular, Ms Graham pointed out that the Committee had already made a determination that it was not persuaded that Dr. Fenton would have complied with the 2017 Order and would have seen Ms Siskind within the requisite time period, even if he had been provided with her name earlier, because even after he was provided with her name, he ignored numerous follow-up communications and did not complete the required course until more than a year after the time provided for in the 2017 Order. In light of that determination, the College position was that none of the evidence that Dr. Fenton sought to call from Mr. Freedlander regarding whether or not he had initially been misled as to the requirements of the 2017 Order was relevant. Having raised its concerns with respect to whether the intended evidence of Mr. Freedlander was relevant, the College advised that it took no position on Dr. Fenton's request to adjourn the proceedings so as to have a summons issued to Mr. Freedlander.

The Committee denied the request to adjourn the proceedings, on the basis that it was not persuaded that Mr. Freedlander had any relevant evidence to provide on penalty. The first category of questions that Dr. Fenton wanted to put to Mr. Freedlander related to why Mr. Freedlander did not ask for an extension to complete the courses. The Committee was not persuaded that this area of evidence would be relevant on penalty. Dr. Fenton had an obligation to comply with the terms of the 2016 Undertaking and 2017 Discipline Committee Order. Whether or not his lawyer could have sought any further indulgences from those at the College responsible for ensuring compliance is not relevant to the issue of penalty.

The second area of questions that Dr. Fenton wanted to put to Mr. Freedlander related to alleged errors by Mr. Freedlander. Again, the Committee was not

persuaded that any evidence in this regard would be of assistance in determining an appropriate penalty. The Committee had in evidence the written communications between Mr. Freedlander and Dr. Fenton. The Committee has already determined that Dr. Fenton was responsible for ensuring that he complied with the terms of the 2017 Discipline Committee Order. Even after he was told in no uncertain terms that he had to receive individualized instruction in ethics and communication from two different people, there was considerable delay before he completed all of this instruction.

Dr. Fenton advised that the third area of intended questions for Mr. Freedlander related to asking why his lawyer did not ask to have certain allegations withdrawn. This is not relevant to determining a proper order in light of the Committee's finding of professional misconduct.

The fourth area of evidence related to a letter dated October 19, 2017, which had previously been entered into evidence. Dr. Fenton took the position that the letter had not been forwarded to him by his lawyer. Dr. Fenton does not need to call Mr. Freedlander to establish that point. The Committee accepts Dr. Fenton's evidence in that regard, but does not find this to be a relevant fact on determining an appropriate penalty.

Finally, the fifth area of questioning that Dr. Fenton wanted to direct to Mr. Freedlander was with respect to the October 19, 2017 letter and why Mr. Freedlander never advised the College that the letter had not been forwarded to Dr. Fenton at the time. Again, this is not a relevant area of evidence on penalty.

For all of these reasons, the Committee denied the adjournment request and did not reissue a summons to witness to Mr. Freedlander, as the Committee found that the scope of evidence that Dr. Fenton sought to call from Mr. Freedlander was not relevant to the issue of penalty.

Dr. Fenton's Evidence

Dr. Fenton testified on his own behalf and submitted four communications between his former counsel, Mr. Freedlander, and himself describing the requirements for education outlined in the 2017 Order. Dr. Fenton was cautioned about waiving solicitor client privilege but was adamant that he wanted to disclose the communication between himself and his former lawyer, as it was his position that the correspondence was misleading. He submitted that there had been errors in informing him who would be providing the education. He noted, regarding the 2017 Order, that he did eventually complete the required courses although three were completed after the deadline. He also noted that he had been regularly attending sessions with his psychiatrist over the last two years.

Under cross-examination, Dr. Fenton acknowledged that he had opened and read the communications that he had submitted as evidence. He also acknowledged receipt of the Committee's 2017 decision regarding the 2017 Order, and agreed that he read it and understood it. He admitted that he had made mistakes in his dealings with the College but reiterated that he felt he had already been punished enough at his last appearance before the Discipline Committee in 2017, referring to the suspension and required clinical supervision. Regarding the 2017 Order, he agreed that he had engaged in "some" professional misconduct and with respect to the 2016 Undertaking, his behaviour "was a little bit unprofessional".

SUMMARY OF DR. FENTON'S EXISTING OBLIGATIONS

Dr. Fenton is currently subject to the following terms, conditions and limitations on his certificate of registration:

(i) The 2017 Order:

This order of the Discipline Committee required Dr. Fenton to retain a clinical supervisor acceptable to the College by September 21, 2017 (i.e., at the conclusion of a 6 month suspension), and for a period of twelve months thereafter to practice only under the supervision of the Clinical Supervisor. The clinical supervision was to be at a moderate level for a minimum of six months, thereafter upon recommendation of the Clinical Supervisor and approval of the College, the clinical supervision could be reduced to low level supervision. The 2017 Order contains further specifications with respect to the clinical supervision and provides for a practice reassessment and ongoing monitoring. The 2017 Order also provides that if Dr. Fenton does not obtain a clinical supervisor (which he did not) then he is to cease practicing medicine immediately.

(ii) The 2017 Undertaking:

Dr. Fenton must also abide by the undertaking he signed on March 3, 2017, whereby he must not prescribe any narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances and all other monitored drugs.

(iii) The 2016 Undertaking:

This undertaking obliges Dr. Fenton to continue to seek treatment from his psychiatrist, pursuant to the terms set out in the 2016 Undertaking.

Dr. Fenton has not been in practice since May 30, 2016. This means he will have to meet the requirements outlined in the College's policy, "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice" prior to any return to practice.

DECISION ON PENALTY

For the following reasons, the Committee orders that Dr. Fenton's certificate of registration be suspended for a period of nine (9) months, effective immediately.

The Committee orders that, Dr. Fenton undergo three months of high-level supervision prior to resuming the clinical supervision, practice assessment and monitoring schedule outlined in the 2017 Order.

The Committee orders that Dr. Fenton appear before the panel to be reprimanded.

The Committee orders that Dr. Fenton pay costs to the College in the amount of \$62,220 within ninety (90) days of the order.

REASONS FOR DECISION ON PENALTY

The principles which guide the imposition of penalty in College disciplinary proceedings are well established. The protection of the public is paramount. The penalty should serve as a specific deterrent to the member and as a general deterrent to the profession. The penalty should express the profession's denunciation of the member's misconduct. It should strive to maintain the public's confidence in the integrity of the profession and in the College's ability to govern the profession in the public interest. The penalty should serve to rehabilitate the member when appropriate. The penalty should be proportionate to the misconduct and be reasonably consistent with previous disciplinary decisions in similar cases.

It is for the Committee to weigh these principles in light of the specific facts and circumstances of the case, including both aggravating and mitigating factors, in order to arrive at a penalty which is just and appropriate.

Aggravating Factors

The Committee was very concerned by Dr. Fenton's repeated breaches of both the 2016 Undertaking to meet with his psychiatrist regularly and the 2017 Order which required him to take various educational courses within six months.

Dr Fenton failed to acknowledge the seriousness of his obligations to the College by ignoring communications which indicated what the College's expectations were, and he failed to fulfill his responsibility to the College as the regulator of the profession. He never made any effort to deal with his perceived challenges of complying with the 2017 Order or the 2016 Undertaking. He never took any steps to inquire about or remedy any confusion that he had relating to the 2017 Order or the 2016 Undertaking, as would be expected of a reasonable individual. Instead, Dr. Fenton attempted to blame his former legal counsel and the College for not communicating frequently or clearly enough about who was to administer the individualized instruction in ethics and in communication, and that these were to be provided by two different people. The responsibility for completing the courses was entirely Dr. Fenton's. He explained his behaviour was in part in response to his belief that he had been punished enough by the College's 2017 Order. He questioned the validity of both the 2016 Undertaking, accepted by the Inquiries, Complaints and Reports Committee (ICRC), and the Discipline Committee's 2017 Order. He suggested that College staff were not doing their jobs properly and tried to shift responsibility to others for his failures. He only completed the courses when the ICRC intended to send his case to the Discipline Committee, which is what ultimately happened. Although an absence of insight or remorse is not an aggravating factor, Dr. Fenton's attitude towards his regulator and the fact that there was more than one default are aggravating factors.

Further, the fact that Dr. Fenton has quite recently been the subject of previous discipline proceedings and breached the 2017 Order is an aggravating factor.

Mitigating Factors

The Committee sympathized with Dr. Fenton over his family member's health issue which was one of his stated reasons for not completing Understanding Boundaries Course offered through the University of Western Ontario within the time specified. However, Dr Fenton did not provide any evidence that he had tried to enroll in the education programs either before or after this family member's illness. The family member's illness also was unrelated to Dr. Fenton's failure to see his psychiatrist as required by the 2016 Undertaking or to complete the individualized instruction in ethics and the individualized instruction in communication.

Dr. Fenton did state that he has been attending continuing medical education courses in addition to those that he was ordered to take and expressed an interest in maintaining his clinical knowledge.

Case Law

The Committee recognized that it is not bound by previous decisions of this Committee and no two cases are identical, but reviewing similar cases may assist in the determination of a reasonable range of penalties. The Committee reviewed previous Discipline Committee decisions provided by the College, including:

- 1) *Ontario (College of Physicians and Surgeons of Ontario) v. Sweet, 2017 ONCPSD 40 (CanLII)*: Dr. Sweet admitted that he had failed to maintain the standard of practice of the profession and that he 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 case proceeded on the basis of an Agreed Statement of Facts and Admission and joint submission on penalty. On August 6, 2002, the Discipline Committee of the College had ordered the

Registrar to impose terms, limitations and conditions on Dr. Sweet's certificate of registration, including that Dr. Sweet be restricted from prescribing any controlled substances as defined by the *Controlled Drugs and Substances Act, 1996* (the "August 2002 Discipline Committee Order"). On October 5, 2006, Dr. Sweet entered into an Undertaking with the College whereby he agreed to cease to practise addiction medicine, chronic pain medicine and psychotherapy (the "October 2006 Undertaking"). Dr. Sweet prescribed controlled substances on three occasions in breach of the August 2002 Discipline Committee Order. Further, Dr. Sweet admitted that he engaged in the practice of addiction medicine and/or chronic pain medicine in his care and treatment of Patient D, in breach of his October 2006 Undertaking. Dr. Sweet also admitted that he failed to maintain the standard practice of the profession in respect of ten patients. Prior to the Discipline hearing, Dr. Sweet entered into an Undertaking, on July 12, 2017, by which he agreed, among other things, that, effective July 12, 2017, he has resigned his membership with the College and had agreed never to re-apply for membership in Ontario or any jurisdiction. Dr. Sweet had a very lengthy discipline history, and had appeared before the Discipline Committee on four previous occasions.

The Committee notes that Dr. Sweet's pattern of conduct "demonstrates that the member is unprepared to recognize his or her professional obligations and the regulator's role. It does not just relate to the serious nature of a prior disciplinary record; rather, it occurs when the member's present attitude to his or her governing body makes it clear that the member is unlikely to cooperate with the College in the future." The Committee accepted the joint submission and ordered a reprimand and costs, recognizing that Dr. Sweet had already resigned his certificate of registration as referred above.

2) *Ontario (College of Physicians and Surgeons of Ontario) v. Botros*, 2018

ONCPSD 51 (CanLII): On March 20, 2018, the Discipline Committee found that Dr. Botros committed an act of professional misconduct, 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, by breaching an undertaking to the College and failing to cooperate with the College investigation. The Committee heard evidence and submissions on penalty and costs. Dr. Botros did not attend and was not represented by legal counsel, at either the finding or penalty phase the hearing.

Dr. Botros resigned from the College prior to the penalty hearing. The Discipline Committee ordered Dr. Botros's certificate of registration be revoked in spite of his resignation. The Committee found there was a repeated and persistent pattern of misconduct, intentional, immoral and dishonest behaviour and noted his history of breaches of Discipline Committee orders and failure to comply with College directives over many years. Due to Dr. Botros's failure to recognize and respond appropriately to the College's repeated disciplinary actions, he was deemed ungovernable. The Committee noted that, in other circumstances, the nature the professional misconduct at issue in this case would not necessarily result in revocation. However, in view the specific circumstance, the aggravating factors at play and taking into account the principles of public protection and maintaining public confidence in the College's ability to regulate the profession in the public interest, the Committee determined that revocation was the appropriate penalty.

3) *Ontario (College of Physicians and Surgeons of Ontario) v. Kamermans*, 2014

ONCPSD 99715 (CanLII): In the 2014 decision on findings, the Committee found that Dr. Kamermans failed to maintain the standard of practice of the

profession and that he was incompetent regarding his treatment of six emergency patients. In 2013, the Committee had found that Dr. Kamermans had failed to maintain the standard of practice of the profession in his care and treatment of 21 of the 25 patients reviewed in his family practice. Subsequently, when his family practice was assessed, he was again found not to meet the standard of practice. Dr. Kamermans did not accept the findings of the Discipline Committee, demonstrating significant lack of insight. The Committee ordered that his certificate of registration be revoked. The Committee found that he had been aware of his own deficiencies for years, but had failed to show any insight or willingness to make changes. The Committee found that his inattentiveness and lack of diligence spoke to his level of receptivity and motivation to improve. The Committee concluded, "The reputation and integrity the profession cannot be maintained when a member denies he has problems and fails to make changes that are required to deal with deficiencies. The profession must recognize that chances for change are not infinite, and that a member who has repeatedly failed to maintain the standard practice and is also found to be incompetent cannot continue with unsuccessful education and remediation forever."

- 4) *Ontario (College of Physicians and Surgeons of Ontario) v. Savic*, 2019 ONCPSD 40 (CanLII): Dr. Savic's certificate of registration was revoked by the Discipline Committee following a finding of professional misconduct in that he contravened a term, condition, or limitation on his certificate registration; failed to maintain the standard practice the profession; and engaged in an act or omission relevant to the practice medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Dr. Savic had a long history with the College. The ICRC (and its predecessor, the Complaints Committee) had sanctioned Dr. Savic five times for deficiencies in care. Dr. Savic failed to comply with an undertaking that he signed to resolve a College investigation, and a prior

referral to the Discipline Committee. He failed to recognize the gravity of the cautions issued, deflected any responsibility and did not demonstrate any insight into his behaviour, which the Committee found was evidence of his ungovernability.

Dr. Fenton submitted one case for consideration:

- 1) *Ontario (College of Physicians and Surgeons of Ontario) v. Thomas*, 2019 ONCPSD 36 (CanLII): Dr. Thomas admitted that he had engaged in an act or omission relevant to the practice medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Dr. Thomas had failed to meet the requirements of a specified continuing education and remediation program (SCERP) directed by the ICRC in 2017. Despite support provided by the College, he did not complete education and supervision as required by the ICRC. By the time the Discipline Committee hearing took place, he had completed the education but had not undergone clinical supervision. Dr. Thomas has been involved in prior compliance-related matters with regulatory authorities. In 1996, the Prescription Monitoring Program of the College of Physicians and Surgeons of Nova Scotia counselled Dr. Thomas with respect to not responding promptly and appropriately to their requests for information. In 2014, the ICRC issued a written caution to Dr. Thomas regarding his lack of appropriate management upon leaving a practice. During the investigation phase of this matter, Dr. Thomas failed to respond to a letter from the College's investigator. Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The Committee accepted the submission and ordered that he be reprimanded and his certificate of registration be suspended for one month, and that clinical supervision be imposed for nine months, to be followed by a reassessment and ongoing monitoring. The fact that Dr. Thomas' matter proceeded by way of admission and joint submission on penalty was a mitigating factor.

ANALYSIS

In the cases in which revocation was ordered, all the physicians had engaged multiple times with the ICRC and/or Discipline Committees and had not demonstrated any improvement or change in their behaviour over years. Most had demonstrated a significant lack of clinical skill and/or judgement and their continuing in practice was not in the public interest. Dr. Fenton appeared before the Discipline Committee once in 2017 due to his failure to meet practice standards which resulted in the suspension of his license, an undertaking not to prescribe narcotics and benzodiazepines and imposition of a period of clinical supervision (which has never been completed). He was unable to find a clinical supervisor so has not practiced medicine since May 30, 2016. No evidence was produced suggesting that he had ever contravened the obligation not to practice, so from that perspective, public safety has been maintained. In the future, as part of the 2017 Order and this Order, he will have to practice under clinical supervision if he intends to seek to return to practice. Further, since he has not practiced for more than two years, he will have to fulfill the relevant requirements to re-enter practice prior to treating patients.

During the hearings, Dr. Fenton repeatedly deflected responsibility for his actions. He blamed his former legal counsel and the College for not pursuing him more aggressively to ensure that the conditions of the 2017 Order were fulfilled. He refused to admit that it was his responsibility entirely to seek the education that was ordered. If he had made any effort to contact the College in the required time, he would have been provided all the information he needed to complete his education.

The College suggests that Dr. Fenton is ungovernable. Again, the case law would suggest that repeated demonstration of this behaviour over a long period of time would constitute “ungovernability”. Dr. Fenton’s behaviour clearly demonstrates a significant lack of insight and comes close to what might be considered

“ungovernable”. The 2017 Discipline Committee decision did find that he “demonstrated contempt for the College, colleagues and others in his delay in producing records.”

In this case, however, the Committee finds that there is not sufficient evidence of recurrent contempt for the College to support a conclusion that Dr. Fenton is ungovernable. The Committee notes, for example, that Dr. Fenton did engage with the Discipline Committee process, representing himself and appearing as required.

Dr. Fenton has already had his certificate suspended for six months but has not returned to practice. The Committee determined that to provide deterrence for both Dr. Fenton and the profession, a suspension of his certificate for a further nine months is the appropriate penalty. A nine month suspension should send a strong message to both Dr. Fenton and the profession that orders of this Committee and undertakings provided to the College must be treated very seriously and are not to be disregarded by a physician at his convenience. The nine month suspension in this case is also appropriate given Dr. Fenton’s prior discipline history.

The Committee was concerned by the Discipline Committee’s finding in 2017 of failure to maintain the standard of practice. Dr. Fenton has not been in practice since March of 2016, and therefore the Committee orders supervision as set out below. The Committee is satisfied that since Dr. Fenton has been out of practice for more than two years, with previously documented clinical deficiencies, this level of supervision is appropriate.

Dr. Fenton has acknowledged that he has a mental health condition. He is currently subject to monitoring by a psychiatrist pursuant to the terms of his 2016 Undertaking. Dr. Fenton failed to comply with the 2016 Undertaking in that he missed ten appointments with his current psychiatrist, including one period in which he did not see his psychiatrist for seven months.

Dr. Fenton's current psychiatrist has signed an undertaking which provides in part:

I agree that if I discover that Dr. Fenton is acting in a manner that suggests that he may not be capable of practicing medicine, that his / her patients may be at risk of harm or injury, that he has missed an appointment (without sound reason) or that he may not be in compliance with his Undertaking, I shall discuss my concerns with Dr. Fenton and I shall immediately notify the College.

Dr. Fenton repeatedly took the position during the current proceedings that he did not have the capacity to enter into the 2016 Undertaking, but the Committee found that the evidence did not support a finding that Dr. Fenton was incapable of understanding the terms of the undertaking when he signed it and returned it to the College on July 3, 2016.

Dr. Hill testified that Dr. Fenton does not have a major psychiatric illness such as schizophrenia or a mood disorder, nor any significant problems with depression or anxiety. While Dr. Hill did not believe that Dr. Fenton had a severe mental illness, he stated he was trying to treat the difficulties Dr. Fenton was experiencing in his professional and personal lives. He also indicated that Dr. Fenton's failure to meet his obligations with the College was something he was trying to work on with Dr. Fenton at his appointments.

The Committee is reassured by the fact that Dr. Fenton will continue to be subject to the terms of the 2016 Undertaking and that his psychiatrist has an obligation to notify the College if he is of the view that Dr. Fenton is not capable of practicing medicine.

The reprimand should serve as a specific deterrent to Dr. Fenton and general deterrent to the profession. It should also serve to maintain public confidence in the College's ability to regulate in the public interest, as it should indicate to the public and members of the profession that the College takes disgraceful, dishonourable or unprofessional conduct by physicians seriously, especially when that conduct involves the breach of a prior order or undertaking and where there has been a history of prior misconduct.

COSTS

The Committee has the power, pursuant to section 53.1 of the Code, to award costs. Costs are always in the discretion of the Committee. Any costs order must be reasonable, and based on the costs actually incurred or pursuant to Tariff A.

Dr. Fenton did not disagree with the College's submission as to the amount of costs that would be appropriate (\$62,220) but he submitted that a period of ninety 90 days to pay would be appropriate, rather than the 30 days which College counsel sought.

The Committee agrees that \$62,220 in costs is an appropriate order to make, given that the hearing on liability took five days and the penalty hearing took one day. The amount is equal to the Tariff rate for six days.

The Committee will order 90 days for payment. The Committee recognises that Dr. Fenton is not currently in practice and has not been in practice for quite some time, and may reasonably require time to make this payment.

ORDER

Therefore, the Committee ordered and directed on the matter of penalty and costs that:

1. Dr. Fenton shall appear before the Committee to be reprimanded;
2. The Registrar suspend Dr. Fenton's certificate of registration for a period of nine (9) months, to commence immediately.
3. Dr. Fenton shall comply with the College's policy "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice".
4. The Registrar impose the following terms, conditions and limitations on Dr. Fenton's certificate of registration:

Clinical supervision

- a. Dr. Fenton shall, by the first day of any future return to practice, retain a clinical supervisor(s), (the "Clinical Supervisor(s)") acceptable to the College, who will sign an undertaking in the form attached to this order as Schedule A. For a period of fifteen (15) months thereafter, Dr. Fenton may practice only under the supervision of the Clinical Supervisor(s). Clinical Supervision of Dr. Fenton's practice shall contain the following elements:
 - i. The Clinical Supervision shall be at a high level for a minimum of three (3) months during which time Dr. Fenton will practice within the Clinical Supervisor's practice with the Clinical Supervisor acting as the Most Responsible Physician, commencing on the date Dr. Fenton returns to practice. The Clinical Supervisor will review all of Dr. Fenton's cases and management decisions.

- ii. After three (3) months of high-level supervision, at minimum, and only upon recommendation by the Clinical Supervisor and approval of the College, the Clinical Supervision may be reduced to a moderate level of supervision for a minimum of six (6) months. During the period of moderate level supervision, 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;
- iii. During the period of moderate supervision, Dr. Fenton shall permit the Clinical Supervisor to directly observe him in practice for one half-day per week or a minimum of five (5) patients per visit, with the Clinical Supervisor providing a report every month to the College;
- iv. After three (3) months of the moderate supervision has elapsed, 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;
- v. After a minimum of six (6) months of moderate supervision, 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 supervision, the frequency of the Clinical Supervisor's meetings with and, if required, observation of Dr. Fenton shall be reduced to monthly;

- vi. 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;
- vii. 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
- viii. If Dr. Fenton is unable to obtain a Clinical Supervisor in accordance with paragraph 3(a) or 3(a)(vii) of this Order, he shall cease practicing medicine immediately until such time as he has done so, and the fact that he has ceased practicing medicine will constitute a term, condition or limitation of his certificate of registration until that time.

Reassessment

(b) 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.

(c) 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

(d) 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 practices ("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.

(e) Dr. Fenton shall inform the College of each and every location where he practices, 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.

(f) 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 this Order.

(g) 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 this Order and any terms, conditions or limitations on Dr. Fenton's certificate of registration.

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

5. Dr. Fenton pay to the College costs \$62,200 within 90 days of the date of the Order.

TEXT of PUBLIC REPRIMAND
Delivered May 6, 2021
in the case of the
College of Physicians and Surgeons of Ontario
and
Dr. Peter Michael Fenton

This is not an official transcript

Dr. Fenton:

It is a concern to us that this is not your first appearance before the Discipline Committee. The practice of medicine is a privilege. Similarly, it is a privilege and not a right for the profession to govern itself through the College. You not only signed an undertaking, but also were previously ordered by the Discipline Committee to take certain educational courses.

The undertaking and Discipline Committee order were meant to protect the public. The public puts its trust in the governing body of our profession to not only effectively govern its members, but also to protect the public interest.

It is the regulator's expectation and that of the public that a member will comply with any terms or conditions of an undertaking or order of the Discipline Committee.

However, by blatantly disregarding the undertaking you signed and Discipline Committee's order you demonstrated contempt for your governing body and you also violated the public trust.

Actions such as yours have the potential to undermine public trust and to raise serious questions as to whether the profession is capable, through the College's regulation, of protecting the public interest. Furthermore your actions also have the potential to damage the profession's reputation as a whole. This cannot and indeed will not be tolerated.

Finally, attempting to blame others for your misconduct clearly demonstrates a significant lack of insight. This also cannot and will not be tolerated.

Dr. Fenton, in moving forward, the Committee, the profession and the public expect that you will fully comply with any terms, conditions or limitations outlined in the undertakings you provide and in the Discipline Committee order.

Finally, it is this Committee's expectation that you will have learned from this experience and that you will not appear before a Discipline panel again.

SCHEDULE "A"

UNDERTAKING OF DR. _____ TO THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

1. I am a practising member of the College of Physicians and Surgeons of Ontario (the "College"), certificate number _____ .

2. I have read the Decision and Reasons for Decision of the Discipline Committee of the College dated March 10, 2020 (the "2020 Order") regarding Dr. Peter Michael Fenton ("Dr. Fenton"). I have also read the Order of the Discipline Committee of the College dated March 20, 2017 (the "2017 Order,") regarding Dr. Fenton, and have read the Agreed Statement of Facts and Admission and the Agreed Statement of Facts regarding Penalty, including any documents attached thereto, with reference to the 2017 Order. I understand the terms, conditions and limitations imposed upon Dr. Fenton's certificate of registration in the 2017 Order and 2020 Order, and I understand the concerns regarding Dr. Fenton's standard of practice. I have also reviewed the 2016 Undertaking and the 2017 Undertaking (restriction on narcotic prescribing) referred to in the 2020 Order. I will review as soon as practicable any additional materials provided to me by the College, including the College's Guidelines for College-Directed Supervision.

3. I agree that, commencing on the date Dr. Fenton returns to practice following the expiry of the suspension of his certificate of registration, I shall act as Clinical Supervisor for Dr. Fenton's practice for a period of fifteen (15) months. My obligations as Clinical Supervisor shall include, at a minimum:
 - (a) For a minimum of three (3) months, Dr. Fenton will practice within my practice and I will act as the Most Responsible Physician, commencing on the date Dr. Fenton returns to practice. I will review all of Dr. Fenton's cases and management decisions;
 - (b) After three (3) months of this high-level supervision, at minimum, and only upon my recommendation and approval of the College, my clinical supervision may be reduced to a moderate level of supervision for a minimum of six (6) months;

- (c) During the period of moderate level supervision, I 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;
- (d) During the period of moderate supervision, I shall directly observe Dr. Fenton in practice for one half-day per week or a minimum of five (5) patients per visit;
- (e) After three (3) months of the moderate supervision has elapsed, and only upon my recommendation and upon approval of the College, the frequency of my meetings with Dr. Fenton and observation by me may be reduced to biweekly;
- (f) After six (6) months of clinical supervision at a moderate level, as set out above, and only upon my recommendation and upon approval of the College, the frequency of my meetings with and, if required, observation of, Dr. Fenton may be reduced to monthly for the following six (6) months;
- (g) Throughout the period of Clinical supervision, my specific duties will include:
 - i. Discussing with Dr. Fenton the charts I have reviewed and the care I have directly observed as well as any other concerns;
 - ii. Making recommendations to Dr. Fenton, including but not limited to recommendations for practice improvements, practice management, and/or continuing education;
 - iii. Following up on any recommendations that I have made to Dr. Fenton to determine his compliance with the same;
 - iv. Any other activities, such as reviewing other documents or conducting interviews with staff or colleagues, that I deem necessary to Dr. Fenton's clinical supervision;
 - v. Submitting written reports to the College monthly. Such reports must be in reasonable detail and contain all information I believe might assist the College in evaluating Dr. Fenton's standard of practice and compliance with the 2020 Order, including but not limited to a list of all charts reviewed and care observed with patient identifiers, review of charts and care discussed with Dr. Fenton and concerns identified, a summary of the topics that we have reviewed and Dr. Fenton's success in implementing changes into his practice; and
 - vi. Notifying the College **immediately** if I am concerned that Dr. Fenton's practice may fall below the standard of practice of the profession, that Dr. Fenton may not be in compliance with the 2020 Order and/or

terms, conditions or limitations on his certificate of registration, and/or that his patients may be exposed to risk of harm or injury.

4. I acknowledge that Dr. Fenton has consented to such sharing of information among myself, any other Clinical Supervisors, Assessors, and the College as any of us deem necessary or desirable in order to fulfill our obligations and in order to monitor his compliance with the 2020 Order and with any terms, conditions or limitations on his certificate of registration.
5. I acknowledge that all information that I become aware of in the course of my duties as Dr. Fenton's Clinical Supervisor is confidential information and that I am prohibited, both during and after the period of Clinical Supervision, from communicating it in any form and by any means except in the limited circumstances set out in sections 36(1)(a) through 36(1)(j) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18 (the "*RHPA*").
6. I undertake to notify the College and Dr. Fenton in advance wherever possible, but in any case immediately following, any communication of information under section 36(1) of the RHPA.
7. I agree to immediately inform the College in writing if Dr. Fenton and I have terminated our Clinical Supervision relationship, or if I otherwise cannot fulfill the provisions of my undertaking.

Dated at _____, this ____ day of _____, 2020.

Dr.

Witness signature

Print name: _____ Print name: _____