NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. John Gerard van Dorsser, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity and any information that would disclose the identity of the patients whose names are disclosed at the hearing-under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: van Dorsser, J.G. (Re)

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. JOHN GERARD VAN DORSSER

PANEL MEMBERS:

DR. C. CLAPPERTON (Chair)
L. MCCOOL-PHILBIN
DR. P. TADROS
D. GIAMPIETRI
DR. P. ZITER

Hearing Date:	**May 30, 2012**
Decision Date:	**May 30, 2012**
Release of Written Reasons:	**July 17, 2012**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on May 30, 2012. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. John Gerard van Dorsser committed an act of professional misconduct:

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

The Notice of Hearing also alleged that Dr. van Dorsser is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the Regulated Health Professions Act, 1991, ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. van Dorsser admitted the allegation of professional misconduct in the Notice of Hearing that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence.

FACTS AND EVIDENCE

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

PART I – FACTS

1. Dr. van Dorsser is a general practitioner with a practice in Peterborough, Ontario. He received his certificate of registration authorizing independent practice from the College in 1971.

2. As a result of information received by the College from a pharmacist in Peterborough in April 2009 regarding Dr. van Dorsser's prescribing of narcotics to a patient, the College commenced an investigation of Dr. van Dorsser's narcotic practice under s. 75(1)(a) of the Health Professions Procedural Code (the "Code").

3. In the course of the investigation, Dr. X was appointed as a medical inspector to provide an opinion. Dr. X opined on six (6) patient charts. The chart of the patient referred to in paragraph 2 was included.

Patient A

4. Patient A had suffered from chronic recurrent migraines since adolescence. Dr. van Dorsser initiated treatment with narcotic medications in 1992 after the patient had a motor vehicle accident and suffered from neck pain thereafter as well as back pain from work-related duties. As of 2010, Dr. van Dorsser had prescribed opiates for eighteen years. The patient did not tolerate nonsteroidal anti-inflammatory drugs so Dr. van Dorsser prescribed Percodan and Demerol (meperidine) for a number of years into 2011 and in significant quantities.

5. Dr. van Dorsser failed to appropriately manage this patient's chronic, non-malignant pain by the prescription of the short-acting narcotic Demerol (meperidine) over a sustained period of time.

Patient B

6. Patient B suffered from migraines for over 30 years and chronic knee and ankle pain after a motor vehicle accident in 2004. Dr. van Dorsser increased his dosing of narcotics for this patient over time such that by 2009, he was prescribing one to two

Percocets, four times daily, as required. In addition, during this period, Dr. van Dorsser was providing Patient B with numerous intra-muscular injections of Demerol and Demerol orally, as required, each month.

7. Dr. van Dorsser failed to appropriately manage this patient's chronic, non-malignant pain by the prescription of the short-acting narcotic Demerol, both orally and by injection for several years.

Patient C

8. Patient C suffered from chronic obstructive pulmonary disease, smoked cigarettes and was on home oxygen intermittently, although she did not qualify for coverage for this expense under the Home Oxygen Program. Patient C had a substance abuse disorder and had hospital admissions in 2003 and 2004 for methadone overdose, before Dr. van Dorsser began prescribing narcotics to her and these admissions were known to Dr. van Dorsser. From January 5 to September 30, 2009, Dr. van Dorsser prescribed Endocet on the following basis: "one to two every four to six hours when required". Also, in October 2009, Patient C underwent hip surgery and Dr. van Dorsser prescribed very large quantities of Endocets in that month.

9. Dr. van Dorsser failed to manage this patient's chronic non-malignant pain appropriately by prescribing large doses and quantities of narcotics to a patient who was known to have a substance abuse disorder and to be at significant risk of overdose because of co-morbidities.

Patient D

10. Patient D had a substance abuse disorder, known to Dr. van Dorsser. Despite this, Dr. van Dorsser prescribed OxyContin (40mg three times daily, 280 tablets per month) and Percocet (one to two, four times daily, 90 tablets per month) throughout 2009 in respect of Patient D's chronic pain, even after being informed in April 2009 that the patient previously had been receiving methadone maintenance treatment without disclosing this fact to Dr. van Dorsser. Moreover, over the years, Patient D was seriously

non-compliant at times and Dr. van Dorsser continued to prescribe narcotics to him without taking sufficient corrective measures to address the non-compliance.

11. Dr. van Dorsser failed to manage this patient's chronic non-malignant pain appropriately by prescribing narcotic medication to Patient D even though he was known to have a substance abuse disorder.

Interim Order

12. On July 5, 2011, effective July 7, 2011, the Inquiries, Complaints and Reports Committee pursuant to section 37 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, imposed restrictions on Dr. van Dorsser's Certificate of Registration pending the hearing before a panel of the Discipline Committee. The restrictions provided that Dr. van Dorsser shall not issue new prescriptions or renew existing prescriptions for any of the following: Narcotic Drugs from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19; and Narcotic Preparations from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19.

Expert Reports

13. Further details of the inappropriate management of chronic non-malignant pain referenced in paragraphs 1 to 11 are found in Dr. X's reports dated August 10, 2010 and April 28, 2011, attached at Schedule 1 [to the Agreed Statement of Facts and Admission] and the report of Dr. Z, an expert retained by Dr. van Dorsser, attached at Schedule 2 [to the Agreed Statement of Facts and Admission]. To the degree that other comments regarding inappropriate patient management are made in these reports, Dr. van Dorsser does not admit to same.

PART II – ADMISSION

14. Dr. van Dorsser admits the facts specified in paragraphs 1 to 12 above and admits that he failed to maintain the standard of practice of the profession in the manner set out above.

FINDING

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

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

The Panel made its decision after considering the oral submissions on penalty from counsel for the parties and after reviewing the agreed facts and appended expert opinions. The joint submission included the following penalty and cost provisions:

- Dr. van Dorsser will be prohibited from prescribing any narcotic or controlled drug and will be required to post a sign in his waiting room advising patients of this restriction;
- Dr. van Dorsser must cooperate with unannounced inspections of his practice by the College to monitor these restrictions;
- Dr. van Dorsser will be reprimanded, with the fact of the reprimand to be recorded on the register.
- Dr. van Dorsser will pay the costs for the one day hearing at the tariff rate of $3,650.

The Panel accepted the proposed penalty and costs order jointly submitted by the parties.

The Panel was cognizant of the fact that there were significant deficiencies in the care Dr. van Dorsser provided his patients over a long period of time, in that he prescribed large doses of controlled substances which were often not indicated or inappropriate in the

treatment of chronic non-malignant pain. Many of these patients had known substance abuse problems already and his prescribing practices often put his patients at risk of serious harm and even death.

Aggravating factors in this case included the fact that Dr. van Dorsser's prescribing practices were serious in nature with potential serious consequences to the patients and the greater community. Furthermore, the inappropriate prescribing occurred over a sustained period of time and involved a number of patients. The Panel stresses that members of the profession must be vigilant in prescribing narcotics and other controlled drugs because of their addictive potential and the potential of other abuse. This is especially true when prescribing to people with known addictions and histories of substance abuse.

Mitigating factors in this case include the fact that Dr. van Dorsser acknowledged the concerns addressed by the experts who provided their opinions on his care of patients. He also admitted that he failed to maintain the standard of practice of the profession and accepted responsibility for his serious misconduct, thereby saving patients the need to testify and the College the expense of a full contested hearing. It was also noted that there are no previous discipline findings against Dr. van Dorsser by the Discipline Committee.

In considering the proposed penalty, the Panel took into account relevant penalty principles. It was proposed that Dr. van Dorsser will be prohibited from prescribing any narcotic or controlled drug and this will be monitored by the College by unannounced inspections. By these measures, the public will be protected and public confidence in the profession's ability to self-regulate will be maintained. In addition, the reprimand will serve to provide general deterrence to the profession at large and specific deterrence to Dr. van Dorsser himself. The proposed penalty also serves to express the profession's abhorrence of Dr. van Dorsser's conduct.

The Panel reviewed the cases provided in the Book of Authorities and agreed that the proposed penalty was in line with penalties imposed in similar cases. The Committee was mindful of the law that a joint submission should not be rejected unless it is contrary to

the public interest and its acceptance would bring the administration of justice into disrepute.

The Panel was satisfied with the joint submission on penalty and costs. It fulfilled the obligation to protect the public and was just in all the circumstances.

ORDER

Therefore, the Committee ordered and directed that:

1. the Registrar impose the following terms, conditions and limitations on Dr. van Dorsser's Certificate of Registration:

(a) Dr. van Dorsser shall not prescribe any drug that is:

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

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

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

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

(b) Dr. van Dorsser shall post a sign that is clearly visible upon entering his office(s) in the form set out at Schedule "C" [to the Order]. For further clarity, this sign shall state as follows: "Dr. van Dorsser is prohibited from prescribing Narcotic Drugs, Narcotic Preparations and Controlled Drugs."; and

(c) Dr. van Dorsser shall cooperate with unannounced inspections of his practice and patient charts and such other steps as the College may take for the purpose of monitoring and enforcing his compliance with the terms of this Order.

2. Dr. van Dorsser pay costs to the College in the amount of $3,650.00 within ninety (90) days from the date of this Order.

3. Dr. van Dorsser appear before it to be reprimanded.

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