**EXECUTIVE SUMMARY**

**of the**

**24 & 25 MARCH, 2017 COUNCIL MEETING**

**COLLEGE OF PHYSICIANS AND SURGEONS OF SASKATCHEWAN**

The Council of the College of Physicians and Surgeons of Saskatchewan operates under an explicit set of governance policies. It strives to make its work as transparent as possible to the medical profession and to the general public.

Those portions of Council's deliberations that are not confidential are open to observation by any person subject to space availability in the meeting room.

At the conclusion of each Council meeting an Executive Summary of the meeting is widely distributed to the district medical associations, related organizations and the public media. This Executive Summary provides a brief overview of issues discussed, decisions made, and/or actions taken by the Council. If any person wishes more detailed information about any of the issues which are not subject to confidentiality constraints, these can be obtained by contacting Ms. Sue Waddington, Executive Assistant to the Registrar, at 101 – 2174 Airport Drive, Saskatoon, Saskatchewan, S7L 6M6, phone (306) 667 4625, Fax (306) 244 2600, or email OfficeOfTheRegistrar@cps.sk.ca.

1. Council received a report from the Associate Registrar on the actions taken in relation to the For Action Items from the previous meeting.

2. Council reviewed and discussed Monitoring Reports from the Registrar with respect to:
   (a) The Registrar's Compliance with Council's Executive Limitation Policies pertaining to:
      (i) EL – 7 – Regulatory Functions;
      (ii) EL – 9 – Communication and Support to Council, and
      (iii) EL – 10 – Emergency Executive Succession.

3. Council reviewed matters brought forward from the January Council meeting:

   i. *Determining Capacity to Consent*/*Informed Consent*
   At the November Council meeting Council had agreed to consolidate the two policies *Determining Capacity to Consent* and *Informed Consent* and directed staff to prepare a section to be added to the document which addressed obtaining consent from patients whose first language is not English. Council reviewed the consolidated document including the section Patients with Limited English Proficiency. The policy was approved with a sunset date of 5 years. The new policy will be posted on the College website.

ii. Council had previously reviewed the guideline *Job Shadowing* at its January meeting and established a committee that was tasked to report to Council with its recommendations relating to including a guideline on observerships. Council received a report from the committee and approved the amended policy entitled Medical Practice Observation/Experience. This new document addresses physicians who have students and unlicensed international medical graduates involved in their practice as observers. This policy was accepted with a 5 year sunset date and will be posted on the College website.

4. Council received a report from the Associate Registrar with respect to a response made in relation to the proposed amendments to *The Disease Control Regulations* pursuant to *The Public Health Act, 1994*.

5. Council reviewed a report with respect to physician access to records needed to respond to a complaint. Council approved a new consent form to be used to deal with complaints that will specifically authorize the physician who is the subject of the complaint to access information, such as hospital records, that they may need to respond to the complaint. The College will obtain records which are not in the physician's custody or control and not authorized by the consent, and provide them to the physician who is the subject of the complaint in order for the physicians to be able to respond to the complaint.

6. Council reviewed a report pertaining to the guideline *Supervision of post-graduate clinical trainees*. Council appointed a committee comprising Dr. Preston Smith, Dean of Medicine, Dr. Brian Brownbridge and College staff to review the *Supervision of post-graduate clinical trainees'* guideline and determine whether a similar guideline for under-graduate clinical trainees would be helpful. This committee is to report back to the next Council meeting in June.

7. Council reviewed the *Communication* Guideline, accepted the proposed recommendations and set a 5 year sunset date.

8. Council received a report from the committee reviewing the *Truth and Reconciliation Commission of Canada's report – Honouring the Truth, Reconciling for the Future*. The committee's focus was on the health recommendations. Council accepted the recommendation from the committee to invite an indigenous health practitioner to assist with informing the committee on indigenous health concerns and also to assist the committee in its work in providing a report to Council on actions which could be taken by the College. The committee requested an invitation be extended to all Councilors to participate in the discussions. Council also supported the committee's recommendation that Council have an educational session with an indigenous health leader dealing with the indigenous health issues and directed the Registrar to make arrangements for a future Council meeting.

   In addition the Council directed the Registrar to contact the Government of Saskatchewan to suggest that an appointment of an indigenous person as a public member on Council would be desirable.

9. Council received a report on the Nominating Committee Terms of Reference and the proposed bylaw amendments. The proposed bylaw amendments with respect to the Nominating Committee were approved and the government will be notified with a certified copy of this administrative bylaw amendment. Council named Mr. Ken Smith to the

Nominating Committee. Council also directed that there be a template developed for Terms of Reference for individual committees and directed it be sent to the Nominating Committee for review.

10. Council reviewed Governance Policy 8 (GP-8) *on Honoraria and Expenses – Council and Committee Members* and determined that it would remain unchanged.

11. Council received a report on the possible realignment of electoral districts and determined it would defer further discussion until the November Council meeting when there is more information known about the potential number of clinical service areas within a single provincial health authority.

12. Council reviewed a report on an Ontario Court decision which commented on the appropriate penalty for sexual abuse by physicians. Council received this for information only.

13. At the January meeting, Council had approved in principle amendments to the Medical Assistance in Dying policy to deal with patient self-administration for the purpose of consulting with physicians and the public. The Council reviewed a report on the result of that consultation. Council approved the amendments to the policy with a sunset date of September, 2019. The updated policy will be posted on the College website.

14. Council agreed with the College of Medicine to jointly nominate Dr. Susanna Martin for consideration for a further two year term to the Board of Directors of the Saskatchewan Prevention Institute.

15. Council received an update from the Registrar on the progress of several aspects of the strategic plan. The following aspects were updated:

    **Strategic Priority 1 – Optimize Practice Excellence**

    Objective C1 – Improve appropriate assessment of physicians for entry into practice
    Objective C2 – Enhance competency throughout the career life cycle (revalidation)
    Objective C3 – Increase compliance of physicians working within their current skill and knowledge

16. Council received a report from the Registrar with respect to Mifegymiso, a new medication for the termination of a developing intra-uterine pregnancy. Council was provided information that outlined Health Canada's decision for a restricted distribution and administration program; an education registration program for Mifegymiso prescribers; a Canadian phase IV observational study of Mifegymiso safety and a 24 hour support line in both English and French for patients taking Mifegymiso. The information will be circulated to physicians in Saskatchewan advising of the restricted distribution and other requirements of Health Canada.

17. Council members were made aware that the FMRAC Annual General Meeting and Educational Session will be on the *Regulation of Opioid Prescribing: Turning Our Minds to Collaborative Solutions*, to be held on June 11 and 12 at The Fairmont Hotel in Winnipeg, Manitoba.

18. Council received a report from the Associate Registrar with respect to the position taken by the Registrar's Office in relation to licensure of physicians who seek licensure in another province to avoid Saskatchewan licensure requirements. Council approved the position taken by the Registrar's Office as set out in Info 67_17.

19. Council reviewed a recommendation from the Health Facilities Credentialing Committee to privilege five physicians to perform procedures in non-hospital treatment facilities. Dr. G. Boudreault, Dr. R. Riyaz, Dr. R. Leger applied for privileges to perform procedures at Lasik MD facility in Saskatoon and were approved. Dr. A. Hawaleshka and Dr. K. Ringaert applied for anesthesia privileges for a new facility in Regina – Children's Dental World Surgical Solutions Inc. and were approved for privileges.

20. Ms. Amy McDonald, Director of Accounting and Finance presented to Council the unaudited 2016 year-end financial reports.

21. Council received a webinar demonstration of the Pharmaceutical Information Program (PIP) by Ms. Rhonda Pearce, BSP, Mr. Nadeem Jamil, Business Analyst and Mr. Wayne Stewart, Program Lead – Drug & Pharmacy Program, e-Health.

22. Council conducted a penalty hearing pertaining to Dr. Susan Bell who entered a guilty plea to two charges of unprofessional conduct. The charges admitted by Dr. Bell were, as follows:

    *You Dr. Susan Bell are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or section 46(p) of* ***The Medical Profession Act, 1981*** *s.s. 1980-81 c. M-10.1, and/or bylaw 18.1 and/or bylaw 16.1 and/or bylaw 16.2 of the bylaws of the College of Physicians and Surgeons.*

    *The evidence that will be led in support of this charge will include one or more of the following:*

    *a) By letter dated January 25, 2016, the Prescription Review Program wrote to you and asked you to confirm that the prescriptions on the profile attributed to you had been written by you;*
    *b) By letter dated January 25, 2016 the Prescription Review Program asked you to provide the latest three urine drug screening records;*
    *c) You did not respond to the requests made to you in the letter dated January 25, 2016;*
    *d) By letter dated February 25, 2016, The Prescription Review Program wrote to you and asked for the information requested in the letter to you dated January 25, 2016;*
    e) *You did not respond to the request made to you in the letter dated February 25, 2016;*
    f) *On or about March 16, 2016 the* Prescription Review Program sent an email to you which stated: "The Prescription Review Program sent letters dated January 25 and February 25 for the following patient: Foster, Garth It appears I have not received your reply. Did you receive these letters?"
    *g) You did not respond to the email sent on or about March 16, 2016;*
    *h) On or about May 19, 2016, Dr. Micheal Howard-Tripp, the deputy Registrar of the College of Physicians and Surgeons, spoke to you and asked you to provide the*

*information which had been requested by the Prescription Review Program;*
*i) In the conversation of on or about May 19, 2016 you stated that you would attend to the request by the Prescription Review Program immediately, or made a statement to similar effect;*
*j) You did not provide the information requested by the Prescription Review Program as you told Dr. Howard-Tripp you would;*
*k) On or about June 20, 2016, Dr. Micheal Howard-Tripp, the deputy Registrar of the College of Physicians and Surgeons, spoke to you and asked you to provide the information which had been requested by the Prescription Review Program;*
*l) In the conversation of on or about June 20, 2016, you stated that you would attend to the request by the Prescription Review Program immediately, or made a statement to similar effect;*
*m) You did not provide the information requested by the Prescription Review Program as you told Dr. Howard-Tripp you would;*
*n) On or about July 29, 2016, Dr. Micheal Howard-Tripp, the deputy Registrar of the College of Physicians and Surgeons wrote to you and asked you to provide the information which had been requested by the Prescription Review Program;*
*o) You did not respond to the letter from Dr. Howard-Tripp sent to you on or about July 29, 2016, nor did you provide the information which had been requested by the Prescription Review Program.*

*The Executive Committee of the College of Physicians and Surgeons directs that, pursuant to section 47.6 of* ***The Medical Profession Act, 1981****, the Discipline Committee hear the following charge against Dr. Susan Bell, namely:*

*You Dr. Susan Bell are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of section 46(o) and/or section 46(p) of* ***The Medical Profession Act, 1981*** *s.s. 1980-81 c. M-10.1, and/or bylaw 8,1(b)(ix), and/or bylaw 8.1(b)(xii) of the bylaws of the College of Physicians and Surgeons.*

*The evidence that will be led in support of this charge will include one or more of the following:*

*a) By letter dated January 29, 2016, Mr. Ivan Ng, of Child and Family Programs, Regina, Saskatchewan asked you to provide records with regards to the health history of an individual referred to in this charge as Patient Number 1;*
*b) By letter dated January 29, 2016, Mr. Ivan Ng, of Child and Family Programs, Regina, Saskatchewan asked you to provide records with regards to the health history of an individual referred to in this charge as Patient Number 2;*
*c) By letter dated January 29, 2016, Mr. Ivan Ng, of Child and Family Programs, Regina, Saskatchewan asked you to provide records with regards to the health history of an individual referred to in this charge as Patient Number 3;*
*d) The records for Patient 1, Patient 2 and Patient 3 were required for the purpose of a potential adoption of one or more of these children;*
*e) You did not respond to any of the three letters dated January 29, 2016;*
*f) On or about February 17, 2016, Mr. Ng sent a follow up to you requesting the records with respect to Patient 1, Patient 2 and Patient 3;*
*g) You did not respond to the communication from Mr. Ng on or about February 17, 2016;*
*h) On or about February 29, 2016, Mr. Ng sent a follow up to you requesting the records with respect to Patient 1, Patient 2 and Patient 3;*

*i) You did not respond to the communication from Mr. Ng on or about February 29, 2016;*
*j) On or about March 21, 2016 Mr. Ng called your clinic asking about his request for the records with respect to Patient 1, Patient 2 and Patient 3;*
*k) You did not respond to the communication from Mr. Ng on or about March 21, 2016;*
*l) On or about April 29, 2016 Mr. Ng called your clinic asking about his request for the records with respect to Patient 1, Patient 2 and Patient 3;*
*m) You did not respond to the communication from Mr. Ng on or about April 29, 2016;*
*n) On or about May 25, 2016, Mr. Ng sent a follow up to you requesting the records with respect to Patient 1, Patient 2 and Patient 3;*
*o) You did not respond to the communication from Mr. Ng on or about May 25, 2016;*
*p) On or about June 2, 2016, Ms. Leslie Frey of the College of Physicians and Surgeons of Saskatchewan called your office and spoke to a member of your staff to discuss your failure to provide the requested records to Mr. Ng;*
*q) On or about July 17, 2016, Ms. Leslie Frey of the College of Physicians and Surgeons of Saskatchewan spoke to you to discuss your failure to provide the requested records to Mr. Ng;*
*r) On or about August 2, 2016, Ms. Leslie Frey of the College of Physicians and Surgeons of Saskatchewan called your office left a message on the answering machine for your office related to your failure to provide the requested records to Mr. Ng. Ms. Frey asked you to return her telephone call;*
*s) You did not return Ms. Frey's call of on or about August 2, 2016;*
*t) You did not provide the patient records for Patient 1 within a reasonable time;*
*u) You did not provide the patient records for Patient 2 within a reasonable time;*
*v) You did not provide the patient records for Patient 3 within a reasonable time.*

Submissions were made by Mr. Salte on behalf of the Registrar's Office and Ms. Anita Fraser on behalf of Dr. Susan Bell. The following penalty was imposed by Council:

*The Council of the College of Physicians and Surgeons imposes the following penalty on Dr. Susan Bell pursuant to The Medical Profession Act, 1981:*

*1) Pursuant to Section 54(1)(b) of The Medical Professional Act, 1981, the Council hereby reprimands Dr. Bell. The format of that reprimand will be determined by the Council;*
*2) Pursuant to Section 54(1)(d) of The Medical Profession Act, 1981, the Council hereby requires Dr. Bell to practise only under the supervision of a duly qualified medical practitioner approved by the Council. The Council approves Dr. Micheal Howard-Tripp as a duly qualified medical practitioner for the purpose of providing the supervision.*
*3) The supervision required by paragraph 2) will include a requirement that Dr. Bell provide reports to the supervisor, on such frequency as may be directed by the supervisor, related to the status of Dr. Bell's practice, including reports and documentation related to her practice.*
*4) Pursuant to section 54(1)(f) of The Medical Profession Act, 1981, Dr. Bell is required to continue to receive treatment from the physicians currently providing treatment to her, including Dr. Anne Bellows, or such other physician or physicians as the Registrar may approve, and to follow treatment recommendations from those physicians.*
*5) Pursuant to section 54(1)(i), the Council directs Dr. Bell to pay the costs of and incidental to the investigation and hearing in the amount of $1,230. Such payment shall be made in full by April 7, 2017*

*6) Pursuant to section 54(2), if Dr. Bell should fail to pay the costs as required by paragraph 5, Dr. Bell's licence shall be suspended until the costs are paid in full.*
*7) The Council reserves to itself the right to amend any of the terms of this penalty decision, upon application by Dr. Bell. Without limiting the authority of the Council, the Council may determine which physician or physicians will be approved as supervisors pursuant to paragraph 2), may alter or remove the requirement of supervision, may alter or remove the requirement of treatment in paragraph 4) and may provide an extension of time for payment of the costs of the investigation and hearing.*

23. Ms. Barb Porter, Director of Registration Services provided a report on nine internationally trained family physicians who have not met the licensure requirements within the required period of time. Council considered each of the cases and supported the recommendation made by the Registrar's Office to allow these physicians who have registered for examinations one further attempt to write the examination. If they fail they will be provided a period of time to wind-up their practice in an orderly fashion. If they pass the examination and they still require one additional examination they will be provided one additional opportunity to challenge the examination at the earliest opportunity and if they fail that examination, they again will be provided a period for orderly wind-up of their practice. These physicians will require extensions to their licences as they currently have a time limited licence expiring April 21, 2017.

24. Mr. Salte provided an update on the status of bylaws.

25. Council conducted a penalty hearing after the physician, Dr. Jordan Velestuk pled guilty to the following charge:

*You, Dr. Jordan Velestuk are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) of The Medical Profession Act, 1981 s.s. 1980-81 c. M-10.1.*

*The evidence that will be led in support of this charge will include some or all of the following:*

*a) On or about the 18th day of November, 2012, you removed a quantity of Ketamine from the Pasqua Hospital;*
*b) The Ketamine removed from the Pasqua hospital was removed for the purpose of personally using the Ketamine;*
*c) You were charged with theft contrary to the Criminal Code arising from your removal of the Ketamine from the Pasqua hospital;*
*d) You entered into an alternative measures program to resolve the criminal charge of theft;*
*e) You admitted the theft by entering into the alternative measures program.*

Submissions were made by Mr. Mason on behalf of the Registrar's Office and Mr. Thera made submissions on behalf of Dr. Velestuk. Council imposed the following penalty:

*Following Dr. Jordan Alexander Velestuk's admission of unbecoming, improper, unprofessional or discreditable conduct pursuant to section 49 of The Medical Profession Act, 1981, the Council makes the following orders under section 54 of that Act:*

*1) Pursuant to section 54(1)(e) of The Medical Profession Act, 1981, Dr. Jordan Alexander Velestuk is hereby reprimanded;*
*2) Pursuant to section 54(1)(c), Dr. Jordan Alexander Velestuk is hereby prohibited from practising as a critical care associate, a surgical assistant or as an emergency room physician. This prohibition will not prevent Dr. Velestuk from providing care in an emergency department if he is on call or treating his own patients;*
*3) Pursuant to section 54(1)(g), Dr. Jordan Alexander Velestuk is hereby required to participate in Physician Support Program of the Saskatchewan Medical Association, to participate in a program of random fluid screening through the Physician Support Program and to follow the recommendations of the program. That requirement will continue indefinitely unless the Council relieves Dr. Velestuk of the requirement;*
*4) Pursuant to section 54(1)(i) of The Medical Profession Act, 1981, the Council directs Dr. Velestuk to pay the costs of and incidental to the investigation and hearing in the amount of $7,386.25. Such payment shall be made in full by September 30, 2017.*
*5) Pursuant to section 54(2) of The Medical Profession Act, 1981, if Dr. Velestuk should fail to pay the costs as required by paragraph 4, Dr. Velestuk's licence shall be suspended until the costs are paid in full.*
*6) The Council reserves to itself, upon application by Dr. Velestuk, the right to relieve Dr. Velestuk from any of the conditions or restrictions contained in this motion, or to amend the conditions or restrictions imposed, or to reconsider and amend the time within which payment of costs must be made.*

26. Council conducted a penalty hearing pertaining to Dr. Hugo who entered a guilty plea to a charge of unprofessional conduct. The charge admitted by Dr. Hugo is as follows:

*You Dr. Pierre Hugo are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) and/or section 46(p) of The Medical Profession Act, 1981 S.S. 1980-81 c. M-10.1 and/or bylaw 8.1(b)(ix) of the bylaws of the College of Physicians and Surgeons of Saskatchewan.*

*The evidence that will be led in support of this charge will include one or more of the following:*

*a) You failed to maintain the standard of practice of the medical profession in relation to your prescribing of Prescription Review Program medications (hereafter referred to in this charge as PRP medications);*
*b) The patient or patients with respect to whom you failed to maintain the standards of the medical profession in relation to your prescribing of PRP medications are the following:*

*i. K.B.*
*ii S. K.*
*iii N. S.M.*
*iv. D.T.*
*v. C.A.*
*vi. W.B.*

*vii. F. K.*
*viii. R.N.*
*ix. G.B.*
*x. G. W.*

*c) With respect to one or more of these patients, you received information from the Prescription Review Program of the College of Physicians and Surgeons (hereafter referred to as the PRP program);*
*d) The information which you received from the PRP program included concerns about the PRP medications that you had prescribed;*
*e) The information which you received from the PRP program included concerns about the patients to whom you had prescribed PRP medications;*
*f) The information which the PRP program provided to you included information that one or more of these patients may have been engaged in trafficking in PRP medications;*
*g)The information which you received from the PRP program included information that one or more of these patients had received prescriptions for PRP medications from other physicians;*
*h) You failed to appropriately modify your prescribing of PRP medications after receiving information from the PRP program;*
*i) You continued to prescribe PRP medications one or more of these patients after having been advised that your patient(s) had received prescriptions for PRP medications from another prescriber;*
*j) You continued to prescribe PRP medications after having been advised that there was information that one or more of these patients were trafficking in PRP medications;*
*k) You continued to prescribe PRP medications after having been advised that one or more of these patients was not taking the PRP medications as directed;*
*I) You continued to prescribe PRP medications when one or more of these patients' urine drug screens indicated that they were not taking the medications that you had prescribed;*
*m) You continued to prescribe PRP medications when one or more of these patients' urine drug screens indicated that they were taking substances including THC or cocaine which you had not prescribed;*
*n) You continued to prescribe PRP medications when one or more of these patients' urine drug screens indicated that they were taking PRP medications which you had not prescribed;*
*o) You prescribed PRP medications to one or more of these patients without performing an appropriate assessment for possible substance abuse;*
*p) You prescribed PRP medications to one or more patients who were, or had been, receiving methadone treatment for opioid dependency;*
*q) You prescribed PRP medications for one or more of these patients for whom there was information that the patient(s) were, or had been, addicted to PRP medications;*
*r) You prescribed PRP medications prior to the date that one or more of these patients would have used those medications as prescribed ("early refine);*
*s) You prescribed benzodiazepines one or more of these patients for long-term use;*
*t) You prescribed more than one benzodiazepine to one or more of these patients during the same time period;*
*u) You prescribed PRP medications to one or more of these patients without obtaining a written agreement from the patient(s) related to the use of those medications;*

*v) You prescribed PRP medications to one or more of these patients which in quantities, dosages or combination failed to meet the standards of the medical profession;*
*w) You prescribed PRP medications to one or more of these patients that were inappropriate for the conditions with which the patient(s) had been diagnosed;*
*x) You prescribed PRP medications to one or more of these patients without performing an appropriate assessment;*
*y) You prescribed PRP medications to one or more of these patients after those patient(s) failed to comply with a referral you made to another physician for assessment;*
*z) You continued to prescribe PRP medications to one or more of these patients after receiving recommendations from other physicians that recommended against continued prescribing of PRP medications;*
*aa) You prescribed immediate release PRP medications to one or more of these patients in circumstances when the standards of the profession required that extended-release PRP medications be prescribed;*
*bb) You prescribed PRP medications for one or more of these patients who had not been recently taking PRP medications in dosages which were excessive for a patient who had not been recently taking those PRP medications;*
*cc) You prescribed PRP medications to one or more of these patients without appropriately charting the rationale for doing so.*

Submissions were made on behalf of the Registrar's Office by Mr. Salte and Mr. Cann made submissions on behalf of Dr. Hugo. Council imposed the following penalty on Dr. Hugo:

*The Council of the College of Physicians and Surgeons imposes the following penalty on Dr. Pierre Hugo pursuant to The Medical Profession Act, 1981:*

*1) Pursuant to Section 54(1)(b) of The Medical Professional Act, 1981, the Council hereby reprimands Dr. Hugo. The format of that reprimand will be to be determined by the Council;*
*2) Pursuant to Section 54(1)(b) of The Medical Profession Act, 1981, the Council hereby suspends Dr. Hugo for a period of one month, commencing on a date to be chosen by Dr. Hugo but not later than April 24, 2017. If Dr. Hugo does not choose an earlier date than April 24, 2017 his suspension will begin at 12:01 a.m. on April 24, 2017;*
*3) Pursuant to section 54 (1)(g) of The Medical Profession Act, 1981, Dr. Hugo is required to take a prescribing course in a form acceptable to the Registrar on or before December 31, 2017.*
*4) Pursuant to section 54 (1)(g) of The Medical Profession Act, 1981, Dr. Hugo is required to take a medical record-keeping course in a form acceptable to the Registrar on or before December 31, 2017.*
*6) Pursuant to section 54(1)(i), the Council directs Dr. Hugo to pay the costs of and incidental to the investigation and hearing in the amount of $3,000. Such payment shall be made in full by April 24, 2017.*
*7) Pursuant to section 54(2), if Dr. Hugo should fail to pay the costs as required by paragraph 6, Dr. Hugo's licence shall be suspended until the costs are paid in full.*
*8) The Council reserves to itself the right to amend any of the terms of this penalty decision, upon application by Dr. Hugo. Without limiting the authority of the Council,*

*the Council may determine what courses in prescribing or medical record-keeping will meet the requirements of paragraphs 3) and 4).*

27. Council conducted a penalty hearing pertaining to Dr. Jansen Van Rensburg who entered a guilty plea to a charge of unprofessional conduct. The charge admitted by Dr. Jansen Van Rensburg is as follows:

*You Dr. Leon Jansen Van Rensburg are guilty of unbecoming, improper, unprofessional, or discreditable conduct contrary to the provisions of Section 46(o) and/or section 46(p) of The Medical Profession Act, 1981 S.S. 1980-81 c. M-10.1 and/or bylaw 8.1(b)(ix) of the bylaws of the College of Physicians and Surgeons of Saskatchewan.*

*The evidence that will be led in support of this charge will include one or more of the following:*

*a) You failed to maintain the standard of practice of the medical profession in relation to your prescribing of Prescription Review Program medications (hereafter referred to in this charge as PRP medications);*
*b) The patient or patients with respect to whom you failed to maintain the standards of the medical profession in relation to your prescribing of PRP medications are the following:*

*i. C.D.*
*ii. V.D.*
*iii. J.G.*
*iv. D.L.*
*v. R.P.*
*vi. D.D.*
*vii. T.N.*
*viii. J. S.*
*ix. B.J.*
*x. T.W.*

*c) With respect to one or more of these patients, you received information from the Prescription Review Program of the College of Physicians and Surgeons (hereafter referred to as the PRP program);*
*d) The information which you received from the PRP program included concerns about the PRP medications that you had prescribed;*
*e) The information which you received from the PRP program included concerns about the patients to whom you had prescribed PRP medications;*
*f) The information which the PRP program provided to you included information that one or more of these patients may have been engaged in trafficking in PRP medications;*
*g) The information which you received from the PRP program included information that one or more of these patients had received prescriptions for PRP medications from other physicians;*
*h) You failed to appropriately modify your prescribing of PRP medications after receiving information from the PRP program;*

*i) You continued to prescribe PRP medications one or more of these patients after having been advised that your patient(s) had received prescriptions for PRP medications from another prescriber;*
*j) You continued to prescribe PRP medications after having been advised that there was information that one or more of these patients were trafficking in PRP medications;*
*k) You continued to prescribe PRP medications after having been advised that one or more of these patients was not taking the PRP medications as directed;*
*I) You continued to prescribe PRP medications when one or more of these patients' urine drug screens indicated that they were not taking the medications that you had prescribed;*
*m) You continued to prescribe PRP medications when one or more of these patients' urine drug screens indicated that they were taking substances including THC or cocaine which you had not prescribed;*
*n) You continued to prescribe PRP medications when one or more of these patients' urine drug screens indicated that they were taking PRP medications which you had not prescribed;*
*o) You prescribed PRP medications to one or more of these patients without performing an appropriate assessment for possible substance abuse;*
*p) You prescribed PRP medications to one or more patients who were, or had been, receiving methadone treatment for opioid dependency;*
*q) You prescribed PRP medications to one or more of these patients for whom there was information that the patient(s) were, or had been, addicted to PRP medications;*
*r) You prescribed PRP medications prior to the date that one or more of these patients would have used those medications as prescribed (''early refills');*
*s) You prescribed benzodiazepines one or more of these patients for long-term use;*
*t) You prescribed more than one benzodiazepine to one or more of these patients during the same time period;*
*u) You prescribed PRP medications to one or more of these patients without obtaining a written agreement from the patient(s) related to the use of those medications;*
*v) You prescribed PRP medications to one or more of these patients which in quantities, dosages or combination failed to meet the standards of the medical profession;*
*w) You prescribed PRP medications to one or more of these patients that were inappropriate for the conditions with which the patient(s) had been diagnosed;*
*x) You prescribed PRP medications to one or more of these patients without performing an appropriate assessment;*
*y) You prescribed PRP medications to one or more of these patients after those patient(s) failed to comply with a referral you made to another physician for assessment;*
*z) You continued to prescribe PRP medications to one or more of these patients after receiving recommendations (run other physicians that recommended against continued prescribing of PRP medications;*
*aa) You prescribed immediate release PRP medications to one or more of these patients in circumstances when the standards of the profession required that extended-release PRP medications be prescribed;*
*bb) You prescribed PRP medications for one or more of these patients who had not been recently taking PRP medications in dosages which were excessive for a patient who had not been recently taking those PRP medications;*
*cc) You prescribed PRP medications to one or more of these patients without appropriately charting the rationale for doing so.*

Submissions were made on behalf of the Registrar's Office by Mr. Salte and Mr. Cann made submissions on behalf of Dr. Jansen Van Rensburg. Council imposed the following penalty on Dr. Jansen Van Rensburg:

> *The Council of the College of Physicians and Surgeons imposes the following penalty on Dr. Leon Jansen Van Rensburg pursuant to The Medical Profession Act, 1981:*
>
> *1) Pursuant to Section 54(1)(b) of The Medical Professional Act, 1981, the Council hereby reprimands Dr. Jansen van Rensburg. The format of that reprimand will be determined by the Council;*
> *2) Pursuant to Section 54(1)(b) of The Medical Profession Act, 1981, the Council hereby suspends Dr. Jansen van Rensburg for a period of one month, effectively immediately;*
> *3) Pursuant to section 54 (1)(g) of The Medical Profession Act, 1981, Dr. Jansen van Rensburg is required to take a prescribing course in a form acceptable to the Registrar;*
> *4) Pursuant to section 54 (1)(g) of The Medical Profession Act, 1981, Dr. Jansen van Rensburg is required to take a medical record-keeping course in a form acceptable to the Registrar;*
> *5) Pursuant to section 54 (1)(b) of The Medical Profession Act, 1981, Dr. Jansen van Rensburg may not apply to be re-licensed until such time as he provides proof to the Registrar of having completed the prescribing course and the medical record-keeping course specified in paragraphs 3) and 4) above;*
> *6) Pursuant to section 54(1)(i), the Council directs Dr. Jansen van Rensburg to pay the costs of and incidental to the investigation and hearing in the amount of $3,000. Such payment shall be made in full by April 24, 2017.*
> *7) Pursuant to section 54(2), if Dr. Jansen van Rensburg should fail to pay the costs as required by paragraph 6, Dr. Jansen van Rensburg's licence shall be suspended until the costs are paid in full.*
> *8) The Council reserves to itself the right to amend any of the terms of this penalty decision, upon application by Dr. Jansen van Rensburg. Without limiting the authority of the Council, the Council may determine what courses in prescribing or medical record-keeping will meet the requirements of paragraphs 3) and 4).*

28. Council received a report from the committee that was reviewing what information should be publicly available. The committee concluded that undertakings between a physician and the College that relate to a restriction or limitation on a physician's ability to practice should be publicly available and published on the College website. Council accepted the amendments to Executive Limitation Policy 6 (EL-6) – *Interactions with Members of the Public t*o include the requirement for the Registrar to ensure that undertakings provided by physicians are available to the public in the following circumstances:

    5.1 The information relates to restriction or limitation on the physician's ability to practice or relates to conditions with which the physician must comply in relation to the physician's practice; and
    5.2 The undertaking was given to the College as a result of concerns arising from the physician's conduct, performance or fitness to practice; and
    5.3 The information made available to the public shall not include information which identifies the health status of the physician except in circumstances that the Registrar

concludes that the information should be released consistent with the Council value of an appropriate balance between confidentiality and transparency found in GP-2; and 5.4 The obligation to make information public about undertakings described in 5.1; and 5.2 shall not apply if the Registrar concludes that failing to make such information publicly available or limiting the amount of information that is publicly available would be consistent with the public interests in the College's Public Protection Mandate in End–2.

29. Council reviewed a document prepared by the Associate Registrar on the process that should be taken for additional information to be considered by Council and accepted the process recommended.

30. Dr. Julie Stakiw, Chair of the committee reviewing alternative dispute resolutions (ADR), discussed the principles in resolving possible disciplinary matters by alternate dispute resolution mechanisms. Council agreed that the cases most amenable to ADR are those which do not involve patient safety. Council determined the Registrar would vet situations of potential ADR and raise them with the Executive Committee for consideration. The Executive Committee will approve the ADR process before it begins with the physician. The ADR committee will continue its work in reviewing the potential of pre-hearing conferences.

31. Council received a report from the committee reviewing reprimands and accepted the recommendations of the committee. If a reprimand is part of the penalty imposed by Council, Council will craft individual reprimands for the physician and the reprimand will be published in Doctalk and on the College website.

32. Council considered draft reasons for the decision pertaining to Dr. A. Anderson, Dr. M. Taratibu and Dr. A. Dudley and adopted the reasons for the penalties previously imposed upon these physicians. The reasons will be posted on the College website.

33. Council reviewed a report with respect to a potential charge of unprofessional conduct against a physician who was involved in a privacy breach. Council determined it would not lay charges and considered the matter suitable for alternate dispute resolution, including education and the requirement to provide an apology to those affected.

34. Council considered a report from Mr. Chris Mason with respect to potential charges of unprofessional conduct pertaining to the physician's persistent tardiness in the completion of insurance forms and failure to respond to the College. Council appointed a preliminary inquiry committee to investigate the matter.

35. Council received a report from the Registrar with respect to challenges pertaining to the payment of dues for membership of FMRAC. Council reaffirmed its commitment to support FMRAC and Council agreed the President would write a letter to the CMQ expressing its disappointment at CMQ's decision to fund FMRAC at a reduced amount compared to the previous funding which was calculated on a per capita basis.

36. Council received a report from the Associate Registrar with respect to potential charges of unprofessional conduct against a physician who was subject to a preliminary inquiry committee. Council reviewed the preliminary inquiry committee report which recommended laying charges against the physician for altering patient records and failing

to maintain proper boundaries. Council laid the charges which will be posted on the College website.

37. Council received a report with respect to consideration of possible charges of unprofessional conduct or a preliminary inquiry investigation pertaining to the inappropriate prescribing of marijuana and billing for such services. Council appointed a preliminary inquiry committee to investigate the nature of these concerns with the members to be named by the Executive Committee.

38. Council reviewed a report with respect to the possible amendment of charges against a physician. Council amended the charges which will allow the matter to proceed without a formal hearing.

39. The Associate Registrar provided Council an update with respect to the discipline tracker and the status of outstanding cases.

40. Council received a report from the Registrar with respect to the provincial government's restructuring of the health system. The Registrar reported on 1) the merging of the existing Regional Health Authorities into one provincial health authority and 2) transforming the health care system and physicians' role in that transformation.