Dr. Pierre HUGO

Council Decision

Date Charge(s) Laid:	March 13, 2017
Outcome Date:	March 25, 2017
Hearing:	March 25, 2017
Disposition:	Reprimand, Suspension, Education, Costs

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.

5) 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.

6) 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.

7) 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).

IN THE MATTER OF A SECTION 54 OF *THE MEDICAL PROFESSION ACT, 1981* PENALTY HEARING FOR DR. PIERRE HUGO

Mr. Nicholas Cann appearing for Dr. Pierre Hugo

Mr. Bryan E. Salte Q.C. appearing for the
College of Physicians and Surgeons of Saskatchewan

REASONS FOR DECISION

Introduction and Background

In January, 2013, after reviewing information pertaining to Dr. Hugo's prescribing of prescription review drugs, the Executive Committee of the Council of the College of Physicians and Surgeons of Saskatchewan concluded that it had reasonable grounds to believe that Dr. Hugo may be guilty of unbecoming, improper, unprofessional or discreditable conduct. The Executive Committee directed that a Preliminary Inquiry Committee be appointed. Following the results of this inquiry, in January 2017, the Council of the College of Physicians and Surgeons laid the following charges.

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. 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;*

l) *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 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.*

Dr. Hugo admitted to the charges on March 22, 2017 (as set out in document Info 102-17). The Council proceeded to address the penalty via a Hearing on March 25, 2017.

Penalty Decision

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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).

Factors in Establishing Penalty

The factors which are frequently considered in imposing an appropriate penalty are outlined in **Camgoz v. College of Physicians and Surgeons**, 1993 CanLII 8952 (SK.Q.B.)
https://www.canlii.org/en/sk/skqb/doc/1993/1993canlii8952/1993canlii8952.html?resultIndex=3

a) the nature and gravity of the proven allegations;

b) the age of the offending physician;

c) the age of the offended patient;

d) evidence of the frequency of the commission of the particular acts of misconduct within particularly, and without generally, the Province;

e) the presence or absence of mitigating circumstances, if any;

f) specific deterrence;

g) general deterrence;

h) previous record, if any, for the same or similar misconduct,

i) the length of time that has elapsed between the date of any previous misconduct and conviction thereon, and, the member's (properly considered) conduct since that time;

j) ensuring that the penalty imposed will, as mandated by s. 69.1 of the Act, protect the public and ensure the safe and proper practice of medicine;

k) the need to maintain the public's confidence in the integrity of the respondent's ability to properly supervise the professional conduct of its members;

l) ensuring that the penalty imposes is not disparate with penalties previously imposed in this jurisdiction in particular, and in other jurisdictions in general, for the same or similar act of misconduct.

m)

Information Considered by Council in Establishing Penalty

Council considered 5 main pieces of information when deciding on penalty in this case:

1. The analysis done by the Preliminary Inquiry Committee of the prescribing done by Dr. Hugo
2. Additional review of medical charts and analysis of Dr. Howard-Tripp
3. Verbal and written presentations by College counsel, Mr. Brian Salte (Saturday, March 25, 2017 and Conf. 30/17)
4. Verbal presentation by Dr. Hugo's counsel, Mr. Cann (Saturday, March 25, 2017)
5. Relevant Legislation and Case Law

Reasons for the Penalty Decision

Council considered that both the Preliminary Inquiry Committee and Dr. Howard-Tripp concluded Dr. Hugo's prescribing as a sufficient departure from acceptable medical standards. As Mr. Salte indicated in his presentation:

"the effect of improper prescribing of drugs of possible abuse can be significant. Patients can become addicted. Patient's addiction can be supported by such prescribing, causing them not to seek other treatments or treatment for their addictions. In addition, prescription medications can be trafficked by patients, supporting the criminal activities that are associated with trafficking in narcotics, benzodiazepines and other medications of possible abuse."

Council appreciated that there were a number of mitigating factors in this case including:

- Dr. Hugo admitted to the charge, saving the College the need to demonstrate that his conduct is unprofessional in a contested hearing and by admitting the charge has not raised the issue of delay as a bar to the College taking disciplinary action
- The preliminary inquiry committee report stating that Dr. Hugo "has shown insight into the problems that caused the difficulties he encountered and that he has taken steps to rectify them", although the implementation of these steps was lengthy
- There was a substantial delay to investigate and lay charges
- There was no evidence that the conduct of prescribing drugs of potential abuse was deliberately improper or that Dr. Hugo knowingly continued to prescribe drugs of possible abuse knowing that the drugs were being abused. As the preliminary inquiry committee wrote:

  Dr. Hugo inherited a practice with large numbers of patients on significant doses of opiod medications and due to his relative inexperience, bad boundaries and poor screening and monitoring of patients he became more entwined in the situation. His poor record keeping contributed to the difficulty in managing aberrant behaviour and he failed to recognize the social and community consequences if his prescribing behaviour.

- Awareness of the seriousness of inappropriate prescribing has increased significantly in the past few years and there are now specific guidelines for prescribing narcotics
- There is no previous record of discipline concerns for Dr. Hugo

However, Council was most concerned that despite previous intervention from the Registrar's Office and a prescribing course prior to 2010, Dr. Hugo's prescribing habits, while initially improved, again deviated from what would be expected from a physician who has a long history of practicing medicine.

Council considered the following cases when determining the penalty:

- In the decision **Lambert v. College of Physicians and Surgeons of Saskatchewan**, 1992 CanLII 8084 (SK QB), http://www.canlii.org/en/sk/skqb/doc/1992/1992canlii8084/1992canlii8084.html?resultIndex=5, upheld on appeal to the Court of Appeal, 1992 CanLII 8212, http://www.canlii.org/en/sk/skca/doc/1992/1992canlii8212/1992canlii8212.html?resultIndex=2, the courts upheld a 6 month suspension from practice for improper prescribing of narcotics.

  That was the second occasion that he was disciplined for improper prescribing. The first decision is **Lambert v. College of Physicians and Surgeons (Sask.)**, 1990 CanLII 7593 http://www.canlii.org/en/sk/skqb/doc/1990/1990canlii7593/1990canlii7593.html?autocompleteStr=lambert%20%26%20college&autocompletePos=2 where Dr. Lambert had been suspended for 30 days for, among other things, improperly prescribing drugs of possible abuse.

- In 1995 Dr. Misra's licence was revoked after the finding of a disciplinary hearing. The decision of the committee included the following assessment:

  The profile of Dr. Misra's patients were almost all low-socio-economic people many of whom appear to be drug addicts and drugseekers -people crying out for appropriate help. There were obvious indications that he chose to ignore the signs of addiction and kept on providing mood-altering drugs.

  Nowhere in the evidence before the Committee was there any indication that Dr. Misra referred his patients to psychiatrists despite his claims that he made all his referrals by telephone. The Committee completely disbelieves him.

  The Committee is satisfied, from the testimony, that there was a pattern of prescribing medication without a proper examination, history, diagnosis, referral and no basis or indication for treatment. There was no special effort to look for signs of addiction nor any attempts at a multi-disciplinary approach.

- The decisions in Ontario have generally resulted in practice restrictions, without a suspension or fine. There were two situations where suspensions were imposed:

  • Dr. Syan – suspended for two months http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2068582

  • Dr. Kingstone suspended for 3 months http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2022603

  In other cases practice restrictions and a reprimand were the outcome:

  - Dr. Sheffield (2011) http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2024733
  - Dr. Redekopp – 2011 http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2053503
  - Dr. Paul Martin – 2011 http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2022122
  - Dr. Amarasekera – 2010 http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2071841
  - Dr. Graham – 2009 http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2022645
  - Dr. Haines – 2014 http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2059413
  - Dr. MacNeil - 2010 http://www.cpso.on.ca/public-register/doctor-details.aspx?view=4&id=%2057095

Counsel for Dr. Hugo argued that the above cases are not precedents for warranting a suspension under *The Medical Profession Act, 1981*, as Dr. Hugo's current prescribing habits have changed substantially and Dr. Hugo does not pose a danger to the public. In addition, Mr. Cann argued that as Dr. Hugo does not have a previous discipline history, **Lambert v. College of Physicians and Surgeons of Saskatchewan (1992)** should not apply. However, Council did note that the first case of improper prescribing by Lambert in **Lambert v. College of Physicians and Surgeons of Saskatchewan (1990)** resulted in a 30 day suspension. Council felt that suspension for Dr. Hugo was warranted in this case to serve as both a general and specific deterrent towards improper prescribing. Council did not feel that simply having the charge be made public served as enough of a deterrent and that suspension would maintain public confidence in the College and indicate the seriousness with which the **College of Physician and Surgeons of Saskatchewan** takes this issue.

With regard to costs, Council agreed with the $3,000 figure provided by the Registrar's Office which was based upon the agreement by Dr. Hugo to admit the charges and waive objection to in-house counsel appearing to present the Registrar's penalty position.

Summary

It was the opinion of Council that Dr. Hugo recognizes the degree of his misconduct and has taken genuine steps to improve his prescribing habits and seek additional measures to ensure that he does not reoffend. Council feels the penalty assigned is appropriate. Given the potential consequences of improper prescribing, particularly for drugs of potential abuse, the Council recognizes the necessity to maintain public confidence in its approach to this serious issue and to deter others from similar behaviour.

Accepted by the Council of the College of Physicians and Surgeons: 17 June, 2017

College of
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of Saskatchewan

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REGISTRAR
KAREN SHAW, M.D.

19 June, 2017

Dr. P. Hugo
[redacted]

Dear Dr. Hugo,

On 24 March, 2017 the Council of the College of Physicians and Surgeons of Saskatchewan accepted your admission of guilt to charges of misconduct. Following deliberation, penalty was determined. One component of that penalty was an official reprimand by the Council. It was the will of Council that I personally compose the reprimand.

> ***You, Dr. Pierre Hugo, having been found guilty of professional misconduct while practising medicine in the province of Saskatchewan are hereby reprimanded by the Council of the College of Physicians and Surgeons of Saskatchewan.***

The Council of the College wishes to convey its extreme displeasure toward the actions that you have engaged in. As medical practitioners, our very first responsibility is to 'do no harm'. Despite adequate training and support resources, you were unable to hold yourself to this basic standard of care.

All physicians are subject to the particular stresses of their practice pattern, location and populations. These factors may influence how we choose to deliver care, but they cannot serve as justification for the delivery of care below a standard which is deemed acceptable for the profession. Your actions have placed patients at very real risk of harm and have brought disrepute on the profession in your community specifically. You have permitted the complexity of chronic care to justify flagrant mismanagement when readily available resources and supports were available to you.

Continued……

You are fully aware, as are all physicians and the public at large, that we are in the midst of an epidemic which is killing thousands of Canadians every year due to the flood of opioids onto our streets. Medical practitioners are playing a central role in the propagation of this crisis, when it is clearly our mandate to do exactly the opposite. It is very disappointing that you allowed your own practice to stray so far off course. Ensure that you learn from this unfortunate set of circumstances and work diligently in the future to hold yourself and your patients to a standard of care that reflects well on yourself and your chosen profession.

[redacted]

[redacted]

[redacted]
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Council of the College of Physicians and Surgeons of Saskatchewan