**NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Allan Zangwill Seltzer, 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 in the patient records filed 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, in relevant part:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
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> (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
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> (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: Seltzer (Re)**

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

**IN THE MATTER OF** a Hearing directed
by the Complaints Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) 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. ALLAN ZANGWILL SELTZER

**PANEL MEMBERS:**

**DR. P. CHART**
**DR. R. SHEPPARD**
**S. BERI**
**DR. J. BROWN**
**E. COLLINS**

| | |
|---|---|
| **Hearing Dates:** | **November 3-5, 2008** |
| **Decision Release Date:** | **February 2, 2009** |
| **Release of Written Reasons:** | **February 2, 2009** |

# PUBLICATION BAN

## DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario ("the Committee") heard this matter at Toronto on November 3, 4 and 5, 2008. At the conclusion of the hearing the Committee reserved its decision with written reasons to follow.

## THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Seltzer committed acts 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;

2. under paragraph 1(1)7 of O. Reg. 856/93, by discontinuing professional services that were needed without the patient requesting the discontinuation, without arranging alternative services and without giving the patient a reasonable opportunity to arrange alternative services;

3. under paragraph 1(1)27 of O. Reg. 856/93, by contravening a regulation made under the *Medicine Act, 1991*; and

4. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

## RESPONSE TO THE ALLEGATIONS

Dr. Seltzer did not attend the hearing or send counsel on his behalf. The Committee proceeded on the basis that Dr. Seltzer denied the allegations as set out in the Notice of Hearing.

**PRELIMINARY MATTER**

As a preliminary matter, the Committee considered the issue of Dr. Seltzer's non-attendance at the hearing.

Section 39 of the *Regulated Health Professions Act*, 1991 (the "*Act*") provides:

> 39(1) A notice or decision to be given to a person under this Act … may be given by mail or by fax.
>
> 39(2) If a notice or decision is sent by mail addressed to a person's last known address, that is a rebuttable presumption that it was received by the person on the fifth day after mailing.

The *Statutory Powers Procedure Act,* R.S.O. 1990, c. S.22, requires the parties to a proceeding be given reasonable notice of the hearing by the tribunal (section 6(1)). A notice of an oral hearing is required to include a notice of the date, place, and purpose of the hearing; and a statement that if the party notified does not attend at the hearing, the tribunal may proceed in the party's absence, and the party will not be entitled to any further notice in the proceedings (section 6(3)). Non-attendance of the party at the hearing after due notice permits the tribunal to proceed in the absence of the party (section 7(1)).

The Committee therefore considered whether Dr. Seltzer had been given reasonable notice of the hearing. The Committee heard the evidence of Ms. N, Hearings Coordinator at the College, on this issue. Ms. N's evidence was supported by a package of documents pertaining to various items of correspondence between the College and Dr. Seltzer between February 1, 2007 and September 24, 2008. These documents were entered into evidence.

The Committee accepted the evidence of Ms. N, and her confirmation of the authenticity of the documents entered into evidence. It was clear that the provision of notice to Dr. Seltzer had been complicated by his apparent changes of address, his residence in Belize, Central America, for a period of time, and possible health issues which may have limited his availability. Nevertheless, the cumulative effect of the evidence adduced left the

Committee with no doubt that Dr. Seltzer had been provided with reasonable notice of the hearing.

Specifically, the Committee was provided with a copy of a sworn Affidavit of Service dated February 1, 2007, which confirmed that the Notice of Hearing dated January 31, 2007 had been sent to Dr. Seltzer to his last known address, by regular and registered mail, on February 1, 2007. This constitutes proper service under s. 39 of the *Act*. Although communication with Dr. Seltzer was subsequently inconsistent, it was clear to the Committee from his responses that he was aware of the proceedings and that he was engaged, albeit to a variable degree, in preparation for the hearing. Dr. Seltzer subsequently participated in a scheduling conference call on January 31, 2008, at which time a pre-hearing conference was scheduled. Disclosure was sent to Dr. Seltzer, and received by him, as confirmed by his email response of February 18, 2008. Confirmation of the final hearing dates was sent to Dr. Seltzer's last known address via email, courier, and registered mail on April 9, 2008. In addition, receipt of this information was subsequently confirmed to Ms. N, along with confirmation that it had been forwarded to Dr. Seltzer. Subsequent confirmation of the final hearing dates was sent to Dr. Seltzer via registered mail, courier, regular mail and email on September 24, 2008. Dr. Seltzer's email response of September 24, 2008 confirmed the receipt of this correspondence and also indicated his intention not to attend the hearing.

After hearing and considering the evidence and submission of counsel for the College on this issue and receiving the advice of independent legal counsel, the Committee concluded that notice of this hearing had been provided to Dr. Seltzer and that Dr. Seltzer had specifically advised that he did not intend to attend or participate in the hearing. The Committee therefore decided to proceed in his absence.

## OVERVIEW OF THE CASE

Dr. Seltzer is a psychiatrist. At the material times he was practising in the Parry Sound-Huntsville area. This case pertains to psychiatric services which he provided to two patients

under his care: Patient A, who was Dr. Seltzer's patient between November 2002 and August 2003 by reason of Dr. Seltzer's role as a psychiatrist with the Community Outreach and Support Team (COAST), a program operated by Muskoka-Parry Sound Community Mental Health Services; and Patient B, who was a patient in Dr. Seltzer's private practice subsequent to August 2004.

The issues before the Committee can be summarized as follows:

1) With respect to Patient A, did Dr. Seltzer's care and treatment of this patient fall below the acceptable standard of care in the areas of: documentation and record keeping; psychopharmacological treatment of the patient's psychiatric disorders; recognition and treatment of the patient's substance dependence and/or performance of his role as consultant to and supervisor of the COAST team, in relation to the patient's substance dependence?

2) (i) With respect to Patient B, did Dr. Seltzer discontinue her treatment without providing notification, without arranging alternative services for her and/or without giving her a reasonable opportunity to obtain alternative services?

   (ii) Did Dr. Seltzer fail to maintain an adequate record for Patient B?

   (iii) Did Dr. Seltzer provide inconsistent and contradictory information to the College regarding Patient B's records, thereby obstructing the College in its investigation?

**SUMMARY OF EVIDENCE**

The Committee heard the evidence of a number of witnesses, and also received in evidence fifty (50) documents. The testimony of some witnesses was required to prove the authenticity and admissibility of the documentation, as these documents could not be entered on consent, given Dr. Seltzer's non-attendance at the hearing. The Committee accepted the College's position that the Business Record exception to the hearsay rule, as

provided for in the *Evidence Act*, R.S.O. 1990, c. E.23, applied to some of the documents entered and certain documents were accepted into evidence on this basis. Proper notice of intention to introduce business records was provided to Dr. Seltzer.

The Committee found the *viva voce* evidence of four of the witnesses to be central to the issues before it: Mr. W, currently Core Program Area Manager with Muskoka-Parry Sound Community Mental Health Services (CMHS), formerly Team Leader with the COAST team; Dr. X, who gave evidence pertaining to Dr. Seltzer's care and treatment of Patient A; Patient B; and, Dr. Y, who gave evidence pertaining to Dr. Seltzer's care and treatment of Patient B. Some of the relevant evidence of these four witnesses is summarized as follows.

***The Evidence of Mr. W:***

Mr. W is currently the Core Program Area Manager for Muskoka-Parry Sound CMHS. Previously he was Team Leader for the COAST team, while Dr. Seltzer was the COAST team psychiatrist and while Patient A was a client of the team. Mr. W's background is in psychiatric nursing.

Mr. W confirmed the authenticity of a number of documents entered into evidence, consisting primarily of the records and documentation pertaining to Patient A's involvement with the COAST team, and with Muskoka-Parry Sound CMHS, from 2000 to 2004. Of particular interest to the Committee were Dr. Seltzer's psychiatric notes, which indicated that his involvement with Patient A commenced in November 2002 and continued until she was discharged from the program in August 2003. The record included three psychiatric notes from Dr. Seltzer for this period of time; the evidence disclosed that he had seen her on eight separate occasions.

Mr. W gave evidence about the manner in which Muskoka-Parry Sound CMHS gathered and stored information pertaining to clients of the organization, both electronically and on paper. He confirmed that he had searched the records pertaining to Dr. Seltzer's

involvement with Patient A at the request of the College, and that all such records had been provided to the College and entered into evidence at this hearing.

The Committee found Mr. W to be a credible witness. He was clearly familiar with the issues in question pertaining to the record-keeping practices of the organization, and his evidence was clear, organized, and helpful to the Committee. The Committee accepted as fact that it had been presented with a complete record of all relevant documentation pertaining to Patient A's care and treatment by Dr. Seltzer while he was her psychiatrist with the COAST team.

***The Evidence of Dr. X:***

The Committee heard the testimony of Dr. X on behalf of the College. Dr. X is a general psychiatrist with experience primarily in the areas of acute inpatient psychiatry, outpatient psychiatry, and emergency psychiatry. The patient population with which she has experience is characterized by extensive co-morbidity, with a high prevalence of substance abuse disorders. The Committee accepted her qualifications as an expert witness.

Dr. X had clearly conducted a very detailed and full review of the case which encompassed a historical investigation of the clinical issues pertaining to Patient A, and an exhaustive enquiry into the care and treatment which Patient A had received while a client of Muskoka-Parry Sound CMHS, focusing specifically on the period of approximately eight months when she was under the care of Dr. Seltzer with the COAST team.

Dr. X testified that, in her opinion, Dr. Seltzer's care and treatment of Patient A fell below the acceptable standard of care in a number of areas, summarized as follows.

Dr. X stated that Dr. Seltzer's documentation pertaining to his treatment of Patient A was grossly inadequate. She noted that for five of the eight clinical sessions which Dr. Seltzer had with Patient A, there was no documentation at all. The notes which do exist are brief, cursory, and give no evidence of thorough psychiatric assessment, of a coherent plan of

care, of the rationale for a number of changes in Patient A's prescribed medication over this period of time, or of attention to the issues of consent to treatment or patient education. These deficiencies are particularly troubling, in Dr. X's opinion, in the context of Dr. Seltzer's role as consultant to the COAST team. Although the COAST records indicate the expectation that Dr. Seltzer's documentation would be completed by him and available to the team for the purposes stated, such documentation was often not completed.

Dr. X opined that Dr. Seltzer's plan for the psychopharmacological treatment of Patient A's psychiatric disorders was inadequate and fell below the acceptable standard of care. She was particularly critical of the multiple changes in prescribed medications with no documented rationale for these changes, and for Dr. Seltzer's failure to prescribe an alternative antidepressant medication after the patient stopped taking the one previously prescribed in early 2003. In light of the patient's history of depression, it was Dr. X's opinion that her psychopharmacological management was inadequate. It was also Dr. X's opinion that Patient A suffered from a number of psychiatric disorders. Dr. X outlined for the Committee the usual psychopharmacological approaches to treatment under those circumstances, and her view that these had not been followed in Patient A's case.

Dr. X stated her opinion that Dr. Seltzer failed to meet the standard of care in his identification and management of Patient A's substance dependence. While a review of this patient's history would leave no doubt as to the significance of the substance dependence issues, according to Dr. X, by July 2003 Dr. Seltzer suggested that she had "no addiction problem"; albeit, earlier, he had confirmed the diagnosis of substance dependence. Dr. X acknowledged that, when Dr. Seltzer assumed Patient A's psychiatric care in November 2002, it would not have been unreasonable at that time for him to continue to prescribe medications on which she was dependent.

Nevertheless, in Dr. X's opinion, the treatment of dependence includes a plan for gradual withdrawal, and there was no evidence that this was considered by Dr. Seltzer. Dr. X's most serious concerns regarding Dr. Seltzer's response to the substance dependence issue pertained to events from March 2003 onwards. At this time, Patient A began to insistently

request assistance from the COAST team in withdrawing from the medications on which she recognized that she was dependent. She did not receive assistance in this area. Circumstances in Patient A’s life had changed, which appeared to have increased the strength of her motivation to address her substance dependence. The implications of this change in circumstance appear not to have been acknowledged by Dr. Seltzer. Finally, when the patient apparently started decreasing and/or episodically stopping her medications on her own, there is documentation to suggest that she started experiencing withdrawal symptoms. It was Dr. X’s opinion that, given the risk of serious harm to the patient under these circumstances, Dr. Seltzer failed to adequately respond to the situation. Dr. X is of the opinion that he should have referred her to a detox centre or a rehabilitation program.

Finally, Dr. X stated her opinion that Dr. Seltzer failed to provide adequate consultation and supervision to the COAST team with respect to the substance dependence issues described above, and that this failure led to Patient A’s abandonment by the COAST team at a critical time. She was struggling to deal with her substance dependence and the support of the COAST team was needed at this time. Evidence established that, previously, Patient A had maintained a solid therapeutic alliance with the team. The rupture in the therapeutic alliance which led to Patient A’s discharge from the program in August 2003 occurred, in the opinion of Dr. X, in large measure because of Dr. Seltzer’s mismanagement of her care with respect to the substance dependence issue.

The Committee found Dr. X to be knowledgeable, experienced, and thoughtful. Her written report was detailed and thorough. Her testimony was articulate, organized, and clear. Her evidence was credible and compelling.

***The Evidence of Patient B:***

The Committee heard the evidence of Patient B. She is retired, and living in the Parry Sound area. She testified that she first saw Dr. Seltzer in August 2002 at a local clinic, at which time she was a recovering alcoholic and suffering from depression. Patient B continued to see Dr. Seltzer at the clinic, approximately once a month, until August 2004.

Dr. Seltzer prescribed antidepressant medication, and she found her counseling with him helpful. She spoke highly of the care provided to her by Dr. Seltzer during this time.

Patient B indicated that Dr. Seltzer stopped seeing her at the clinic in August 2004. Subsequently he continued to see her at her residence. He came to her apartment for this purpose, and the sessions became somewhat more frequent, up to once every three weeks. Dr. Seltzer continued to prescribe antidepressant medication for her.

Patient B testified that, in April 2005, her sessions with Dr. Seltzer suddenly stopped. He failed to attend a scheduled appointment without notification. She tried to contact him many times by phone, but was unsuccessful; his cell phone mailbox was full, and she was unable to leave a message. She was upset about this development, because she had found her sessions with Dr. Seltzer helpful, and she wanted them to continue. Further, she initially had no way of having her prescription renewed. She eventually contacted her family doctor who was able to continue her prescription.

Patient B stated that she was initially reluctant to contact the College, and that she didn't want to complain about Dr. Seltzer because he had been so helpful to her. She was, however, disappointed regarding the way in which her involvement with Dr. Seltzer had been terminated, and she wanted her clinical record from Dr. Seltzer. Eventually, she did correspond to a limited extent with Dr. Seltzer, who was living in Belize at that time, but the requested records were never obtained. Patient B testified that she felt "abandoned".

The Committee found Patient B's evidence to be credible. She was straightforward, forthright, and consistent. She freely acknowledged her mental health issues and her alcoholism, and spoke positively of Dr. Seltzer and the care which he had provided her in the past. She continued to feel that he had eventually treated her in a manner which "wasn't right", and she was determined to have this acknowledged. The Committee accepted her evidence.

***The Evidence of Dr. Y:***

The Committee heard the testimony of Dr. Y on behalf of the College. She is a general psychiatrist with extensive experience in both hospital and community-based practice. She has consulted to and worked with a number of community mental health services. The Committee accepted her qualifications as an expert witness.

Dr. Y had conducted a review of documentation pertaining to Dr. Seltzer's care and treatment of Patient B, and pertaining to events subsequent to the termination of this care.

It was Dr. Y's opinion that Dr. Seltzer's care and treatment of Patient B fell below the accepted standard of care in a number of areas, summarized as follows.

Dr. Y reviewed the evidence which established that Dr. Seltzer did not keep any clinical notes pertaining to his clinical sessions with Patient B between September 2004 and March 2005. The evidence indicated that he nevertheless billed OHIP for thirteen hours of psychotherapy for these sessions, as confirmed by the OHIP records which were entered into evidence, and which Dr. Y had also reviewed. Dr. Y confirmed that there are accepted standards for record keeping pertaining to psychotherapy. She stated her opinion that, in light of the evidence, Dr. Seltzer had clearly not met these standards in this case.

Finally, Dr. Y opined that the manner in which Dr. Seltzer terminated his involvement with Patient B was unacceptable, and fell below the accepted standard of practice. She stated that it is incumbent on a physician leaving practice to inform the patient of this in advance, if possible, and that this is particularly important in the context of a psychotherapeutic relationship, so that the patient has an opportunity to work through the loss. Furthermore, Dr. Seltzer had taken no steps to ensure that Patient B's antidepressant medication would continue to be available to her which, in Dr. Y's opinion, indicates a substandard level of care. He had made no effort to ensure the availability of alternative services.

The Committee found Dr. Y to be a credible witness. Her analysis of the issues on which she gave evidence was informed and thorough, and her testimony was clear, focused, succinct, and helpful. Her experience with the practicalities of psychiatric practice in community-based, non-academic settings was evident. She appeared prepared to give Dr. Seltzer the benefit of the doubt with respect to some aspects of his care and treatment of Patient B, but was also clear in the areas in which she felt that his care had been deficient.

**FINDINGS AND DECISION**

The burden of proving professional misconduct is on the College. Proof is required on a balance of probabilities, and must be clear and convincing, supported by cogent evidence.

The acts which constitute professional misconduct, specific to members of the College of Physicians and Surgeons of Ontario, are delineated in O. Reg. 856/93. Included among these acts is a failure to maintain the standard of practice of the profession. The College alleges that Dr. Seltzer has committed several acts of professional misconduct, including failure to maintain the standard of practice of his profession.

The standard of practice of the profession is the standard which is reasonably expected of the ordinary competent practitioner in the member’s field of practice. The standard may be breached notwithstanding an absence of harm suffered as a result of the practitioner’s actions.

There are generally three sources that can guide a Committee in determining the standard of practice in a particular case: the pertinent regulations that apply to the member; advisory notices published by the College and which ought to be known to the practitioner; and expert evidence on professional standards. The Committee can and should rely on its own expertise in assessing and considering the foregoing types of evidence. Ultimately, the Committee must determine the standard of practice.

After hearing and considering the evidence in this case, and the submissions of counsel, the findings of the Committee with respect to the identified issues are as follows:

1) With respect to Patient A, the Committee finds that Dr. Seltzer failed to maintain the standard of practice of the profession. He did so in two ways:

   First, Dr. Seltzer failed to maintain adequate records pertaining to his care and treatment of Patient A. The evidence in this regard is clear and compelling. Dr. Seltzer completed no documentation whatsoever for five of his eight sessions with Patient A. The psychiatric notes which were completed are brief, colloquial, do not adequately address the clinical issues at hand, and do not reflect a coherent treatment plan. These deficiencies are particularly concerning in light of changes in the prescription of psychiatric medications with no identified rationale and in light of the extent to which the COAST team would have expected to be able to rely on the psychiatric documentation for guidance, and for the provision of specialized expertise in their management of complex and evolving clinical issues. Dr. Seltzer's failure to maintain adequate records is a breach of the accepted standard of care.

   Second, Dr. Seltzer failed to recognize and respond adequately to Patient A's substance dependence disorder. It should have been clear to him that she was dependent on certain drugs. Dr. Seltzer appeared to recognize this at one point but, subsequently, concluded that substance dependence was not a significant issue. Patient A eventually made increasingly insistent requests for assistance in withdrawing from her medications, but received no assistance in this regard. When she attempted to stop the medications on her own and experienced withdrawal symptoms, the emerging clinical issues were neither adequately assessed nor managed. Dr. Seltzer had an obligation to his patient to address the substance dependence issue more thoroughly and consistently, and to respond to Patient A's requests for assistance in this area. His failure to do so is a breach of the accepted standard of care.

Notwithstanding the evidence of Dr. X, the Committee is not persuaded, on the basis of the evidence, that Dr. Seltzer's psychopharmacological management of Patient A's psychiatric disorders fell below the accepted standard of care. Patient A presented with a complex constellation of psychiatric co-morbidities. She had a history of exposure to trauma and was experiencing fluctuating, sometimes high, levels of psychosocial stress. An unstable clinical course was not unexpected, and she would have presented management difficulties under any circumstances. Dr. Seltzer's psychopharmacological treatment of Patient A can be questioned and his inadequate documentation is of no assistance in understanding his rationale in this regard. Nevertheless the Committee is of the view that the evidence falls short of establishing a clear breach of the standard of care on this basis.

Similarly, neither is the Committee of the view that a breach of the accepted standard of care had been proven with respect to the performance of Dr. Seltzer's role as consultant to and supervisor of the COAST team. While it is clear that there was eventually a rupture in the previously positive therapeutic alliance between Patient A and the COAST team, the evidence that this occurred because of Dr. Seltzer's failure in his role as the COAST psychiatrist is largely speculative. The Committee heard no evidence from any member of the COAST team to substantiate this allegation. The documentation reviewed, on this relatively narrow issue, is inconclusive. Accepting that Dr. Seltzer mismanaged Patient A's substance dependence as her attending psychiatrist, as indicated above, it remained unclear to the Committee the extent to which his actions in this area eventually caused the patient to feel abandoned by the COAST team. Therefore, the evidence falls short of establishing a breach of the standard of care on this issue.

2) With respect to Patient B, the Committee makes the following findings:

(i) The Committee finds that Dr. Seltzer discontinued professional services that were needed without Patient B requesting discontinuation, without arranging alternative services, and without giving Patient B a reasonable opportunity to arrange

alternative services. The evidence on this issue is clear. Dr. Seltzer abruptly stopped seeing Patient B without any notification. He left the country and she was unable to contact him. No alternative services had been arranged; Patient B initially had no way of having her prescription for antidepressant medication refilled. Dr. Seltzer's actions in this regard constitute professional misconduct.

(ii) The Committee finds that Dr. Seltzer failed to maintain an adequate record for Patient B. The evidence, again, is clear. The Committee accepted Patient B's evidence (corroborated by the evidence of Dr. Seltzer's OHIP billings) that he had regular clinical sessions with her between September 2004 and March 2005; yet, no records pertaining to these sessions were ever produced, and Dr. Seltzer eventually acknowledged that no records existed. Dr. Seltzer's failure to maintain a record constitutes professional misconduct.

(iii) The Committee finds that Dr. Seltzer provided inconsistent and contradictory responses to requests for Patient B's records. From the outset Dr. Seltzer would have known that the requested records were non-existent. Yet he misled Patient B by informing her that they were safely secured in Ontario, and misled the College by stating that he would, or that he had, taken the records with him to Belize. The Committee finds that Dr. Seltzer's actions were intentionally misleading, thereby undermining the College in its investigation. The Committee has concluded this conduct would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional and thereby constitutes professional misconduct.

**CONCLUSIONS:**

The Committee concludes that Dr. Seltzer has committed professional misconduct:

1. under paragraph 1(1)2 of O. Reg. 856/93, in that he has failed to maintain the standard of practice of the profession in his care and treatment of Patient A;

2. under paragraph 1(1)7 of O. Reg. 856/93, by discontinuing professional services to Patient B that were needed, without the patient requesting the discontinuation, without arranging alternative services and without giving the patient a reasonable opportunity to arrange alternative services;

3. under paragraph 1(1)27 of O. Reg. 856/93, by contravening a regulation made under the *Medicine Act, 1991*, in relation to his failure to keep a record for Patient B; and

4. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in relation to giving contradictory and misleading statements to the College regarding the records of Patient B.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to these findings.

**NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Allan Zangwill Seltzer, 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 in the patient records filed 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, in relevant part:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
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> (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
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**Indexed as: Seltzer (Re)**

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

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

**B E T W E E N:**

**THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. ALLAN ZANGWILL SELTZER**

| **PANEL MEMBERS:** | **DR. P. CHART** |
|---|---|
| | **DR. R. SHEPPARD** |
| | **S. BERI** |
| | **DR. J. BROWN** |
| | **E. COLLINS** |

| **Penalty Hearing Date:** | **March 31, 2009** |
|---|---|
| **Penalty Decision Date:** | **June 17, 2009** |
| **Release of Written Reasons on Penalty:** | **June 17, 2009** |

# PUBLICATION BAN

**PENALTY AND REASONS FOR PENALTY**

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on November 3, 4 and 5, 2008. At the conclusion of the hearing, the Committee reserved its decision. On February 2, 2009, the Committee delivered its written decision and reasons and found that Dr. Seltzer had committed professional misconduct:

1. under paragraph 1(1)2 of O. Reg. 856/93, in that he has failed to maintain the standard of practice of the profession in his care and treatment of Patient A;

2. under paragraph 1(1)7 of O. Reg. 856/93, by discontinuing professional services to Patient B that were needed, without the patient requesting the discontinuation, without arranging alternative services and without giving the patient a reasonable opportunity to arrange alternative services;

3. under paragraph 1(1)27 of O. Reg. 856/93, by contravening a regulation made under the *Medicine Act, 1991*, in relation to his failure to keep a record for Patient B; and

4. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in relation to giving contradictory and misleading statements to the College regarding the records of Patient B.

The Committee heard evidence and submissions on penalty on March 31, 2009, and reserved its decision.

Dr. Seltzer did not attend the penalty hearing. He had also not attended the original hearing of the Committee. The Committee was provided with evidence that Dr. Seltzer had been given reasonable notice of the penalty hearing. This evidence consisted of the Affidavit of Service of Ms. N, Hearings Coordinator at the College, dated February 18, 2009 (Exhibit 1). The Committee heard that this was sent to Dr. Seltzer's last known

addresses in Huntsville and Belize, and via email. The Committee concluded that this was reasonable notice, and decided to proceed in Dr. Seltzer's absence.

**EVIDENCE AND SUBMISSIONS ON PENALTY**

The College called evidence with respect to penalty, summarized as follows:

The Committee heard the evidence of Ms. P, Complaints Committee Coordinator at the College. Ms. P's evidence, accompanied by copies of correspondence between herself and Dr. Seltzer and copies of internal College emails (Exhibits 2, 3, 4, & 5), established that Dr. Seltzer had previously failed to attend at the College for a proposed personal caution by the Complaints Committee. This was in relation to a complaint which was unrelated to the allegations which had been before this Committee, and which eventually formed the basis for the findings of Professional Misconduct.

The Committee also heard the evidence of two additional witnesses: Mr. Q, who is an investigator for the College, and Mr. R, who is the advertising manager for several local newspapers in the Huntsville-Muskoka area. The evidence of these two witnesses was accompanied by copies of relevant documentation (Exhibits 6, 7, 8 & 9). This evidence established that Dr. Seltzer had placed advertisements in two local newspapers, in February and September 2008, which suggested that he was engaged in, or preparing to engage in, the practice of Psychiatry in Ontario. It had previously been established that Dr. Seltzer had resigned his membership in the College in April 2006. The substance of this evidence, again, was unrelated to the allegations which had been before this Committee.

Counsel for the College submitted a proposed penalty, along with a Book of Authorities pertaining to previous penalty decisions of the Discipline Committee, each of which bore some similarity to aspects of Dr. Seltzer's case. Counsel reminded the Committee that, although Dr. Seltzer resigned from the College in April 2006, he is still subject to the

jurisdiction of the College for professional misconduct committed during the period of time that he was a member.

Counsel for the College submitted that the proposed penalty was consistent with the cases cited in the Book of Authorities. Counsel argued that Dr. Seltzer's conduct in abandoning a patient and in misleading the College in its investigation required a reprimand recorded on the Register, for the purposes of specific and general deterrence and to maintain public confidence in the integrity of the profession. It was argued that the remedial and monitoring components of the proposed penalty would contribute to the rehabilitation of the member, and would serve to protect the public in the event that Dr. Seltzer chose to reapply to the College for a certificate of registration.

Counsel for the College submitted that Dr. Seltzer's failure to attend an earlier scheduled caution with the Complaints Committee demonstrates ongoing attempts to evade the authority of the College, and a refusal to abide by the legislation. It was submitted that Dr. Seltzer's advertisements in local newspapers are misleading or potentially misleading, that he has yet to respond directly to the concerns of the College that he may be misusing the title of "Doctor", and that this sort of behaviour undermines the College in its mandate to protect the public.

## DECISION AND REASONS ON PENALTY

The principles of penalty, which guided the Committee in its deliberations, are the protection of the public, the maintenance of public confidence in the integrity of the profession and in the principle of effective self-regulation, the denunciation of wrongful conduct, specific deterrence of the member, general deterrence of the membership, and the potential rehabilitation of the member.

The Committee carefully considered the evidence adduced and the submissions of counsel for the College. The Committee accepted the submission of the College that a

comprehensive penalty is required, in order to address the principles of penalty as they apply to Dr. Seltzer's case.

The Committee reviewed the Book of Authorities submitted by counsel for the College, which cites previous penalty decisions of the Discipline Committee. While the Committee recognizes that it is not bound by previous decisions, these previous cases do provide some guidance. Precedent appears to establish that, in cases involving both failure to meet the standard of care and a finding of dishonest, obstructionist, or otherwise unethical behaviour, a comprehensive penalty is generally imposed which can include a reprimand, recording of the reprimand on the Register, a suspension of the member's certificate of registration, costs, and a program of remediation tailored to the specific aspects of the member's care which have been found to be deficient.

The Committee considered the evidence adduced at the Penalty hearing pertaining to Dr. Seltzer's failure to attend at the College for an earlier caution from the Complaints Committee when he had agreed to do so. The failure to attend at the caution before the Complaints Committee may be considered as a factor in the penalty to be administered in this case as it demonstrates a disregard and disrespect for the authority and procedures of the College. While we did consider this matter, it was not given significant weight in determining the penalty in this case.

The advertisements which Dr. Seltzer placed in local Muskoka newspapers in February and September 2008 which were allegedly misleading or potentially misleading fall into a different category. The Committee notes that no allegation of professional misconduct has been made with respect to this conduct, and that Dr. Seltzer is not subject to penalty in this regard. The Committee considered this evidence not as an aggravating factor for the penalty in this case but as a contextual point as concerns the fact that Dr. Seltzer may have intentions to seek to return to practice in Ontario.

The Committee finds that further aggravating factors with respect to penalty are Dr. Seltzer's failure to admit the wrongfulness of his behaviour despite multiple opportunities

to do so, his failure to express remorse, his failure to demonstrate insight into his deficiencies, and his failure to engage consistently, at any stage, in the disciplinary process. A mitigating factor is considered to be Dr. Seltzer's resignation from the College.

The Committee notes that Dr. Seltzer's care of the two patients in question was deficient in several areas. He failed to maintain the standard of practice of the profession, his record keeping was grossly inadequate, and he behaved unethically in discontinuing professional services to a patient. Remedial measures are required in these areas, in addition to provisions for monitoring Dr. Seltzer's practice should he reapply for a certificate of registration with the College. Furthermore, Dr. Seltzer intentionally misled the College in its investigation. He failed to maintain the required standard of honesty, integrity, and professionalism in his dealings with the College. This cannot be tolerated in the interests of effective self-regulation, and in maintaining public confidence in the integrity of the profession. The penalty must reflect denunciation of Dr. Seltzer's conduct in this regard, to serve the purposes of specific and general deterrence, and to maintain public confidence in the integrity of the profession and the ability of the College to complete its investigations and regulate itself.

**ORDER**

In consideration of the foregoing, the Discipline Committee ordered and directed that:

1. Dr. Seltzer appear before the panel to be reprimanded.
2. The results of this proceeding be recorded in the Register.
3. The Registrar be directed to suspend Dr. Seltzer's certification of registration for a period of six months.
4. The Registrar be directed to impose the following terms, conditions and limitations on his certificate of registration:

a) Dr. Seltzer be required to complete, at his own expense, the Medical Record Keeping for Physicians and the Medical Ethics and Informed Consent courses at the College;

b) Dr. Seltzer be required to complete, at his own expense, a program that is approved by the College that establishes that Dr. Seltzer has the appropriate knowledge, skill, and judgment to practice psychiatry in the Province of Ontario relating to:

i) monitoring patient prescription drug use according to current standards;

ii) record keeping;

iii) psychopharmacology;

and which will encompass assessment, remediation, and reassessment; and

c) Dr. Seltzer be required to engage, at his own expense, a Clinical Supervisor who is acceptable to the College, who will supervise Dr. Seltzer's completion of the program identified in 4 b), and who will deliver to the College a written report satisfactory to the College confirming successful completion of the program, and stating that Dr. Seltzer has the required knowledge, skill, and judgment in the areas identified in paragraph 4(b) above [the matters referred to in paragraphs 4 (b) and (c) shall be referred to as the "Remediation Program"].

5. The Registrar shall be directed to impose the following further terms, conditions, and limitations on Dr. Seltzer's certificate of registration:

a) Following the successful completion of the Remediation Program, Dr. Seltzer's practice shall be subject to clinical review. The assessor will review Dr. Seltzer's practice generally, and particularly with respect to the identified areas of deficiency outlined in the Remediation Program. This review, together with a review of Dr. Seltzer's pharmacological prescribing records, will be performed by an assessor satisfactory to the College, who will report the findings to the College initially at six months after the Remediation Program and, thereafter, at six months intervals for a period of two years, and then annually for a period of three years;

b) Dr. Seltzer will be responsible for all costs associated with these assessments and reports. If the reports are not satisfactory to the College during the period of review, the College will take such actions as are deemed appropriate;

c) Dr. Seltzer will provide to the College on an annual basis proof of his participation in continuing medical education in accordance with the guidelines of the Royal College of Physicians and Surgeons of Canada.

We also order and direct that Dr. Seltzer pay costs of the College of this proceeding in the amount of $10,950. We are of the view that this is an appropriate case to make such an order of costs.