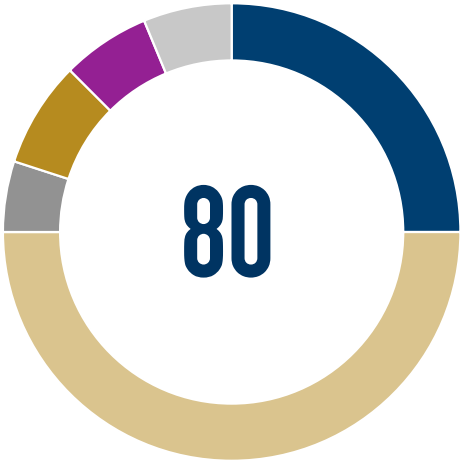
2021 PROFESSIONAL CONDUCT REPORT

The Medical Act, 2011, requires the College of Physicians and Surgeons of Newfoundland and Labrador (the College) to accept and process all written complaints against physicians licensed in NL.

This report communicates the College's complaints and discipline activities during 2021. It summarizes cases in which the Complaints Authorization Committee issued a caution/counsel, a publicized settlement was reached through the Alternative Dispute Resolution process, or a finding was made by the Adjudication Tribunal.

DECISIONS OF THE COMPLAINTS AUTHORIZATION COMMITTEE (CAC), BY OUTCOME

(FILES CLOSED IN 2021)



- 20 Resolved at initial stage
- 40 Dismissed
- 4 Dismissed with direction
- 6 Cautioned or counselled
- 5 Referred to Tribunal
- 5 Referred to Alternative Dispute Resolution

ALLEGATIONS RECEIVED IN 2021

- 27 Standard of Practice
- 76 Professionalism

FROM COMPLAINTS TO PROFESSIONAL CONDUCT

Following discussions in 2021, the College's Complaints Department has been officially renamed the Professional Conduct Department, to align its title with terminology used by other regulatory bodies across the country.

YEAR-OVER-YEAR SUMMARY	2021	2020
Complaints received	103	63
Complaints files closed	80	86

11 CAC meetings in 2021

For further details about the complaints process, visit www.cpsnl.ca.
The CPSNL Professional Conduct Coordinator can be reached at (709) 726-8546.

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2021 AMENDMENTS TO THE COLLEGE'S CODE OF ETHICS

The following additions were made under the definition of "professional misconduct":

- Failing to provide a patient or a patient's authorized representative with access to, or copies of, all medical records in the medical practitioner's custody or control upon request, unless an exception to disclosure applies.
- Dispensing medication contrary to a Standard of Practice or Practice Guideline.
- Engaging in a boundary violation contrary to a Standard of Practice or Practice Guideline.
- Contravening or failing to comply with a directive issued by the Quality Assurance Committee.

The definition of "incapacity or unfitness to engage in the practice of medicine" was updated to read:

- Continuing to practise the profession in circumstances where a medical practitioner knows, ought to know, or has been advised that they have a deficient clinical ability as a result of a physical or mental condition, disease, or disorder.

TWO NEW STANDARDS OF PRACTICE IN 2021

- **Continuity of Care**: The College holds expectations for continuity of care in primary, consultative, specialist, and episodic care. The new Standard addresses such matters as making and receiving referrals, transfer of care, availability, management of test results, and walk-in clinics.
- **Physical Examinations**: This Standard covers College expectations for physicians conducting physical examinations, which includes (but is not limited to) conducting examinations in a respectful professional manner that promotes patient comfort and ensures patients have an understanding of the scope of the examination.

SIX AMENDED STANDARDS OF PRACTICE IN 2021

- **Advertising**: Addressing expectations for advertising medical services and products, amendments to this Standard include direction on how a physician can advertise their credentials and practice interests.
- **Bloodborne Viruses**: Addressing practice expectations with respect to bloodborne viruses, amendments include safeguarding health, knowing serological status, and reporting serological status (in circumstances where physicians perform or assist in exposure prone procedures). The revised Standard incorporates guidance from the Public Health Agency of Canada on routine practices and precautions and ways to prevent transmission.
- **Boundary Violations**: This Standard covers practice expectations for maintaining boundaries (both sexual and non-sexual) with patients. It includes a definition of a "patient" as well as presumptions and considerations regarding how long an individual remains a "patient" after the provision of medical care.
- **Chaperones**: This Standard outlines the expectations for physicians engaging a third-party chaperone for a clinical encounter. It includes both general expectations for any

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time a chaperone is used as well as specific expectations for sensitive examinations.

- **Disclosure of Harm**: This Standard covers expectations with respect to disclosing unintended "harmful" or "no-harm" incidents to patients. Amendments include updated definitions and expectations for physician practice that are consistent with those used by the Canadian Patient Safety Institute.
- **Virtual Care**: Physicians practising virtual care are held to the same standards of legal, ethical, competent, and professional care as physicians providing personal face-to-face medical services and must only provide virtual care in appropriate circumstances. This Standard outlines expectations for physicians when providing medical care by means of telecommunications and information technology. The revision to the Standard reminds physicians of their duty of non-abandonment in circumstances where virtual care is not appropriate.

Physicians have a duty to familiarize themselves with all Standards of Practice and Practice Guidelines that apply to their practices. Find them at cpsnl.ca.

2021 CAUTIONS AND COUNSELS

The Complaints Authorization Committee (CAC) issues a caution or a counsel when it finds reasonable grounds to believe a physician has engaged in "conduct deserving of sanction" (as defined in the *Medical Act, 2011*) but determines that a referral to a hearing is not warranted. Most cautions/counsels are issued for one of these reasons:

- Failing to apply and maintain standards of practice expected by the profession unless the departure or modification was made in accordance with five defined conditions*
- A breach of the CMA Code of Ethics and Professionalism, often in respect to communication
- Failing to appropriately document a patient encounter

* **The defined conditions are:**

(a) There was a reasonable basis for the departure or modification

(b) The departure or modification is an exceptional circumstance and does not represent the norm for patient management by the medical practitioner

(c) The departure or modification is limited, in extent and duration, to the minimum necessary to respond to the exceptional circumstance

(d) The departure or modification, and the reasons for it, are documented in the patient's chart

(e) The medical practitioner has complied with any other conditions for departing from the standard

CASE #1: Performing the least invasive, most effective procedure

A physician was counselled with respect to the expected standard of practice in the performance of medical procedures. The CAC retained an external consultant who stated that while there was no evidence to suggest any adverse outcomes, the physician had placed patients at a higher risk of harm than required in the performance of certain types of procedures.

In its review of the associated medical records, the Committee also noted that the documentation regarding procedures was deficient and did not meet the College's expectations.

CASE #2: Vigilance in providing emergency room care

A physician was counselled with respect to the expected standard of practice of an emergency room physician. The CAC concluded that the physician had not

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Case # 2 continued . . .

demonstrated a full appreciation for vigilance and continued monitoring along with the need for a timely reassessment of changes in the vital signs, symptoms, and complaints of the patient.

The Committee also raised concerns about the brevity and quality of the medical records because the history and assessment did not reflect the date/time it was prepared or the time that the patient was assessed. The CAC also expected that the physician would have written more to explain observations and medical judgments reached regarding the patient.

CASE #3: Clear, readable, and accurate medical records

A physician was counselled with respect to medical record keeping practices that did not fulfil the related Standard's desired outcome: ensuring a clear, readable, and accurate record of patient encounters.

In reviewing the allegation, the CAC identified errors in the physician's record and ordered a practice review. The practice review revealed medical records that were sparse and not always able to be clearly interpreted.

CASE #4: Comprehensive assessment for cancelling involuntary certification

A physician was counselled with respect to the expected standard of practice of a psychiatrist when cancelling an involuntary certification under the *Mental Health Care and Treatment Act*. The CAC noted that the assessment conducted by the physician was brief and that comprehensive documentation of the assessment and clinical decision was lacking.

The Committee also noted that the physician did not contact the named patient advocate, despite the advocate's repeated requests for a consultation with the attending physician.

CASE #5: Identifying and managing sepsis

A physician was counselled with respect to the expected standard of practice of a general surgeon in the identification and management of abdominal and pelvic sepsis. The CAC retained an external consultant who judged that the physician demonstrated deficits in knowledge with respect to recognizing that pelvic sepsis differs from general abdominal sepsis and demonstrated a lack of recognition of drainage as the key manoeuvre in managing pelvic sepsis.

CASE #6: Practising after end date of licence

A physician was cautioned for practising medicine after the specified end date of their physician's locum licence.

The CAC agreed that physicians are solely responsible for ensuring that they hold a current licence at all times when they engage in the practice of medicine.

DISCIPLINARY HEARINGS

CPSNL HEARING 2021-001 IN THE MATTER OF: Dr. Adekunle Owolabi

In a written decision dated January 8, 2021, an Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador found Dr. Adekunle Owolabi, a general practitioner, guilty of professional misconduct in relation to a complaint filed by a patient on December 18, 2018.

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CPSNL HEARING 2021-001
IN THE MATTER OF:
Dr. Adekunle Owolabi (cont.)

At the time of the hearing, Dr. Owolabi did not hold a licence to practise medicine in the province, his previous licence having ended on November 26, 2018.

The Tribunal accepted an agreed statement of facts as well as Dr. Owolabi's plea of guilty to the complaint. According to the decision of the Tribunal, the patient attended appointments with Dr. Owolabi on November 19 and 20, 2018, with concerns relating to her mental health and symptoms of acute mental distress. When the patient advised Dr. Owolabi that one of her stressors was "nobody to have a tea or go for a walk," Dr. Owolabi replied that he could "go for coffee" or speak with her on the phone if she had nobody to talk to when in crisis. During the clinic appointment, Dr. Owolabi provided the patient with his personal cell phone number. One hour following the appointment, Dr. Owolabi telephoned the patient but she did not answer. The following morning, Dr. Owolabi texted the patient indicating he regretted "telling you to be my friend" and that he "apologize[d] for his conduct from the bottom of my heart." He ended the text by asking the patient to forgive him. The patient did not reply. Dr. Owolabi then proceeded to attend at the patient's workplace, requesting to speak with her. The patient refused to speak with him. At the time of Dr. Owolabi's clinical encounters with the patient, his licence contained a restriction which required a chaperone when seeing all female patients. During the November 19 and 20, 2018, appointments with the patient, no chaperone was present in the examination room. An office assistant led the patient into the examination room and entered an adjacent office. The office assistant was seated in the adjacent office during the appointment but could hear and see the patient. The patient was not aware of, and did not consent to, the chaperone's presence.

The Tribunal found Dr. Owolabi's conduct was in violation of s. 4(oo) of the College's Code of Ethics which prohibits "inappropriate comments or questions reflecting a lack of respect for the patient's dignity or privacy." The Tribunal found that his conduct amounted to conduct deserving of sanction as defined in the *Medical Act, 2011*.

The Tribunal ordered as follows:

1. The appropriate period of suspension is 2 months.
2. Dr. Owolabi's licence will be restricted to state that he shall not provide medical care to female patients unless a chaperone is present in the examination room for the entire patient encounter. This restriction will commence

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CPSNL HEARING 2021-001
IN THE MATTER OF:
Dr. Adekunle Owolabi (cont.)

upon his return to the practice of medicine and will remain in place for a period of 24 months.

3. Prior to returning to the practice of medicine, Dr. Owolabi will execute documentation setting out the detailed terms and conditions of the chaperoning arrangement in a format developed by the College.
4. Dr. Owolabi shall pay the costs of the College in the amount of $5,000.
5. The Registrar will publish a summary of the decision and the order of the Tribunal.

CPSNL HEARING 2021-002
IN THE MATTER OF:
Dr. Jonathan Jaco Maritz

In a written decision dated July 26, 2021, an Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador found Dr. Jonathan Jaco Maritz, a psychiatrist, guilty of five (5) counts of professional misconduct. The Tribunal accepted an agreed statement of facts as well as Dr. Maritz's plea of guilty in respect of each of the five Complaints.

All five Complaints were filed by the Registrar against Dr. Maritz.

In the First Complaint, the patient attended at Dr. Maritz's psychiatry clinic for ongoing methadone maintenance treatment (MMT). During an unscheduled, brief visit for methadone maintenance, Dr. Maritz engaged in a conversation with the complainant about gender reassignment, during which the patient removed his pants and undergarments. Dr. Maritz provided the patient with a piece of medical tape along with instructions as to how to conceal his genitals between his legs. The patient experienced bruising and groin pain later that day. The patient denied ever expressing an interest in gender reassignment. Dr. Maritz does not have expertise or specialized education in the treatment of transgender patients.

The Tribunal found that with respect to the First Complaint, Dr. Maritz used inappropriate comments and/or questions which reflected a lack of respect for the patient's dignity and privacy, resulting in a violation of the College's By-Law 5: Code of Ethics, sections 4(oo), amounting to professional misconduct which is conduct deserving of sanction under the *Medical Act, 2011*.

In the Second, Third, and Fourth Complaints, the College received reports from the provincial Prescription Drug Monitoring Program raising concerns relating to Dr. Maritz's prescribing practices, particularly as it [*sic*] related to MMT

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CPSNL HEARING 2021-002
IN THE MATTER OF:
Dr. Jonathan Jaco Maritz (cont.)

and opioids. The medical records showed that Dr. Maritz's prescribing practices were non-standard and did not adhere to the relevant standards of practice, including in that they were often prepared days, weeks, or months after the patient encounter; some documentation of clinic visits was totally absent; the content of the records was deficient in several respects; and that Dr. Maritz had failed to use objective screening to verify patient's self-reports of adhering to their MMT protocol. Dr. Maritz acknowledged that he had not met the standard of practice in relation to his prescribing practices for methadone and other opioids, including in that he prescribed opioids to patients at the same time as they were taking methadone; methadone was commenced at a high dose or increased rapidly; additional doses or take-away methadone doses were prescribed without question to patients who were travelling; and patients were given additional opioids when they informed him that they had run out or taken more than their prescribed dosage. Dr. Maritz admitted that his prescribing practices with respect to methadone and opioids in the Second, Third, and Fourth Complaint were not in full compliance with the College's Methadone Maintenance Treatment Standards and Guidelines.

The Fifth Complaint related to the same patient affected by the First Complaint. Dr. Maritz had seen this patient on approximately 110 occasions. The medical records documenting the treatment relationship were found to be inadequate, including that they lacked critical information about the patient; used stock phrases and sentences which were sometimes internally inconsistent; and did not contain the information expected of a provider of MMT. Dr. Maritz admitted that his prescribing practices with respect to methadone and opioids in the Fifth Complaint were not in full compliance with the College's Methadone Maintenance Treatment Standards and Guidelines.

The Tribunal found that Dr. Maritz was guilty of professional misconduct in the Second, Third, Fourth, and Fifth Complaints in that he failed to apply and maintain the standards of practice expected by the profession so as to indicate gross negligence or reckless disregard for the health and well-being of the patient, including in the treatment provided and his documentation of the treatment, in violation of the College's By-Law 5: Code of Ethics, section 4(h), which is conduct deserving of sanction under the *Medical Act, 2011*.

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CPSNL HEARING 2021-002
IN THE MATTER OF:
Dr. Jonathan Jaco Maritz (cont.)

The Tribunal accepted Dr. Maritz's plea that he was guilty of conduct deserving of sanction with respect to each of the five Complaints.

The Tribunal accepted a joint submission on sanction from the parties, and ordered on July 26, 2021, that:

1. Dr. Maritz had already served a period of suspension totalling 21 months, pursuant to an order of the Complaints Authorization Committee suspending his medical licence effective September 23, 2019.
2. Dr. Maritz is eligible to apply for a medical licence as of the date of the Tribunal's order or decision.
3. Before returning to practice, Dr. Maritz will successfully complete, at his cost:

    a. The CPEP Medical Record Keeping Seminar, including the six-month follow-up records management component; and

    b. The Safer Opioid Prescribing Skills Workshop offered by Saegis.
4. Within six months of the Tribunal's order, Dr. Maritz will successfully complete a professional development course on maintaining appropriate boundaries between patients and physicians.
5. Dr. Maritz's medical licence will be limited in the future as follows:

    a. He will be prohibited indefinitely from prescribing narcotics, including opioids;

    b. For a period of one year following his return to practice he will be accompanied in the examination room by a chaperone for the entire encounter; and

    c. For a period of one year following his return to practice, he will be subjected, and must adhere, to the College's policy entitled "Sponsorship of Provisionally Licensed Physicians."
6. As a condition of his return to practice, Dr. Maritz is required to execute documentation allowing the College to oversee the chaperoning arrangement.
7. Dr. Maritz pays the costs of the College in the fixed amount of $10,000.
8. The Registrar will publish a summary of the decision and order of the Tribunal.

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ALTERNATIVE DISPUTE RESOLUTION AGREEMENTS

IN THE MATTER OF:
Dr. Eric Elli

Dr. Eric Elli is a medical practitioner licensed pursuant to the *Medical Act, 2011* to practice family medicine. On January 16, 2019, a patient filed an allegation against Dr. Elli in relation to his conduct during a clinical encounter which occurred on January 4, 2019. Following an investigation, the Complaints Authorization Committee of the College referred the allegation back to the Registrar for Alternative Dispute Resolution in accordance with s. 44(1)(a) of the *Medical Act, 2011*.

Dr. Elli admitted that prior to conducting an examination of the Complainant's ear, he made comments to the Complainant about another (unnamed) patient which were not appropriate or clinically warranted. Dr. Elli acknowledged that his behaviour constituted professional misconduct. In particular he acknowledged that his behaviour was in violation of the College's By-Law 5: Code of Ethics (2019 version): 4(oo) Inappropriate comments or questions reflecting a lack of respect for [a] patient's dignity or privacy.

Dr. Elli and the College agreed to the following disposition of this allegation:

1. Dr. Elli was cautioned for his admitted professional misconduct.
2. Dr. Elli must successfully complete, at his cost, the SAEGIS Clinical Communication Program.
3. This summary will be posted on the College website.