NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Martin Jugenburg, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients referred to orally or in the exhibits 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:

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

DISCIPLINE COMMITTEE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Citation: *College of Physicians and Surgeons of Ontario v. Jugenburg*, 2021 ONCPSD 22
Date: May 12, 2021

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Martin Jugenburg

FINDING AND PENALTY REASONS

Heard: February 1, 2021, by videoconference

Panel:

Dr. Barbara Lent (chair)
Mr. J. Paul Malette, QC
Dr. John Rapin
Ms. Linda Robbins
Dr. Robert Sheppard

Appearances:

Ms. Carolyn Silver and Ms. Sayran Sulevani, for the College
Ms. Nina Bombier, Mr. Paul-Erik Veel and Ms. Brianne Westland, for Dr. Jugenburg
Mr. David Rosenbaum, Independent Legal Counsel to the Discipline Committee

Introduction

[1] In December 2020, the Committee found that plastic surgeon Dr. Jugenburg had committed an act of professional misconduct. Dr. Jugenburg had permitted a television crew to film a patient's surgical procedure without her informed consent, which resulted in a major breach of her privacy. He had failed to ensure the privacy of another patient as a result of the inadvertent posting of her images on social media on two occasions. He also failed to consider adequately the privacy interests of the patients of his clinic, over a two-year period, through the design and operation of the clinic's video surveillance system.

[2] The Committee's reasons for decision on that finding are found at *College of Physicians and Surgeons of Ontario v. Jugenburg*, 2020 ONCPSD 40.

[3] In February 2021, we heard a further allegation of professional misconduct against Dr. Jugenburg. At the conclusion of that hearing, we made a finding of professional misconduct on this new allegation, and we reserved our decision on penalty with regard to all of our findings.

[4] Below are the reasons for our finding regarding the third patient (Patient C), our penalty order with respect to all our findings, and our reasons for penalty.

[5] For the reasons set out below, we order Dr. Jugenburg to appear before the Committee to be reprimanded and direct that his certificate of registration be suspended for six months, to commence 30 days from the date of this order, and that a term, condition and limitation be placed upon it. We also order Dr. Jugenburg to pay the College's costs of $31,110.

Combining the proceedings

[6] Section 9.1(1)(a) of the *Statutory Powers Procedure Act*, RSO 1990, c. S.22, states:

> If two or more proceedings before a Tribunal involve the same or similar questions of fact, law, or policy, the Tribunal may:
>
> (a) Combine the proceedings or any part of them, with the consent of the parties.

[7] On December 23, 2020, Mr. David Wright, Chair of the Discipline Committee, made an order on consent pursuant to section 9.1(1)(a) of the *Statutory Powers Procedure Act* that the allegations against Dr. Jugenburg contained in a new Notice of Hearing dated May 20, 2020 (with respect to Patient C) should be combined with the existing matter (with respect to Patients A and B) into a single proceeding.

Facts & finding on allegation regarding Patient C

[8] The parties submitted an Agreed Statement of Facts on Liability to the Committee for consideration. The agreed facts on liability are summarized below.

[9] Dr. Jugenburg performed three cosmetic surgeries on Patient C on October 16, 2013, including a facelift. Photographs of her face were taken prior to the surgery and at follow-up appointments. Prior to the procedure, Patient C had declined to provide her consent to the use of these photographs for "scientific, educational, or illustrative purposes." She had wished not to be a part of marketing or to be on the internet in any way. She considered her surgery private and of a sensitive nature and she did not want any information about her surgery disclosed publicly.

[10] Five years later, in November 2018, Patient C happened to visit Dr. Jugenburg's website. She was shocked to discover the "before and after" images of her face in the image gallery, with her eyes obscured. She immediately emailed the clinic to notify them that she had not consented to this posting, and to request that the images be immediately removed. This was done, and a member of Dr. Jugenburg's staff apologized to Patient C by email.

[11] With respect to Patient C, the clinic's procedure for verifying patient consent for the posting of patient images on the clinic website had failed. As a result, images of Patient C, which were of a sensitive and personal nature, were posted without her consent, where they remained on the website for over five years.

<u>Admission to the allegation regarding Patient C</u>

[12] Dr. Jugenburg admitted that based on these facts, he engaged in conduct or 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, contrary to paragraph 1(1) 33 of O.Reg. 856/93.

Finding regarding Patient C

[13] The Committee accepted as correct the facts contained in the Agreed Statement of Facts on Liability with respect to Patient C, and found that these facts constitute professional misconduct in that Dr. Jugenburg engaged in conduct or 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.

Penalty

[14] The combined findings on liability which we took into account when considering penalty encompass both:

a. the Committee's findings set out in its decision of September 24, 2020 pertaining to the complainants Patient A and Patient B, referred to in paragraphs 1 and 2, above; and

b. the finding we made on February 1, 2021 with respect to the complainant Patient C, set out in paragraph 13, above.

Agreed Statement of Facts on Penalty

[15] The Agreed Statement of Facts on Penalty, summarized below, set out changes that Dr. Jugenburg has made to his clinic's systems, as well as training that he has undergone, to address the issues that led to the Committee's findings that he had committed professional misconduct.

[16] With respect to the operation of the video surveillance system at Dr. Jugenburg's clinic which led to violations of patient privacy, Dr. Jugenburg agreed to remove security cameras from areas where patient encounters may occur, and to post signage in every location where security cameras were operational, notifying patients that the premises are monitored by video surveillance. He voluntarily entered into an undertaking with the College to this effect, dated February 28, 2019. He has complied with the terms of this undertaking, which remains in effect.

[17] The clinic's policies regarding patient privacy and social media transparency have been updated and revised. The clinic's procedures for obtaining and confirming patient consent for the use of their images on the clinic's website, and on social media platforms have also been revised, and include additional safeguards to ensure that consent, or lack of consent, is always documented and confirmed. Dr. Jugenburg has hired a social media coordinator to prepare and post images and videos to the website and social media and to ensure that appropriate consent is in place. Finally, Dr. Jugenburg has personally reviewed all of the postings on the clinic's website to ensure that each patient has consented to the use of their images.

[18] With respect to Dr. Jugenburg's understanding of the importance of patient privacy and of the sensitivity of confidential personal health information, he has voluntarily undergone training in these areas by completing the Ontario MD Privacy and Security Training Module and a three-part privacy and security course, and he has also undergone individualized coaching. The coach provided a positive report about Dr. Jugenburg's participation, engagement and the benefits achieved.

Positions of the parties

[19] The parties agreed that the penalty for Dr. Jugenburg's professional misconduct should include a public reprimand and a suspension of Dr. Jugenburg's certificate of registration, and that he should be subject to a costs order. However, they disagreed on the length of the suspension and the amount of costs that should be awarded.

[20] The College requested a suspension of Dr. Jugenburg's certificate of registration for 12 months and an order that Dr. Jugenburg pay costs of $41,480 to the College for four days of hearing.

[21] Counsel for Dr. Jugenburg submitted that the suspension of Dr. Jugenburg's certificate of registration should be for three months and that the costs order should be for $20,740, for two days of hearing.

[22] In addition, the College sought an order that a term, condition and limitation be placed on Dr. Jugenburg's certificate of registration that he completes one-on-one instruction in professionalism, communications and informed consent with an instructor selected by the College.

Reasons for penalty

[23] The principles guiding the imposition of penalty in disciplinary proceedings are well-known and not in dispute. Foremost is the protection of the public. The penalty imposed should also denounce wrongful conduct, assist in maintaining public confidence in the integrity of the profession and in the profession's ability to regulate itself effectively in the public interest, serve as a specific deterrent to the member and as a general deterrent to the membership as a whole and, where applicable, attempt to address the rehabilitative needs of the member. The penalty imposed should be proportionate to the misconduct committed and should generally be consistent with previous decisions in similar cases.

The nature of the misconduct

[24] There are several facets to Dr. Jugenburg's professional misconduct.

[25] First, Dr. Jugenburg failed to appreciate the importance of informed consent. This failure is reflected in his authorizing the presence of a television news crew in the operating room for Patient A's surgical procedure, following his brief, last-minute discussion with her which was inadequate for the purposes of obtaining her consent to this event. This culminated in a major violation of Patient A's privacy, when she was filmed for television contrary to her wishes. Furthermore, the procedure that Dr. Jugenburg implemented in his clinic to secure patient consent to have their images posted on his social media platforms was inadequate. The result, again, was breaches of confidentiality and patient privacy, for which Dr. Jugenburg bears responsibility.

[26] Second, Dr. Jugenburg was alarmingly insensitive to his patients' privacy interests. This is most obviously reflected in his decision to implement and operate a surveillance system at his clinic, prominently including patient care areas, which resulted in the recording of visual images of thousands of patients,

often unclothed or partially clothed, most of whom had no knowledge that this system was in operation. Dr. Jugenburg's insensitivity to patient privacy concerns extended also to his use of social media. Patient B felt pressured to participate in social media. Although there was no overt coercion in this regard, Dr. Jugenburg seems to have been oblivious to the risks of posting highly personal patient images and to the potential for this practice to have a negative impact on the emotional well-being of his patients. In the case of Patient C, the failure of his clinic's procedure for verifying patient consent to the posting of her images was Dr. Jugenburg's responsibility as the director of the clinic and as the physician responsible for her care. As is clear from the evidence, some patients were seriously traumatized by these breaches of their privacy.

[27] Third, there is a troubling pattern of Dr. Jugenburg pursuing his own interests, in terms of the perceived security needs of his clinic and of his interests in publicity and in cultivating a strong social media presence, at the expense of the privacy of his patients. Physicians must always be aware, however, of the power imbalance inherent in the doctor/patient relationship and must exercise vigilance to ensure that they are not using their patients for their own purposes. Otherwise, public trust in the medical profession and public confidence that patient interests are always at the forefront of medical practice will be eroded.

[28] Fourth, as a result of the actions referred to above, Dr. Jugenburg caused harm to some of his patients. The violations of their privacy, in circumstances where they had a legitimate expectation that their most private personal health information would be protected, caused some patients to feel distressed and traumatized. The fact that not all patients suffered harm is to be expected, as patients have different vulnerabilities and differing ways of processing and adapting to circumstances. This does not, however, diminish the negative impact that Dr. Jugenburg's actions had on some.

[29] We accept that Dr. Jugenburg did not intend to harm his patients. By his actions, however, he demonstrated a reckless disregard for their privacy interests in pursuit of his own objectives. He should have been more aware of his patients' vulnerabilities and of the risks to which he was exposing them. This was a very serious failure of professionalism.

[30] The responsible use of social media in medical practice is a relatively novel issue. This may well present new and unfamiliar challenges to physicians, such as how to ensure that consent is properly obtained, and that the interests of participating patients, including with respect to confidentiality and privacy, remain paramount. A physician whose practice includes a social media component has an obligation to ensure that the imperatives of good clinical care, in all its aspects, are respected.

[31] We considered the letters and emails of support for Dr. Jugenburg, both from his patients and from his colleagues. We accept that some of Dr. Jugenburg's patients, perhaps many, are very satisfied with the care that he provided, and that some were not troubled by his video surveillance system. Similarly, we accept that some of Dr. Jugenburg's colleagues hold his clinical skills in high regard.

[32] In arriving at a decision on penalty, however, we place little weight on these expressions of support. The fact that many patients were not harmed by Dr. Jugenburg's actions does not diminish the harm sustained by some which, in light of the impact statements we reviewed, was severe. Dr. Jugenburg's clinical knowledge and skills cannot lessen the impact of the other areas of clinical practice, notably judgment and sensitivity to patient vulnerabilities, in which he was lacking.

Aggravating factors

[33] The most prominent aggravating factor, in our view, is the multifaceted and longstanding nature of Dr. Jugenburg's professional misconduct.

[34] Dr. Jugenburg's misconduct affected many patients, numbering in the thousands with respect to the video surveillance system, and persisted over a period of years. The magnitude of the misconduct is an aggravating factor.

[35] An additional aggravating factor is that, initially, Dr. Jugenburg's understanding of the risks to which he was exposing his patients was slow to develop. He was warned in late 2016 of patient concerns with respect to privacy violations on social and other media, yet he nevertheless proceeded with installing a video surveillance system that resulted in even more egregious and ongoing violations

of patient privacy. Similarly, with respect to patient consent to appear on social media, it wasn't until relatively recently that Dr. Jugenburg took the initiative to personally review all postings to ensure that consent was in place. He should have acted more expeditiously to address the concerns brought to his attention. By failing to do so, he conveyed the impression that, at the time, he still wasn't considering these issues to be a high priority.

Mitigating factors

[36] The strongest mitigating factor, in our view, is that it appears that Dr. Jugenburg has now taken full responsibility for his misconduct. His insight, albeit slow to develop as noted above, now appears to be good.

[37] We note that Dr. Jugenburg did not contest the vast majority of the multiple allegations made by the College. This allowed much of the hearing to proceed by way of an Agreed Statement of Facts, thus reducing hearing time and associated costs and sparing most of the complainants from having to testify.

[38] Dr. Jugenburg has taken steps to improve the procedures in his clinic to obtain patient consent to the use of their images on social media. He has revised his written consent form, instituted safeguards to ensure that consent or lack thereof is clear and hired a social media coordinator to assist with this process. Although the College took issue with some of the revisions, suggesting that Dr. Jugenburg was still not giving adequate attention to consent, we find that his efforts to improve his clinic's procedures in this area do speak to his improved insight.

[39] Dr. Jugenburg has accepted that his understanding of issues pertaining to patient privacy and the sensitivity of health care information was deficient. He has pursued remediation in the areas in which his knowledge and judgment were lacking, as evidenced by the rehabilitative programs and counselling which he has undertaken, notably the Ontario MD Privacy and Security Training Module, Privacy and Security for Toronto Academic Health Science Network (TAHSN) hospitals, and individual counselling pertaining to Health Privacy Coaching for Physicians with Kate Dewhirst of Kate Dewhirst Health Law. Dr. Jugenburg's commitment to his rehabilitation is a strong indicator of his insight and his sincerity in addressing his deficiencies.

[40] Dr. Jugenburg responded to the privacy concerns raised by his surveillance system by disabling the system and replacing it eventually with a new one, which better safeguarded patient privacy. He also made an attempt to notify patients, after the fact, about what had occurred with the previous system. We find that this attempt, albeit somewhat belated, to correct a surveillance system whose flaws should have been apparent from the outset, eventually resulted in positive change.

[41] Finally, the Committee finds that Dr. Jugenburg's lack of a prior disciplinary history with the College is a mitigating factor. Although this could logically also be seen as simply the absence of an aggravating factor, previous decisions of the Discipline Committee have found it to be mitigating and, in any event, the effect is the same. This is not a case of a physician who has failed to learn from previously imposed sanctions, leading to possible inferences of intractable deficiencies in insight, poor response to remediation, or ungovernability. With respect to Dr. Jugenburg there is, in fact, evidence to the contrary which hopefully suggests a favourable prognosis.

Prior cases

[42] A general principle guiding the imposition of penalty is that similar factual circumstances should attract similar penalties. Although not binding on the Committee, prior decisions of the Discipline Committee in similar cases can assist the Committee by providing guidance as to an appropriate range of penalties and enhancing consistency in the regulatory process to the benefit of the profession and the public.

[43] In considering the prior cases that were presented to us, we note that the facts of this case are unique. Although there are prior cases pertaining to the importance of informed consent and to the misuse of personal health information, and cases involving the surreptitious recording of patients and others without their knowledge, in none of these cases are the facts similar to those in Dr. Jugenburg's case. The parties acknowledged that this was so.

[44] That said, some of the cases we reviewed raised issues that resonated with some aspects of Dr. Jugenburg's misconduct and provided some guidance for what an appropriate length of suspension might be.

[45] In *College of Physicians and Surgeons of Ontario v. Brooks*, 2016 ONCPSD 29, Dr. Brooks misused his status as a regulated health professional to access the confidential health records of two individuals with whom he had a close personal connection, resulting in a serious breach of confidentiality and violation of these patients' rights to privacy. Dr. Brooks accepted responsibility and the Committee found he had engaged in disgraceful, dishonourable or unprofessional misconduct. The Committee ordered a five-month suspension of his certificate of registration, a reprimand, a requirement that he complete individualized instruction in medical ethics and that he pay costs of $5,000. This case differs from Dr. Jugenburg's in that, among other things, Dr. Brooks had a personal connection with the complainants whose personal health information he misused.

[46] In *College of Physicians and Surgeons of Ontario v. Di Paola*, 2016 ONCPSD 48, Dr. Di Paola repeatedly accessed confidential and sensitive personal health information of two patients at the Centre for Addiction and Mental Health, over a two year period, without consent or legal authority. Dr. Di Paola had a close personal connection with both patients. She admitted to the allegations and the Committee found she had engaged in disgraceful, dishonourable or unprofessional conduct. The Committee ordered a reprimand, a suspension of Dr. Di Paola's certificate of registration for three months, that Dr. Di Paola complete individualized instruction in medical record-keeping and that she pay costs of $5,000. We note, again, that Dr. Jugenburg had no personal connection with any of the patients whose personal health information he misused, in contrast to Dr. Di Paola, and thus his motivations were quite different.

[47] Dr. Jugenburg referred to several cases that involved nurses who misused their authority as regulated health professionals to improperly access medical records of patients not under their care, or of other individuals known to them (*College of Nurses of Ontario v. Quinn*, 2018 CanLII 62038 (ON CNO); *College of Nurses of Ontario v. Church-Labrie*, 2020 CanLII 45992 (ON CNO); *College of Nurses of Ontario v. Trudel*, 2018 CanLII 62040 (ON CNO)). The Discipline Committee of

the College of Nurses of Ontario ordered, amongst other things, suspensions in these cases of either three or four months.

[48] Dr. Jugenburg also relied on *Ontario College of Pharmacists v. Shenouda*, 2018 ONCPDC 10. In that case, the Ontario College of Pharmacists Discipline Committee found that a pharmacist had breached patient privacy by posting prescriptions on a Facebook page, accessible to a large number of people in a public forum. The Committee ordered, amongst other things, that the pharmacist's certificate of registration be suspended for three months total, two months of which could be remitted by participation in remediation.

[49] In *College of Physicians and Surgeons of Ontario v. Jiaravuthisan*, 2016 ONCPSD 50, Dr. Jiaravuthisan, in his physical examinations of two patients, failed to communicate adequately with them about the nature and purpose of his examinations, failed to ensure patient understanding and consent and failed to respect the dignity and privacy of his patients. Dr. Jiaravuthisan admitted the facts as alleged, and that this conduct would reasonably be regarded as disgraceful, dishonourable or unprofessional. He undertook with the College to resign his certificate of registration and not to reapply, and the Committee ordered a reprimand and costs of $5,000. A significant distinguishing feature of this case from Dr. Jugenburg's is that Dr. Jiaravuthisan failed to take sufficient care to maintain spatial boundaries: with both patients he placed his hands on a sensitive area without warning or explanation.

[50] By contrast, several other cases submitted were so different from Dr. Jugenburg's case that we did not consider them to provide much guidance, if any.

[51] In *College of Physicians and Surgeons of Ontario v. Martin*, 2018 ONCPSD 61, Dr. Martin, amongst other deficiencies in his care of two transgender adolescents, failed to obtain properly informed consent in the prescription of cross-sex hormones. He admitted the facts as alleged, admitted that he had failed to maintain the standard of practice of the profession, and admitted that he was incompetent. Dr. Martin had a prior disciplinary history with the College with respect to a range of issues and this was an aggravating factor. Dr. Martin resigned from the College and undertook not to reapply for registration to practise

medicine in Ontario or elsewhere. The Committee ordered a reprimand and costs of $6,000. This case was significantly different from Dr. Jugenburg's: the misconduct involved adolescent patients, Dr. Martin's treatment decisions posed a significant risk of harm, and there were findings of both a "gross failure" to meet the standard of practice and incompetence.

[52] In *College of Physicians and Surgeons of Ontario v. Hwang*, 2019 ONCPSD 33, Dr. Hwang surreptitiously made audio and video recordings of a number of individuals, most of them not patients, in an intensely invasive manner resulting in egregious violations of their privacy. He was criminally charged with voyeurism contrary to Section 162 of the *Criminal Code*, convicted, and sentenced. In the disciplinary proceedings, Dr. Hwang entered a plea of no contest to allegations of disgraceful, dishonourable or unprofessional conduct, conduct unbecoming a physician, and having been found guilty of an offence relevant to his suitability to practise medicine. The Committee accepted a joint submission and ordered that Dr. Hwang's certificate of registration be revoked, that he be reprimanded, and that he pay costs of $6,000. This case bears little similarity to that of Dr. Jugenburg, aside from the fact of the video recordings made without patient knowledge or consent, as Dr. Hwang's conduct was criminal in nature and his motivation was the expression of deviant sexuality.

[53] A general conclusion, based on the above, is that misconduct by regulated health professionals involving breaches of patient privacy, misuse of personal health information, and disregard for informed consent attracts significant sanctions including reprimands, costs and often suspensions of various lengths of up to several months in duration. However, given the unique set of facts that make up Dr. Jugenburg's case, the prior decisions are of limited assistance in assessing what an appropriate length of suspension would be in this case.

Decision on penalty

[54] Dr. Jugenburg is to appear before us to be reprimanded. A public reprimand is expected to send a strong message to Dr. Jugenburg, to the profession and, importantly, to the public that the misconduct committed by Dr. Jugenburg is serious, unacceptable and that it needs to be denounced in the strongest terms.

[55] We find that a significant suspension of Dr. Jugenburg's certificate of registration is required in order to fairly express the principles of denunciation of wrongful conduct, specific and general deterrence and maintenance of public confidence in the reputation and integrity of the profession. Dr. Jugenburg, by his actions, permitted egregious violations of patient privacy which affected a great many patients over a prolonged period of time. His actions had a lasting effect on some of his patients, leaving them in some cases traumatized, with diminished trust in the medical profession. Patients have a right to know that their personal health information will remain confidential, safe and secure. Particular vigilance is required in safeguarding the sort of sensitive personal images such as those captured in a cosmetic surgery practice. Dr. Jugenburg's seeming indifference to these issues was appalling and is deserving of significant sanction.

[56] That said, we find that Dr. Jugenburg's accepting responsibility for his misconduct, his development of insight and his commitment to remediation in the areas in which his understanding and judgment were lacking, constitute a strong mitigating factor. We are satisfied that he has the ability to learn from his mistakes, and that he has developed a better understanding into issues of patient privacy and consent. Remediation of the member is an important aspect of penalty.

[57] Balancing the severity of the misconduct committed with the positive steps Dr. Jugenburg has taken with respect to rehabilitation and his potential for a successful return to practice, a six-month suspension of Dr. Jugenburg's certificate of registration is fair, necessary, and appropriate.

[58] At the hearing, the College requested that the suspension of Dr. Jugenburg's certificate of registration commence 15 days after the date of our order. Dr. Jugenburg submitted a draft order that called for the suspension to begin 30 days after the date of the order. The Committee invited the parties to deliver written submissions as to the appropriate start date. The College indicated that the decision was in our hands. We were satisfied based on submissions from Dr. Jugenburg that the appropriate start date was 30 days after the date of our order. This will allow Dr. Jugenburg time to communicate with his patients, address any time-sensitive appointments and arrange for referrals to other surgeons for

patients who wish to have their procedure during the time Dr. Jugenburg is suspended, as well as provide timely notice to his employees.

[59] We include a term in our order requiring Dr. Jugenburg to take one-on-one instruction in professionalism, communication and informed consent with an instructor selected by the College. This instruction is to be somewhat broader in scope and more tailored to the particular areas of Dr. Jugenburg's practice than the remediation which he has undertaken thus far. The instruction will solidify and expand on the gains he has made. The protection of the public will be enhanced as a result.

[60] Finally, we agree with the parties that this is a suitable case in which to order costs. We order Dr. Jugenburg to pay costs to the College, at the usual tariff rate, equivalent to three hearing days. This is a fair division of costs between the parties, at a hearing in which the College was mostly, but not entirely, successful in proving its case.

Order

[61] The Discipline Committee orders and directs:

1. Dr. Jugenburg is to attend before the panel to be reprimanded.

2. The Registrar is to suspend Dr. Jugenburg's certificate of registration for a period of six months, commencing 30 days after the date of this order.

3. The Registrar is to place the following term, condition and limitation on Dr. Jugenburg's certificate of registration effective immediately:

    a. Dr. Jugenburg shall successfully complete one-on-one instruction in professionalism, communication, and informed consent with an instructor selected by the College within 60 days of the date of this order.

4. Dr. Jugenburg is to pay costs to the College of $31,110 within 30 days of the date of this order.