NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Hung-Tat Lo, this is notice that the Discipline Committee ordered that there shall be a ban on the publication of the name or identity and any information that could disclose the name or identity of any patients whose name or identities are referred to at the hearing or in any documents 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.

Indexed as: Lo, H. (Re)

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

IN THE MATTER OF a Hearing directed
by the Complaints Committee and the Executive Committee
of the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) and Section 36(1) 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. HUNG-TAT LO

PANEL MEMBERS:

S. DAVIS (CHAIR)
DR. M. DAVIE
DR. P. CHART
DR. J. WATTS

Hearing Dates: **2010:** January 14 (motion), February 1-5, February 9-11, April 22-23, June 14-17, and September 27-30; **2011:** February 7-8.
Decision Date: January 13, 2012
Release of Written Reasons: January 13, 2012

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto, in 2010 on January 14 (motion), February 1-5, February 9-11, April 22-23, June 14-17, and September 27-30; and in 2011 on February 7-8. At the conclusion of the hearing, the Committee reserved its decision on finding.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Lo committed an act of professional misconduct:

1. under paragraph 27.21 of Ontario Regulation 448/80 and paragraph 29.22 of Ontario Regulation 548/90 made under the *Health Disciplines Act*, R.S.O. 1980 and paragraph 1(1)3 of Ontario Regulation 856/93 made under the *Medicine Act,* 1991, in that he failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Lo is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is schedule 2 to the *Regulated Health Professions Act*, 1991, subsection 60(4) of the *Health Disciplines Act*, R.S.O. 1980, c.196, and subsection 61(4), *Health Disciplines Act,* R.S.O. 1990 c. H.4 in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

RESPONSE TO ALLEGATIONS

Dr. Lo denied the allegations in the Notice of Hearing. Counsel for the College withdrew the allegation of incompetence on February 8, 2011, at the conclusion of the hearing.

OVERVIEW OF THE ISSUES

In February of 2006, Patient A tragically murdered his common law wife and two children. The allegation of professional misconduct in this case arises from the alleged care and treatment provided by Dr. Lo to Patient A between 1988 and 2006, specifically focusing on his care and treatment at three appointments: two in September of 2005 and one in January of 2006.

Following the tragic events of February 2006, and as a result of concerns surrounding Dr. Lo's care of Patient A, the College initiated a broader investigation under s.75 of the Code. Review of fifteen of Dr. Lo's patients' charts led to allegations of failure to maintain the standard of practice in record keeping and of a failure to maintain the standard of practice in Dr. Lo's assessment, diagnosis and/or treatment of patients. In her closing submissions, counsel for the College informed the Committee that with respect to the s.75 allegations, she was seeking a finding that Dr. Lo had failed to maintain the standard of practice with respect to record keeping in fourteen of the cases and that he had failed to maintain the standard of practice with respect to patient care in nine of the cases.

Consequently, the Committee considered the following issues:

i) Did Dr. Lo fail to maintain the standard of practice in his care and treatment of and record keeping for Patient A?;

ii) Did Dr. Lo fail to maintain the standard of practice in his care and treatment of nine of the fifteen patients identified in the s.75 investigation?; and

iii) Did Dr. Lo fail to maintain the standard of practice in his record keeping for fourteen of the fifteen patients identified in the s.75 investigation?

APPLICABLE LEGISLATION, LEGAL PRINCIPLES AND DEFINITIONS

Burden and Standard of Proof

The College has the burden of proving an allegation of professional misconduct against a member. The standard of proof to be met is on a balance of probabilities, based on clear, convincing and cogent evidence.

Failure to Maintain the Standard of Practice

A failure to maintain the standard of practice of the profession is an act of professional misconduct under paragraph 1(1)2 of O. Reg. 856/93. The standard of practice has been defined as the standard which is reasonably expected of the ordinary, competent practitioner in the member's field of practice. It is not necessary to find that there has been harm in order to find that there has been a failure to maintain the standard of practice.

The duty of the Committee is to review all of the evidence and the arguments of both parties and to determine what the standard is and whether it was maintained.

THE CASE OF PATIENT A

(i) Did Dr. Lo fail to maintain the standard of practice in his record keeping for and care and treatment of Patient A?

a) Facts and Evidence

With respect to the allegations regarding the care of Patient A, the College called Patient A's sister, Ms X, and his brother, Mr. Y. The College also called Dr. R to provide expert opinion evidence on the standard of practice. Dr. Lo also testified regarding his care and treatment of Patient A from 1988 to January 2006. Dr. Lo also called the expert evidence of Dr. Z regarding the standard of practice and Dr. Lo's care and treatment of Patient A.

Ms X

Background

Ms X is Patient A's older sister. Her family came to Canada from Asia in the 1980's. She testified that her brother, Patient A, and a sister have had schizophrenia for many years. Ms X had become a significant caretaker for them both as she can drive and has a car. She was able to help them attend medical appointments and do errands and shopping.

Ms X testified that Patient A first started having psychiatric problems about 20 years ago. She testified that she first took her brother to see Dr. Lo around that time.

Ms X testified that her brother and Ms W (Patient A's common law partner) had been together for four years before the tragedy. They lived together in a basement apartment with their two children. A child from Ms W's first marriage also resided with them until October of 2005.

Summer/Fall of 2005

Ms X testified as to her observation of Patient A's behaviour during the summer and fall of 2005. She described bizarre behaviours such as boiling water to chase away the devil, destroying the family shrine on two occasions, moving the children's belongings out onto the street several times, and telling Ms X that the new baby boy was the devil. Ms X testified that her brother's behaviour was accompanied by loss of appetite, weight loss and insomnia.

She testified that Patient A was particularly stressed by the birth of his son. Ms X helped with the care of the infant and Patient A's daughter. She testified that she visited Patient A's family every one to two days because her family was worried about Patient A's behaviour.

Ms X testified that she was very concerned about her brother and his family. She became very concerned about her brother's health, as he had been displaying bizarre behaviours.

She advised Ms W that if anything should happen, she should call 911 or just take the two children and leave the house.

Although Ms X sometimes drove Patient A to medical appointments, she did not accompany Patient A on his appointments with Dr. Lo in September of 2005.

January 2006

Ms X testified that in the first week of January of 2006, she had a telephone conversation with Ms W. She could not recall who had called whom, but as a result of the call she attended at her brother's residence.

The Committee heard submissions regarding the admissibility of statements Ms W made to Ms X on the phone on that day in January of 2006, and later that day when Ms X attended at Patient A's home and spoke with Ms W regarding Patient A's behaviour. After hearing submissions from counsel and advice from our independent legal counsel, the Committee applied a principled approach to determine if this hearsay evidence should be admitted. Given the deceased (Ms W) is unavailable to give the evidence, the Committee found that the test of necessity had been met. The Committee, however, did not find that the statements by Ms W were inherently reliable. The truth and accuracy of the statements could not be tested by other means. Patient A was not called to testify. The Committee ruled the evidence was not admissible for the proof of the truth of its contents but agreed to hear the evidence as part of the narrative.

Ms X testified that when she arrived at her brother's home, Ms W told her that Patient A had locked his family in a room without food or water for 24 hours and that he kept boiling water on the stove. Ms X testified that when she asked Patient A why, Patient A told his sister it was to chase away the devil. Ms X let Ms W and the children out of the locked room. Ms X then called Dr. Lo's office to make an urgent appointment for her brother. She was told by Dr. Lo's office that they would try and fit him in that day but they were not sure they could. Later that day, when she couldn't wait any longer, Ms X

took Patient A in the car to Dr. Lo's office, calling on the way to tell them they were coming.

Ms X testified that when she saw Dr. Lo she was very nervous and very upset and asked for a letter to have Patient A admitted to the hospital. She states that she told Dr. Lo of Patient A's recent bizarre behaviours. She testified that she informed Dr. Lo that: (1) Patient A had locked his family in a room; (2) he had twice destroyed the family shrine; (3) he had thrown away all the baby's clothing; (4) he had boiled water for 24 hours straight without sleep; and (5) that Ms W had told her that he had had two needles in one week. She testified she told Dr. Lo she had a concern about the children and their ability to protect themselves. She says that she urgently asked for a "hospital letter", but Dr. Lo refused to provide one.

She stated that Dr. Lo did not listen to her and raised his hand signalling her to stop talking. She testified that she was very angry and disappointed by this response and left the appointment to wait in the car. On cross-examination, she agreed that Dr. Lo only told her to stop after she was repeating her story for the third time.

Ms X testified that she did ask Dr. Lo if there was any better medicine for her brother, but she denied asking for the specific medicine that Dr. Lo had prescribed for her sister who had been doing well.

When Ms X left, she went down to the car to wait and Patient A stayed with Dr. Lo. She testified that her brother came down very quickly after she left, after he dropped off a prescription at the pharmacy. She did not know if the prescription had been filled.

Ms X did not take Patient A to the hospital on her own, but took him back to his house. She stated she did not take him to the hospital because he was very angry at her and just wanted to go home.

After this appointment in January 2006, Ms X continued to visit her brother daily and worried more and more that something was going to happen.

Ms X testified that she blames herself for the tragedy as she felt something was going to happen. She had been secretly removing sharp objects and knives from Patient A's home over the preceding weeks. She also blames Dr. Lo for not admitting Patient A to hospital on the day of the January 2006 appointment. The Committee found Ms X to be sincere in her testimony and extremely distraught by the events of the summer and fall of 2005, leading up to the tragedy in February 2006.

Mr. Y

Mr. Y is Patient A's older brother. He testified that he too has been a patient of Dr. Lo. Mr. Y testified that during the fall of 2005 he was seeing his brother, as usual, several times a week. He testified that he noticed that Patient A was acting weird, talking to himself. He testified that, over the years, Patient A's behaviour would change when it was getting close to the time for his monthly injection from his family doctor. He testified that, after the injection, he would notice an "emotional smoothness" to Patient A.

Mr. Y did not attend the appointment in January 2006, or any other appointments of Patient A's with Dr. Lo.

The Committee found that while Mr. Y, through an interpreter, was an earnest and credible witness, his testimony was of little assistance to the Committee since he did not attend the appointments with Dr. Lo.

Dr. Hung-Tat Lo

Background and Practice

Dr. Hung-Tat Lo is a 63-year-old community based psychiatrist who has been practising in Toronto since receiving his fellowship in psychiatry from the Royal College of Physicians and Surgeons of Canada (RCPSC) in 1977. He has been affiliated with several

Toronto hospitals over his thirty plus years of practice and now maintains associate staff status at Mt. Sinai Hospital. His primary practice is out of an office in Scarborough. Seventy to eighty percent of his patients are of Chinese origin.

Dr. Lo also does consultation work for the Hong Fook Mental Health Association, Across Boundaries Interracial Mental Health Centre and York Support Services Network. Dr. Lo was involved in the start up of Hong Fook Mental Health Association for Chinese people, a case management charitable organization, in 1982, at which time the Chinese community was small but needed assistance with unique problems. He testified that with the arrival of the "Vietnamese Boat People" more services were needed. The organization received funding from the Ministry of Health and Long Term Care (MOHLTC) and has continued to receive this funding for the last twenty-eight years.

Dr. Lo is an assistant professor at the University of Toronto in the department of psychiatry. He has become an expert in the new field of cultural psychiatry; consulting, teaching and writing on the subject regularly, as outlined in his lengthy curriculum vitae. Dr. Lo admits his record keeping is not perfect. He approached record-keeping as an aid to his memory. After completing the CPSO record keeping course on June 6, 2008, however, he testified that he now knows the chart must tell the story of the patient. He tried electronic medical records in 2003, but had multiple technical problems and abandoned it in 2006. He has recently, at the end of 2009, started with another electronic record computer program. This program has useful assessment templates, including mental status exam and DSM IV diagnosis and treatment plans. Dr. Lo has also been practising with a practice monitor, Dr. M, since May 2008, as per a s.75 investigation undertaking with the College. Every two weeks, he and Dr. M meet to review fifteen patient charts.

Dr. Lo testified that the mental status examination is an integral part of any psychiatric encounter. It includes appearance, speech patterns, thought content and affect. He noted it is not a discrete activity but rather occurs over the whole session. The psychiatrist observes the patient's appearance and how they talk, and the content of thought comes

out in conversation. Dr. Lo testified that one can't just ask a psychotic person if they are suicidal; it has to be presented to the patient at an opportune time.

Dr. Lo acknowledged that not making a reference in his records to a mental status examination is a deficiency, but stressed that this does not mean that he does not assess the patient. He also testified that discussions with patients about medications and side effects are mostly not recorded in his charts.

Dr. Lo's risk of violence assessments are similarly done throughout a psychiatric encounter in his practice. Dr. Lo told the Committee of a mnemonic he uses to help remind him of all the areas that must be explored when evaluating a patient's risk; B (background), C (current situation), M (mental status), E (environment), S (spirituality). Dr. Lo also outlined for the Committee, using this same acronym, how he assesses a patient during a psychiatric encounter for suicidal risk. He then methodically relayed to the Committee his approach when he identifies these risks in patients. Dr. Lo commented that the only tool psychiatrists have is themselves and their rapport with the patient, and that they may be a lifeline for the suicidal patient.

He also addressed his lack of diagnosis in charts. He testified that he agreed it was helpful to have a diagnosis for OHIP billing and for inter-professional communication. However, he believed that the very use of the multi-axial DSM IV psychiatric diagnosis tool underscores the complexity of psychiatric diagnoses. He would argue that a cultural axis is needed in the multi-axial diagnoses. In his view, with complex patients a clear cut diagnosis is not always possible. The experts shared this view.

Dr. Lo testified about his new policies regarding missed appointments and no shows. He is much more active in having his secretary or himself follow-up if a patient misses an appointment or fails to make an appointment on the way out following a session.

Patient A

Dr. Lo testified that he first saw Patient A in January 1988. Patient A's mother called to make the appointment with Dr. Lo, who had been treating Patient A's older schizophrenic sister for approximately three years. His mother reported to Dr. Lo bizarre behaviour of throwing away clothes, sitting for long periods of time and not sleeping. Dr. Lo assessed Patient A. He did not make a diagnosis, but asked to see him back in three weeks time. At the second appointment, with more information, Dr. Lo was able to make a diagnosis of schizophrenia, as Patient A exhibited paranoia at that visit. Dr. Lo gave Patient A a long acting injectable antipsychotic medication and an oral medication to help with sleep.

Patient A went to see Dr. P, a family doctor, for the monthly injections on two occasions, but then returned to Dr. Lo. Dr. Lo sent a letter to Dr. P indicating he would continue Patient A's care and he saw Patient A regularly until 1994. By 1994, Patient A was stabilized and care was transferred to a Dr. S (a family doctor) while maintaining a 'door ajar' policy that Patient A could return to see Dr. Lo at any time. Patient A did return sixteen months later when he was having symptoms, and Dr. Lo altered his medication, wrote a note to Dr. S and returned Patient A to his care.

In 1997, Patient A came to see Dr. Lo after having missed an injection. Dr. Lo gave him an injection. On follow-up, the patient informed him he had a new family doctor, Dr. K. Dr. Lo testified that he and Dr. K have had shared office space for thirteen years. They have separate charts and separate secretaries. Dr. Lo testified that he did not see Patient A for another three years until the year 2000. At that time, Patient A complained of being troubled and suspicious, and informed Dr. Lo he had been drinking alcohol for two weeks. Dr. Lo gave him an oral medication to help him. Dr. Lo testified that it was sloppy not to have written a note to Dr. K, but that he trusted the patient to tell his family doctor. Dr. Lo also testified that this visit was billed in error to OHIP as a consultation.

Between 2000 and the first appointment in September of 2005, Patient A did not visit Dr. Lo. On that first September 2005 appointment, Patient A came to see Dr. Lo to discuss family issues. He reported to Dr. Lo that there had been an allegation by his daughter that

her older half-brother had touched her, and CAS was involved. Dr. Lo testified that those were the only details he was told regarding the allegation. Patient A did inform Dr. Lo that his common law wife, money and a new baby were sources of stress for him, but he did not reveal that he had struck his stepson or that he believed the new baby was from the devil. Dr. Lo admits that failing to chart the medication he prescribed at that visit was sloppy record keeping. He did chart "F/U Dr. K monthly IMI."

Patient A returned to see Dr. Lo in ten days, the second September 2005 appointment. He reported feeling more settled and stated that his stepson had gone to live with his maternal grandmother. Dr. Lo testified that he felt things were resolved and told Patient A to follow up with Dr. K.

The next visit was in the first week of January 2006. Dr. Lo testified that he had an independent memory of this visit. Patient A came with his sister, Ms X, who was the first to speak. Dr. Lo testified that Ms X asked for Patient A's medication to be changed to the medication her sister was on because it was working well for her. She also said that Patient A was not doing well. Dr. Lo recollects her stating that sleeping was the problem. Dr. Lo testified that Ms X indicated concern for the children, but only because Patient A needed to care for them, not that they were in danger. Dr. Lo testified that he agreed to change Patient A's medication but that this did not seem to satisfy Ms X. Dr. Lo testified that she seemed to be in a hurry and left the office.

Dr. Lo then spoke with Patient A alone. He asked about hallucinations and paranoia and assessed Patient A's mental status. Dr. Lo's plan had been to add Zyprexa, an oral anti-psychotic, and eventually take Patient A off the monthly injections. Dr. Lo did make a short contemporaneous note in Patient A's chart outlining these facts. Patient A was asked to come back. Dr. Lo believed he would come back, as he had done so in the past. No follow up appointment was noted in the chart and Dr. Lo testified that this was "a deficiency" (Vol. 9, p. 163). He stated that his usual practice is to tell patients to make an appointment with his secretary outside.

Dr. Lo specifically denied being told that Patient A was boiling water 24 hours at a time to chase away the devil, throwing away the baby's belongings, cutting the children's toys to pieces, that he was afraid of the children's crying, that he smashed the family shrine on two occasions, that he had stopped feeding the children or that he had locked his wife and children in a room. Dr. Lo testified that, if he had been told of any of these behaviours, he would have encouraged Patient A to go to the hospital, and if he had wanted to go home he would have tried to keep him in the office and call the police.

Dr. Lo also testified that had Ms X told him of these behaviours at the January 2006, appointment, he would have no reason not to believe her, as he knew her to be active in the care of her siblings over the years and very responsible.

College counsel sought to cross-examine Dr. Lo using transcripts of evidence Dr. Lo had given as a compelled witness at the criminal trial of Patient A. The Committee heard submissions from both parties, including extensive case law and advice from independent legal counsel in a *voir dire* as to whether that evidence should be admitted. The judge in the criminal trial explicitly granted Dr. Lo protection under the *Canada Evidence Act* during his testimony. On the second day of Dr. Lo's testimony during the criminal trial of Patient A, the trial judge stated as follows:

> "Retroactively to yesterday, I will grant you protection under the *Canada Evidence Act*. I believe you also have the protection of a section of the *Charter of Rights and Freedom* [sic], and that will be retroactive to the events of your testimony, which means that nothing you said yesterday or today can be used against you in any criminal or civil proceeding. You realize, of course, that you're not protected if you commit perjury."

The judge then continued:

> "So, you testify without any worries whatsoever about your testimony being used against you in the future. Good. All right, sir."

The Committee heard submissions regarding protection under s.5 of the *Canada Evidence Act*, s. 9 of the *Ontario Evidence Act* and s. 13 of the *Charter of Rights and Freedoms*. Dr. Lo had been compelled to testify at the criminal trial and was not represented by counsel.

Section 9(1) of the *Ontario Evidence Act* compels a witness to answer questions, which may tend to incriminate the witness or may tend to establish his or her liability in a civil proceeding, such as a disciplinary proceeding. However, there are protections available in certain circumstances to ensure that witnesses come forward so that the trier of fact is able to get at the truth. Section 9(2) of the *Ontario Evidence Act* provides that if the witness objects to answer a question, and if but for this section he would be excused from answering, that answer shall not be used or receivable in evidence against him in any civil proceeding. The Committee agreed with the defence position that Dr. Lo could have been exposed to criminal charges and under common law could have refused to answer any questions on the care and treatment of Patient A if it were not for s.5 of the *Canada Evidence Act* and s.9 of the *Ontario Evidence Act*. Although Dr. Lo did not specifically invoke the protection of the *Ontario Evidence Act,* the judge clearly informed him that, "you testify without any worries whatsoever about your testimony being used against you in the future." It was for these reasons that the Committee ruled not to admit into evidence in this hearing excerpts of the transcripts of Dr. Lo's evidence at the criminal trial of Patient A.

The Committee found Dr. Lo to be direct in his answering of questions and a reliable, well-spoken witness. He was thoughtful in conveying his approach to patient care. When giving oral evidence, he admitted freely his shortcomings and areas where improvement is needed; specifically in charting the story of the patient and management plans. These areas are particularly important in cases such as Patient A's, where care has spanned over some twenty years. The Committee found Dr. Lo to be a truly caring, empathetic physician who has cared for a severely psychotic patient population that has been maintained in the community for over twenty years without need for institutionalization.

Dr. R

Dr. R graduated from the University of Toronto in 1966 and received his fellowship in psychiatry from the RCPSC in 1974. He is presently the Medical Director of the Mental Health and Justice Program at a Toronto hospital. He has had experience evaluating other psychiatrists during his tenure as Chief of Psychiatry at this hospital from 1996 to 2007, and in providing expert opinion on the standard of practice for the CPSO and the courts.

Dr. R was qualified, on consent of the parties, to provide expert opinion on general psychiatry, including schizophrenia.

Dr. R's first report is dated January 6, 2010. For that report, Dr. R reviewed several documents, including Patient A's patient chart and correspondence between the CPSO and Ms X. Dr. R's report of January 12, 2010, was prepared in response to the report of Dr. Z dated July 10, 2009, which was provided to Dr. R on January 8, 2010. On January 22, 2010, the College provided additional documents to Dr. R, consisting of documents from the CAS, OHIP, and a Pharmaplus patient profile dated May 2009. In response, Dr. R prepared a brief report dated January 25, 2010. Dr. R then provided a further Addendum Report on January 26, 2010.

Dr. R noted that Patient A suffered from chronic schizophrenia and was followed intermittently by Dr. Lo from January 1988 until his last visit in the first week of January 2006.

In his first report, dated January 6, 2010, Dr. R concluded that there were no significant irregularities regarding psychiatric care prior to January 2006. However, he found that Dr. Lo had failed to maintain the standard of practice in his record keeping for the medications prescribed in January 2006. Further, it was his opinion that if Ms X's story was true, Dr. Lo would have failed to maintain the standard of practice by failing to communicate this information to the family physician and arranging adequate follow-up.

After receiving and reviewing the OHIP records and pharmacy records, Dr. R amended his original report and concluded that Dr. Lo failed to maintain the standard of practice by failing to document prescriptions for Patient A written and filled on the day of his first September 2005 appointment, for Loxapine and Trazadone. As well, Dr. R opined that Dr. Lo did not maintain the standard of care applicable to consultations on a July 2005 appointment, and on the first September 2005 appointment, in that he failed to request a letter from the referring family physician, failed to document the consultation and failed to document communication back to the family physician.

Dr. R testified that the shared care model is not uncommon. According to Dr. R, Dr. Lo's 'door ajar' policy, in which a patient can return to see Dr. Lo on his or her own accord after care has been transferred back to the family physician, as occurred in Patient A's case in 1997, is not shared-care. Patient initiated visits by Patient A occurred on three occasions between 1997 and 2005, two of which were billed, the defence states in error, as consultations. This is in contrast to the 117 visits Patient A had with his family doctor, Dr. K, in that same time period. In a shared-care model, one would expect to see more communication between the treating physicians.

The chart entry for the visit to Dr. Lo in July 2000 indicated that Patient A had been having increasing hallucinations. Dr. Lo had managed this with a 30-day prescription of an oral antipsychotic to supplement the injectible medication. The chart shows his symptoms improved and the prescription was not refilled. It was suggested to Dr. R, and he agreed it was possible, that this might have been the strategy Dr. Lo was engaging in September 2005. However, this is not explained in the patient's chart.

Dr. R noted that Dr. Lo did not document on the January 2006 appointment why Ms X had requested a medication change, but noted that Dr. Lo appeared to be sufficiently concerned so as to make changes to the oral medications and provide prescriptions for Patient A. Dr. Lo's record keeping failed to provide a rationale for the additional medications prescribed. According to Dr. R, this fell below the standard of the profession. The Committee concluded that adding three new oral medications did indicate that Dr. Lo

had significant concerns. However, there was no documented follow up arranged. Additionally, Dr. R concluded that failing to collect or share important information with Patient A's family physician, who was responsible for the monthly injections of anti-psychotic medication, also fell below the standard of practice.

Dr. R testified that often schizophrenics will down play their symptoms and that families may exaggerate symptoms. He testified that it is important for the psychiatrist to assess all the information available to determine the level of risk. If a psychiatrist does not believe there is a risk of harm and chooses not to send a patient to hospital, close follow up is very important. The choice is individual; it is dependent on the patient's promise to take the medication, the history of that patient in similar situations, and the relationship the doctor has with the patient. Every psychiatrist has to live with a certain degree of risk.

The Committee found Dr. R to be a helpful witness with respect to establishing the standard of practice for outpatient psychiatry in Ontario.

Dr. Z

Dr. Z graduated from Queen's Medical school in 1971. He practised family medicine from 1972 to 1982 and then took a position with the Ministry of Health to start up a psychiatric patient advocate program. In 1986, he entered a psychiatry residency and received his fellowship in psychiatry from the RCPSC in 1990. He was the Chief of Psychiatry at a Toronto hospital from 1998 to 2009 and continues to practise there as a staff psychiatrist. Dr. Z was qualified as an expert in psychiatry.

Dr. Z concluded that between 1988 and 2005, Dr. Lo's care of Patient A clearly met the standard of care. He characterized Dr. Lo's treatment of Patient A as "almost like shared care, but not really." Dr. Lo met the patient from time to time, communicated with the family, had meaningful interventions and was available as needed.

With respect to Dr. Z's overall impression of the documentation, he indicated that some areas were excellent, but some were not. He indicated there was not a lot of reference to

diagnosis or mental status evaluations. There was more focus on the positive findings. He noted, however, that Dr. Lo refers to the fact that there has been a diagnosis or mental status examination. He indicated this was common in practice. Dr. Z found that the inadequate charting did not reflect adversely on Dr. Lo's care of his patients. Dr. Z's evidence with respect to charting will be discussed in greater detail below in the review of the s.75 cases.

Dr. Z agreed that if Ms X's evidence regarding the information conveyed to Dr. Lo on the January 2006 appointment is correct, then Dr. Lo did not maintain the standard of care. He should have considered a Form 1.

If Dr. Lo's note of the January 2006 visit is correct, Dr. Z's opinion is that Dr. Lo did maintain the standard of care. Dr. Z did not think that there was anything unusual about leaving the responsibility of booking a follow-up appointment with the patient and his family. The Committee found Dr. Z provided expert opinion in a fair, balanced and credible manner on the standard of psychiatric practice in the Province of Ontario, especially the provision of outpatient care and record keeping of the very complex cases in Dr. Lo's practice.

b) Findings

The Committee recognizes that Ms X and Dr. Lo had very different accounts of what was said during the January 2006 appointment. The experts agree that if Ms X's version of the events is correct, Dr. Lo failed to maintain the standard of practice with respect to his care of Patient A.

The Committee finds Ms X to be a very caring and concerned relative in a family that has clearly suffered an enormous tragedy. It was evident from her testimony that she was very distraught during that last appointment with Dr. Lo in January 2006. It is the Committee's view, however, that on that day in January 2006, she was unable to communicate effectively with Dr. Lo her concerns about her brother. Unfortunately, it is

not always easy for family members to fully understand and explain the nature of someone else's illness to that person's physician. Despite her present conviction that she informed Dr. Lo of the specific concerns she had regarding Patient A, the Committee accepted Dr. Lo's evidence with respect to what was conveyed to him by Ms X during the January 2006 visit. Although Ms X testified that she specifically told Dr. Lo five specific concerns, the Committee concludes that if she had done so, this would be reflected in Dr. Lo's charting and treatment. He noted medication changes and testified that he expected outpatient follow-up as had been his practice in the past. Dr. Lo had a very good understanding of the long term progression of Patient A's illness and a long-term relationship with him. Even in light of his generally poor charting, this particular encounter had detailed notes of negative symptoms – specifically no hallucinations and no paranoia. These contemporaneous notes are inconsistent with Ms X's evidence of what she told Dr. Lo. The Committee placed significant weight on these notes. The Committee does not believe that Ms X has intentionally tried to mislead this Committee. We accept that she sincerely believes she informed Dr. Lo of her concerns, but in our view Ms X's ability to accurately recollect the events of the January 2006 appointment has been impacted by the enormity of this tragedy.

To be clear, the Committee is not placing any blame on Ms X for this tragedy. Information conveyed by the family is only one part of what a physician must take into consideration. The doctor is also responsible for examining the individual and formulating his own diagnosis and management plan. In this case, Dr. Lo assessed Patient A independently (spending time with Patient A after Ms X left), made changes to his medication and expected Patient A to follow-up with him. It would appear that at this time, it simply was not possible to predict what would occur in February 2006. The evidence does not support a conclusion that Dr. Lo ignored an overtly psychotic patient or ignored collateral family information at the January 2006 appointment. Dr. Lo's interpretation of Ms X's information, in conjunction with his assessment of Patient A on the January 2006 appointment, was not conclusive that Patient A was at risk of harming himself or others to warrant immediate action such as hospitalization. However, Dr. Lo

did choose to alter Patient A's medications and expected him to return as he had in the past.

The Committee acknowledges that within the standard of care applicable to the practice of out-patient psychiatry there is a broad variability. Dr. Lo's "door ajar" style of practice led to holes in his collateral information gathering. He did not know information in the possession of the family doctor, such as the extent of the CAS investigation, the history of violence towards family members, or the bizarre behaviours Patient A was exhibiting that fall. If there had been better communication between Dr. Lo and Dr. K, this information would have been known to Dr. Lo. As pointed out in the testimony of Dr. R, psychiatrists live with a degree of risk dependent on the relationship they have with the patient, but there should have been better collateral fact gathering and closer follow up should have been arranged following the January 2006 appointment. Furthermore, in the Committee's view, there should have been some doctor initiated follow-up following the prescription of a new drug.

Consequently, the Committee finds that Dr. Lo failed to maintain the standard of practice in the care and treatment of Patient A with respect to his collateral fact gathering and follow-up.

The Committee also finds that Dr. Lo failed to maintain the standard of practice with respect to record keeping in the case of Patient A. Dr. Lo's patient record for Patient A is largely illegible, and most entries contain scant information. Changes to medications were made at the last three appointments without documented communication with Patient A's family doctor, who was managing the patient's medications on a more consistent basis. Instead, Dr. Lo relied on the patient to convey important medication changes to his family doctor. There is no evidence, in the Committee's opinion, that risk assessments were not performed during patient encounters with Patient A, but the assessments and their conclusions were not documented. This should have been done.

SECTION 75 CASES

(i) Did Dr. Lo fail to maintain the standard of practice in his care and treatment of nine of the fifteen patients identified in the s.75 investigation? - and -

(ii) Did Dr. Lo fail to maintain the standard of practice in his record keeping in fourteen of the fifteen patient charts identified in the s.75 investigation?

Evidence and Findings

Fifteen patient charts were reviewed in the investigation into Dr. Lo's practice. The College alleges that Dr. Lo failed to maintain the standard of care in his treatment in nine of the fifteen cases, and failed to maintain the standard of care in his record keeping in fourteen of the fifteen cases. The College relied on the testimony of Dr. Q. Dr. Lo testified with respect to each of the patients and called Dr. Z to address these issues.

Dr. Q

The College relied upon the expert evidence of Dr. Q. Dr. Q is a community psychiatrist who received his fellowship in psychiatry from the RCPSC in 1985. He practises in Stittsville, Ontario and is an assistant professor at the University of Ottawa. He is involved part-time in Outreach with Kirkland and District in Northern Ontario and has been an assessor for the College since 2003. Dr. Q was accepted by the Committee to be an expert in general psychiatry.

Dr. Q reviewed fifteen of Dr. Lo's patient charts, two reports from Dr. G (the original expert retained by the College who was excused due to a conflict of interest which arose after preparing two reports), as well as Guidelines for the Assessors Reports, and correspondence with College investigator, Ms E. In addition, Dr. Q met with Dr. Lo and Ms E to have specific questions answered by Dr. Lo regarding five patients.

Dr. Q had broad generalized criticisms of all but one of Dr. Lo's charts. He found the charts to be illegible and required transcriptions in order to make his report. He commented that the charts lacked detailed initial histories and assessments. Dr. Q was

critical of the scantiness of the entries and abbreviations used for medications; often prescriptions were not clear, nor side effects monitored. As will be discussed in greater detail below, he concluded in many cases that Dr. Lo failed to maintain the standard of practice in his record keeping.

The Committee, in assessing Dr. Q's evidence, recognized he is experienced in clinical psychiatry but has a very different practice than Dr. Lo's urban, immigrant, culturally-sensitive practice. The Committee found Dr. Q's report contained errors and was not prepared very carefully. He was alarmist and scathing in his criticisms and his fixed views and rigidity decreased the reliability of his opinions in the Committee's view. He made mistakes in his report and was dismissive of the investigator's assistance, which could have aided him in producing a more accurate report.

Dr. Z

Dr. Z reviewed the fifteen charts, Dr. Q's report, and a list of documents pertaining to the case of Patient A, including the patient chart. He also met with Dr. Lo.

Dr. Z testified that the majority of the cases he reviewed were quite complex patients with psychotic illnesses and co-morbid mood and physical issues, with additional major issues which included medication side effects and psychosocial problems. Given his experience in overseeing the department of psychiatry and other psychiatrists' practices, he opined that Dr. Lo's practice was more complex than most. He stated that, in general, the intensity of symptoms and the emergence of new symptoms can happen at any time, especially if a patient comes on and off medications, and this is a major challenge in private practice.

Prior to being retained in this case, Dr. Z knew of Dr. Lo by reputation as a leader in the Asian community in delivering mental health care. He opined that language and culture are important and noted that the Asian family members tend to bring Dr. Lo's patients to see him, unlike Dr. Z's own practice experience of patients without support.

With respect to the standard of care applicable to risk assessments, Dr. Z testified that the obligation arises when there is a likelihood of bodily harm. A Form 1 is not always appropriate. Other options might be to change medications or bring the patient back more frequently.

Dr. Z testified that there is no formal standard for follow up for missed appointments. Psychiatrists tend to leave it up to patients. Generally, psychiatrists will either practise in an office alone with an answering machine or a receptionist, and families of long standing patients will know the usual practice to make an appointment on the way out.

Dr. Z testified that all medications have side effects, some very debilitating. With patient-centered care, like Dr. Lo's practice, the doctor-patient relationship is very important. The better the relationship, the better the information that is available to the psychiatrist, who in turn can deliver a better quality of care.

Dr. Z disagreed with many points made by Dr. Q. He did, however, share concerns about errors to which Dr. Lo admitted. Dr. Z also raised a number of additional concerns regarding Dr. Lo's patient care. Dr. Z gave opinion evidence on all fifteen patient charts.

The Committee found Dr. Z to be very helpful and balanced in his approach. His clinical experience in a multicultural urban setting was relevant to Dr. Lo's practice and he was better able to speak to the standard of practice. He did acknowledge knowing Dr. Lo's reputation, but was unbiased in his assessment of the shortcomings noted in Dr. Lo's practice through his chart review and interview with Dr. Lo.

Dr. M

Dr. M is both a psychiatrist and a lawyer. He is a psychiatrist with 49 years of clinical experience and maintains a small part-time practice while practising law. He agreed to monitor Dr. Lo's practice and has been doing so since April 2008. They meet twice a month and review fifteen charts that Dr. Lo gives to Dr. M at the end of their previous meeting.

Dr. M has reviewed some 621 cases of Dr. Lo's patients with 199 repeats. Dr. M testified that Dr. Lo's charts were deficient when he started monitoring him. The charts did not reflect the work Dr. Lo was doing because of these deficiencies. Early reports of Dr. M's recommended that Dr. Lo improve charting of patient encounters. He testified that Dr. Lo has implemented his suggestions and Dr. M has no concerns at present. Some of his recommendations included adopting the conventional "S.O.A.P." format for charting patient visits, i.e., subjective complaint, objective complaint, assessment and plan. Additionally, Dr. M has suggested that a cumulative patient profile be included in each patient chart, that Dr. Lo provide consultation reports to family physicians, that he contact hospitals and request discharge summaries for his patients after hospitalization, and that he adopt a re-call policy for no-shows.

The Committee found Dr. M to be a credible witness. He had the opportunity to review Dr. Lo's notes contemporaneously and had a true exposure to the charts of Dr. Lo's practice. The Committee found his testimony to be helpful.

(i) The Nine Section 75 Patients where Care and Treatment are at Issue

Patient #1

This Asian man with schizophrenia was seen by Dr. Lo from 1992 to 2007. He was brought to his first visit with Dr. Lo by his brother-in-law. After immigrating to Canada in the 1980's, he developed paranoia and could not work; voices at night and insomnia were his main complaints. He has had bizarre fixed delusions regarding electricity for the past twenty years. He lives with extended family and came to Dr. Lo already on medication, which Dr. Lo increased and added Restoril for sleep.

This patient has had fluctuating symptoms, particularly insomnia, over the years and a few episodes of vandalism of a neighbour's property. He has taken himself to the hospital on various occasions when he has been having increased paranoid symptoms. Dr. Lo testified that his level of risk before and after these incidents is low. Dr. Lo testified that he has a good working relationship with the patient and family.

Dr. Q testified that the chart entry for the initial visit was lacking background information, and there was little collateral information from the family. Although no mental status examination is noted in the chart, Dr. Q testified that Patient #1 seemed to be delusional and violent, as it was reported that he broke car and house windows.

Dr. Q criticized the scantiness of the record over the fourteen years of care, and the lack of notation regarding three hospitalizations over that time period. He did acknowledge that Dr. Lo was responsive to a crisis, and reassessed the patient closely and frequently, when he was brought by his mother to see Dr. Lo following an episode of vandalism of a neighbour's door.

Dr. Q did not interview Dr. Lo regarding this patient's chart. Dr. Q concluded Dr. Lo's care and treatment of Patient #1 was substandard.

Dr. Z clarified for the Committee that the definition of a violent person in the *Mental Health Act* pertains to violence against other persons only. It does not apply to property damage.

Dr. Z agreed that the documentation was "bare bones." He informed the Committee, however, that when in-laws bring a patient to see the psychiatrist, one knows the patient has a supportive family. Dr. Z testified that there were documentary concerns with this chart. An adequate history was not recorded, and no risk assessment was charted.

Overall, however, it was Dr. Z's opinion that Dr. Lo's care met the standard of practice. The Committee accepted Dr. Z's opinion.

This is a sick patient, and to be kept in the community speaks to Dr. Lo's management skills. Involvement with the patient and his family, talking to the mother at that first visit, changing his medications and having him return for follow up, quickly and often, show Dr. Lo did have a management plan. The Committee accepts Dr. Lo's testimony that he did do a risk assessment on this patient, but it was not documented. The Committee is

mindful of the fact that the history of violence referred to by Dr. Q, and the episodes while in Dr. Lo's care, were vandalism against property, which is not encompassed in the *Mental Health Act*. The Committee is persuaded by Dr. Lo's testimony that he had a good understanding of the problems this patient expressed in his acting out behaviours, and he was not threatening to harm himself or others. The Committee heard no evidence regarding what tests were done or how often testing should be done to monitor metabolic side effects of antipsychotics. Therefore, the Committee finds the allegation that Dr. Lo failed to maintain the standard of practice in his care and treatment of this patient is not proved.

The lack of documentation in this case makes it problematic to follow patient care from just a chart review. Although the Committee accepts that Dr. Lo did do a risk assessment on this patient, it was not documented and it ought to have been. With respect to monitoring of extrapyramidal signs (EPS), the Committee finds that Dr. Lo was aware of it, but again failed to document adequately. The Committee finds that Dr. Lo failed to maintain the standard of practice with regard to record keeping for this patient.

Patient #2

This woman has been a patient of Dr. Lo's for twenty-four years and suffers from chronic schizophrenia and depression. Dr. Lo was the inpatient psychiatrist at a Toronto hospital in 1983 when, in a psychotic state, this woman attacked her mother with a cleaver and was referred by the Metropolitan Toronto Forensic Service (METFORS) to the hospital inpatient service. She was in hospital for one month under Dr. Lo's care. She has schizophrenia with occasional paranoia. She had another hospitalization in 1985 requiring electroconvulsive shock therapy (ECT) for depression. She has been managed in the community since, and her problems have mostly been side effects of her medications.

Dr. Lo was taken through the patient chart and was able to fill in the story around his brief notes. This woman is still his patient and he mentioned she has recently been in a bad state and went to a hospital ER two days before his testimony.

Dr. Lo prescribed Lithium for the patient's depression. Dr. Q criticized the Lithium dosing and the lack of ongoing monitoring of the Lithium blood level. Dr. Lo admitted, under cross examination, that it is important to follow Lithium levels to ensure therapeutic range, especially in a patient with hypothyroidism, and that such monitoring was overlooked in this patient. He only checked the level once and was not aware she had had thyroid carcinoma and was on thyroxin, a thyroid hormone replacement.

Dr. Q testified that the patient showed hypersensitivity and side effects to the various medications Dr. Lo prescribed, and had a tendency to be noncompliant. Dr. Lo testified that this patient, if allowed to collaborate in the decision process regarding her medications, is compliant.

Dr. Q criticized the use of low doses of antipsychotic medication, poor charting of medications due to use of abbreviations, and the lack of side effect monitoring, especially of akathasia, a well known extrapyramidal side effect of the first generation antipsychotics that this patient was on.

With respect to criticism by Dr. Q regarding medication dosage, Dr. Lo testified that his approach to medication, especially in the [type of Asian ethnicity] patients who tend to be sensitive to side effects, is to "start low, go slow." Dr. Lo also explained that this patient had some increasing difficulty walking in 1996 and Dr. Lo referred her to a neurologist, Dr. F. It was determined that her symptoms weren't drug induced but rather psychogenic.

This patient was very ill and had numerous hospitalizations. On one occasion, when the hospitalization was for an extended period of a few months, Dr. Q criticized Dr. Lo's charting for not having a discharge summary from the hospital in the chart. There was, in fact, a summary in the chart but Dr. Q did not see it when writing his report. He admitted during his testimony that he had missed it.

Dr. Q interviewed Dr. Lo regarding this patient's care. During that interview, he learned that Dr. Lo had been the treating psychiatrist during the hospitalizations. Despite learning

that Dr. Lo had been the treating hospital psychiatrist and being provided with explanations for the low dosage and physical side effects, Dr. Q maintained his criticisms regarding medication dosages, side effect and drug level monitoring, and charting.

Dr. Q concluded that the charting for this patient was below the standard of care. In addition, he concluded that the care and treatment of this patient was also below the standard of practice.

Dr. Z testified that this was a difficult patient who Dr. Lo followed for 264 visits from 1983 to 2007 for her schizophrenia with mood disorder and various somatic problems, including movement.

He agreed with Dr. Q that there were inadequacies in the documentation. One needed to look at visits before and after "to contextualize visits." It was not possible to get an understanding of the status of the patient by simply looking at individual appointment notes. Dr. Z disagreed that the care was substandard. Dr. Lo had early follow-up after hospital discharge and saw this patient frequently to keep her out of hospital.

Dr. Z testified that when Dr. Lo started this patient on Lithium, as a mood stabilizer at a low dose, monitoring of levels was not necessary unless there was a coexisting kidney disease. Dr. Z noted that 5-10% of patients will develop a thyroid disorder in the first six months and so he would expect a check of her TSH level at three or six months, but there is no evidence that Lithium is carcinogenic. Dr. Z did not conclude that the overall care was substandard, although he would have liked to have seen the Lithium levels checked and said the lack of awareness of the thyroid cancer and medications was a "problem". Dr. Q's opinion was that Dr. Lo failed to maintain the standard of practice in failing to monitor the patient's Lithium levels.

Both of the experts agreed this was an exceptionally difficult patient. Managing such a patient is a balancing act of medication dose to control symptoms and simultaneously

minimizing the risk of EPS. The Committee finds that Dr. Lo noticed EPS early and recorded a list from the start of treatment.

Dr. Lo did admit that he failed to adequately monitor the Lithium level for this patient. It is true it was a low dose, and it might be argued that it was not in the standard therapeutic range and so toxicity was not a concern. But Dr. Lo did increase the Lithium to a more standard dose and levels ought to have been checked at that point. Dr. Lo admitted that he was unaware that this patient had had thyroid carcinoma and was on hormone replacement for many years while he was treating her with Lithium. Dr. Lo testified in his defence that the patient did not tell him her history or her medications.

Based on the evidence presented on the standard of practice, the Committee accepted that when Lithium is used in therapeutic dosage it is necessary to monitor Lithium levels as there is a low margin of safety, and thyroid function needs to be checked as hypothyroidism may result. The Committee finds that Dr. Lo failed to maintain the standard of practice in his care and treatment of this patient as a result of failing to adequately monitor the Lithium levels and failing to make the necessary inquires that would have led to the disclosure of the patient's thyroid carcinoma.

With respect to risk assessments for this patient, the Committee concluded that there is inadequate documentation of risk assessments in this patient's chart over the course of her care, and finds that this is a failure to maintain the standard of practice with regard to record keeping.

Patient #3

This middle aged Asian man with a wife and two grown children suffered a head injury in a motor vehicle accident in 1993. He subsequently developed severe depression, which required prolonged hospital stay and ECT. He has remained in the home, but is very poorly functioning. Dr. Lo testified that an insurance company psychologist referred Patient #3 to him.

Patient #3 was very depressed and Dr. Lo testified that he did assess risk of suicide with this patient. In addition, he had a therapeutic alliance with the patient's wife, as well as regular communication with his psychologist, Dr. J.

Dr. Q was very critical of the care Patient #3 received from Dr. Lo. Dr. Q was critical of Dr. Lo's assessment of suicidal risk for this patient, as well as risk to his children. From his chart review, Dr. Q opined that Dr. Lo did not seem to be monitoring the concerns of the patient's psychologist, Dr. J, whose report was in the patient chart and referenced involvement of the CAS with the family. Dr. Q did not interview Dr. Lo regarding this patient's care.

Dr. Z commented that this patient was a very sick and very dysfunctional man with severe psychiatric problems and significant physical problems. Only electroconvulsive shock therapy was helpful for his depression.

Dr. Z noted that there were other professionals in addition to Dr. Lo involved with this man and his family: his psychologist, Dr. J, whom he saw weekly, and who saw his wife from time to time, as well as a counsellor for the children. He opined the care was adequate, but, again, the documentation was a concern.

This was a very complex long-term patient with significant disability, both physically and mentally. The Committee, on assessing the evidence regarding Dr. Lo's assessment of risk to others, accepts Dr. Lo's testimony that he was not aware of all of the concerns surrounding the children. Having a patient and his family monitored by the family physician, a psychologist and at times the CAS does not lessen Dr. Lo's primary responsibility for the psychiatric care of his patient. However, the experts agreed that there was a plan in place with respect to monitoring the risk of suicide with this patient, with the psychologist, the family doctor, the patient's wife and Dr. Lo all communicating together. The Committee finds the allegation that Dr. Lo failed to maintain the standard of practice with respect to the care and treatment of this patient is not proved.

The Committee concluded there should have been more documentation with regards to the assessment of risk to others and of all of the concerns surrounding the children. With respect to charting, the chart entries for this complex patient are, again, very scant and inadequate, and did not reflect Dr. Lo's awareness of all of this patient's issues, which he was able to share with the Committee during his testimony. The Committee finds that, in general, Dr. Lo failed to maintain the standard of practice of the profession in his record keeping for this patient.

Patient #4

Dr. Lo testified that this elderly woman was from [a city in Asia] and had been a patient of his mentor in [a city in Asia]. After she had been in Canada for about twenty years, she looked up Dr. Lo and he began treating her. She had many physical complaints, some real, some not, and he diagnosed her with anxiety and depression.

Dr. Lo testified he has a good, collaborative, and respectful relationship with this patient. Her major concerns and anxieties are about her skin. She did not like to take medication. Dr. Lo testified he used benzodiazepines with this patient and supportive psychotherapy.

This patient had many somatic symptoms and was seen by a number of specialists. Dr. Lo treated her with a number of antidepressants and anxiolytics.

A neurologist saw this patient and he prescribed amytriptyline. Dr. Lo testified that this medication is a nonspecific treatment for sleep, headaches, and depression and has a wide range of uses, but was not helping this patient and he discontinued it.

Dr. Q reviewed the chart and testified that there was no formal diagnosis and very scant initial assessment. Dr. Q, in his report, criticized Dr. Lo as being dismissive when he discontinued a medication prescribed by a consultant neurologist. He retracted this criticism during his cross-examination. Dr. Q did not interview Dr. Lo regarding this patient's care.

Dr. Z testified that this patient was a difficult case with a lot of physical health issues as well as anxiety and depression, and it was difficult to discern what was caused by the psychiatric illness. There was no clear-cut diagnosis and so no clear-cut treatment. The amytriptyline started by the neurologist in a low dose is often used but has side effects, the most common being constipation. Dr. Z testified that he didn't get the sense that Dr. Lo was dismissive, but agreed that not a lot was documented.

The Committee accepts that this patient was a difficult patient to manage for Dr. Lo. She suffered from anxiety, depression and hypochondraisis, with some real physical complaints and some not real physical complaints. Dr. Lo managed her symptoms with anxiolytics and supportive psychotherapy.

The Committee was persuaded by the evidence of Dr. Z and Dr. Lo that Dr. Lo's care and treatment of this patient maintained the standard of practice. The Committee, therefore, finds the allegation that Dr. Lo failed to maintain the standard of practice in his care and treatment of this patient is not proved.

The patient's chart, on review, lacked a clear diagnosis. Therefore, the Committee finds that Dr. Lo failed to maintain the standard of practice in his record keeping for this patient.

Patient #5

This middle aged woman with schizophrenia was referred to Dr. Lo in 1994, as her psychiatrist was moving. She had had two previous suicide attempts, one where she jumped in front of a TTC train.

She was on Orap and Triptal. Dr. Lo testified that it seemed to be a good combination for her. She developed some intractable obsessive fears of cockroaches which Dr. Lo and she worked on in psychotherapy. She was doing well until the manufacturer discontinued Triptal in 2001 and Orap was in shortage in 2007, during which times her symptoms

returned. She heard voices and was worried others were scolding her. Dr. Lo altered her medications.

Dr. Lo testified she was a challenging patient and side effects were a problem. He would have started anti-cholinergic medication to treat her side effects but she was stubborn and said no to medication. She tried acupuncture with some success, and he tried to change her to Zyprexa when it became available, however, she developed side effects as well.

Today, he is treating her with psychotherapy alone, as once Orap was available again she refused to restart it.

Dr. Q testified that his main concerns were around risk assessment and side effects from the antipsychotic medications, especially the oral symptoms of tardive dyskinesia, which, he concluded from his chart review, were not managed adequately.

On cross-examination, Dr. Q agreed that this patient came to Dr. Lo already on antipsychotic medications, and that numerous notes over the years of care indicate that the patient was reluctant to change medications. Medication doses were changed, and the side effects resolved and reappeared during her care and treatment under Dr. Lo. Dr. Q conceded in cross-examination that he was mistaken when he made reference in his report to a history of sexual molestation. Further, Dr. Q was firm in his opinion that Dr. Lo’s care and treatment of this patient fell below the standard of care, even though she was maintained in the community with no hospitalizations or further suicide attempts under Dr. Lo’s care.

Dr. Z testified that, in his opinion, this was a tough patient with depression and a psychotic illness with extrapyramidal signs and symptoms, but Dr. Lo managed these problems without hospitalization. He disagreed with Dr. Q about the Orap dosage. In his view, this was a complicated psychopharmacological situation. Dr. Lo had to be conservative with medication changes. Dr. Z testified that the care provided met the standard but there were documentation deficiencies, specifically lack of documentation of

risk assessment, no clear diagnosis documented, and deficient patient history. The Committee accepts Dr. Z's opinion.

This patient was managed successfully by Dr. Lo in the community for many years. The parties agreed this was a difficult patient to manage. She developed side effects from the antipsychotic medications but she refused to take medications for the tremor. Dr. Lo managed this by altering her medication doses and changing the medications she was on over the years. Additionally, she was supported by ongoing psychotherapy. With respect to the monitoring of the metabolic side effects of the antipsychotic medications, the Committee heard no evidence as to the frequency and specific testing that should be done in this regard and accepts the evidence of Dr. Z that, generally, psychiatrists rely on family doctors to do the monitoring. The Committee finds the allegation that Dr. Lo failed to maintain the standard of practice with respect to his care and treatment of this patient is not proved.

The Committee accepts there were, again, documentation problems in this patient's chart. We are persuaded by Dr. Lo's evidence that he was aware of the diagnosis but he had not written it in the chart. As well, although he did address risk assessment in this patient, he again did not document this. Dr. Lo's failure to document communication with this patient's family doctor is also an area of concern for the Committee. The Committee finds this lack of documentation is a failure to maintain the standard of practice of the profession with respect to record keeping.

Patient #6

This married Asian woman with agoraphobia and anxiety disorder was first seen by Dr. Lo in 1989 and continues to be a patient. Dr. Lo testified she had been under the care of a psychiatrist in [a city in Asia]. She did not have a psychosis but was treated with an antipsychotic medication. Dr. Lo testified that in the 1980's Pimozide (also known as Orap) was being used for hypochondriacal psychosis, and he thought it might help. Dr. Lo clarified that his note of "tongue trembling" was a complaint she had expressed and

was not observed by him. Dr. Lo testified that she continues today on medication and is doing better now.

Dr. Q testified that the charting was deficient in monitoring on extrapyramidal side effects. Additionally, with no clear diagnosis specified in the chart, Dr. Q opined the use of the antipsychotic, Orap, did not maintain the standard of care.

Dr. Q was critical of Dr. Lo ordering a urinalysis and the lab work not being in the chart. During his testimony, Dr. Q retracted this criticism as the lab work was, in fact, in the chart and he had missed it in his review. Dr. Q did not interview Dr. Lo about this patient.

Dr. Z testified that there is a long history of psychiatrists using low dose antipsychotics for the treatment of anxiety and somatization. He noted that the chart had a notation of "tongue tremor" in July 2001, and the medication was stopped later that year. Dr. Z testified that he was of the opinion that the care of this patient met the standard of practice.

This patient came to Dr. Lo with significant anxiety and agoraphobia and was tried on a variety of medications. The Committee accepted Dr. Lo's evidence that the medication he used, Pimozide, in low dose with this patient was known to be of benefit for patients with monosymptomatic hypochondriacal psychosis, and Patient #6 did seem to improve on the drug. Additionally, a low dose of the antipsychotic, Seroquel, was used, as is agreed by the experts, for sleep. The experts disagree with the general use of antipsychotic medication for nonpsychotic indications, but it is done. The Committee accepted the evidence of Dr. Z that this does not fall below the standard of care. The Committee also accepts Dr. Lo's evidence that the one reference in the chart to "tongue trembling" was a report by the patient and not a sign elicited by the doctor. Therefore, the Committee finds the allegation that Dr. Lo failed to maintain the standard of practice in the care and treatment of this patient is not proved.

Again, more explicit and complete charting by Dr. Lo could have better assisted the experts and the Committee in their review of Dr. Lo's care and treatment of this patient. The Committee finds that Dr. Lo failed to maintain the standard of practice with respect to his record keeping for this patient.

Patient #7

Dr. Lo testified that this nurse with bipolar disorder was referred to him by her family doctor, Dr. H. The patient was already on mood stabilizers. Dr. Lo changed her Lithium to Duralith, a slow release preparation, as they were tapering her off Lithium. Dr. Lo admitted his monitoring of this patient's Lithium levels was inadequate.

Dr. Lo testified there was a mental status exam on the first visit, as noted by 'MS' at the bottom of the page. He did not write negative findings in the chart. [He testified that his new EMR system does that now.] He sent a consultation form back to her family doctor stating he would follow her, and did not monitor the Lithium levels as they were tapering the dose. He did monitor the Valproic acid level. She came to him later stating she was married and wanted to have a baby. Dr. Lo met with her and her husband and had a discussion about the decision making process. He reported that he has not seen her in a few years. He called for an update recently and she has a five year old child and is doing well.

Given her medications, namely the mood stabilizer Valproic Acid, Dr. Q criticized Dr. Lo for not being more detailed in his charting around his discussions with the patient on the topic of having children, as Valproic Acid is a known teratogen. Dr. Q was also critical of Dr. Lo prescribing Lithium to this patient for a year, but only found one subtherapeutic Lithium level reported on the chart. Dr. Q did not ask Dr. Lo about this patient during his interview with him.

Dr. Z was of the opinion that Dr. Lo helped this patient to decrease her medication so she could have a safe pregnancy. He testified that he found it incredulous to suggest that Dr. Lo did not provide information to the patient and her husband. This was a "savvy patient"

who came with her history typewritten to her first appointment with Dr. Lo. Dr. Z testified that the Lithium monitoring was adequate. She came to Dr. Lo having been taking Lithium for two years. Blood levels are to look for toxicity. Further, since Dr. Lo was tapering the use of Lithium, Dr. Z did not think more monitoring was required. Overall, Dr. Z opined the care of this patient met the standard.

The Committee finds the Lithium doses were low and decreasing as the medication was being tapered, and following blood levels was unnecessary. The Committee accepts, given the evidence of the long introductory letter this patient brought to her first appointment, that Dr. Lo was aware of her concerns regarding long term medication use. This was a sophisticated patient. We accept Dr. Lo's evidence that she was well aware of the effect her medications might have on any pregnancy. Documentation in the patient's chart does indicate two appointments, one including her husband, with Dr. Lo to discuss pregnancy. Again, the charting does not completely outline all that was discussed, but the Committee finds, on the balance of probabilities, that the risks to the patient and her fetus were discussed with the patient and her husband. Therefore, the Committee finds the allegation of failing to maintain the standard of practice in the care and treatment of this patient is not proved.

The Committee does, however, find that Dr. Lo failed to maintain the standard of practice with respect to record keeping, as he should have been more detailed in his charting.

Patient #8

Dr. Lo testified he met Patient #8 as an inpatient at a Toronto hospital. The patient was admitted for alcohol detoxification. He came to Dr. Lo's office four days after discharge and then went for a month of residential rehabilitation. He was then followed by his family doctor but did come to see Dr. Lo two years later in 1990. The patient was then under Dr. Lo's care for three years, and then went back to the family doctor. He again returned in 1997 to see Dr. Lo.

Dr. Lo testified that he diagnosed anxiety as the main issue for Patient #8, and that Patient #8 had used alcohol from time to time to self medicate to address his anxiety and insomnia. The use of benzodiazepines in alcoholism is a partial contraindication and Dr. Lo knew he had to watch for excessive use of benzodiazepines. Dr. Lo testified that Patient #8 abided by his prescriptions for twenty years and, except for two occasions, they have had a good therapeutic relationship.

After nine years, Dr. Lo started Patient #8 back on antabuse, which he had used for a time after his residential rehabilitation, as he was having more stress at work. A note in the chart indicated Patient #8 was experimenting and tried to drink on antabuse. The patient reported nothing happened and so stopped the antabuse. Dr. Lo interpreted this as a plan to start drinking. In addition, he reported he couldn't sleep and went to a walk-in to get Ativan. Dr. Lo discussed this with the patient, increased the frequency of his visits and started him on an antidepressant. He continued for a year but had side effects from the antidepressants. Dr. Lo reported he had another "slip up" regarding alcohol use. He had medical problems and hip pain, and with the slip up went on and off antabuse. This was all revealed in the chart over a number of years with regular visits with Dr. Lo.

There was evidence that the patient was involved in a car accident. Dr. Lo testified that the car accident was in a period of sobriety. Dr. Lo felt he had a good therapeutic relationship with Patient #8 and believed this patient when he told him the car accident was not related to the use of alcohol. He continued to see Patient #8, who continued on antidepressants.

Dr. Lo acknowledged the first reference in the chart to Alcoholics Anonymous (AA) was in 2005. Dr. Lo admitted that he could have targeted Patient #8's alcohol addiction earlier in the treatment; his approach had been to address the anxiety. Dr. Lo admitted that he is not fully knowledgeable regarding alcohol addiction.

Patient #8 had a relapse of his drinking after three years of abstinence and Dr. Lo continued to prescribe the benzodiazepines, which Dr. Q opined was substandard care.

Dr. Q testified that this patient should have been referred to a self-help or drug and alcohol treatment program. Dr. Q questioned Dr. Lo during his interview about the use of antabuse and Dr. Lo acknowledged that antabuse given to a patient who continues to drink alcohol was potentially dangerous. Dr. Q testified that Dr. Lo lacked knowledge of the 12 step AA program and did not recognize this patient's double addiction to alcohol and benzodiazepines.

Dr. Z concluded that the ultimate outcome with this patient was reasonably good, but he would have liked to see the patient referred to an addiction specialist as Dr. Lo was treating on basic principles and not up to date management. He pointed out that success for treating alcohol addiction is not very high and is most likely to be successful when rehabilitation is patient driven.

Dr. Z opined that Dr. Lo should not have continued to prescribe antabuse to a patient who was admitting he was drinking actively, though it is acceptable if the alcohol intake is intermittent. He did not feel the prescription of benzodizepines was completely prohibited, but certainly a risk and below the standard of care.

Dr. Lo admitted that some aspects of the care and treatment of this alcoholic patient with significant anxiety fell below the standard of the profession. He acknowledged, and the Committee accepts, that Dr. Lo does not have the expertise to manage alcoholics adequately. Dr. Lo managed this difficult patient closely over the years but with outdated treatment. Dr. Lo renewed and continued prescription of antabuse in the face of evidence that the patient was taking alcohol more frequently and which suggested the prescription was not working. The Committee accepts the evidence of Dr. Lo that when this patient was involved in a motor vehicle accident there was no reason to suspect alcohol was involved, as this was during a period of sobriety for the patient. Dr. Lo also failed to refer the patient to a specialist or supplementary resources sooner. Dr. Z's evidence was that the judicious use of benzodiazepines in this patient for underlying anxiety did not fall below the standard, but management of the Restoril prescription for sleep and Xanax for anxiety was "less than optimal." In considering the above deficiencies, the Committee

finds that Dr. Lo failed to maintain the standard of practice in the care and treatment of this patient.

Dr. Lo had poor charting of the addiction therapy. Therefore, the Committee finds that Dr. Lo failed to maintain the standard of practice in his record keeping for this patient.

Patient #9

Dr. Lo testified that this single Asian lady started seeing him in 1986 and is still under his care. She suffers from somatoform disorder with depression and chronic insomnia. Dr. Lo reported a typographical error in the first visit notation where the chart says “suicidal”, yet should have had a “naught” (nothing) symbol in front of the word. She was not suicidal; she had thoughts from time to time. Dr. Lo started Patient #9 on the tricyclic antidepressant, Norpramine, and the benzodiazepine, Ativan. He planned to start psychotherapy and considered involving the family at the first visit.

This patient was particularly sensitive to somatic symptoms and she stopped her medications on her own often. Dr. Lo was mindful that he had to be respectful of her symptoms or she would either not take any medications or stop coming to see him. Over the years, twelve antidepressants were tried, and at present she is not on an antidepressant. She now is receiving only psychotherapy and taking a mild tranquilizer. Each of the medications was a very short trial since the side effects were unacceptable. With the monoamine oxidase inhibitor (MAOI), Nardil, Dr. Lo gave this patient his Chinese food handout sheet, which tells patients what food/medications to avoid when taking this medication.

After five years, in 1991, Tylenol #2 was added. Dr. Lo testified that Patient #9 asked him to renew a prescription she got from her family doctor for headaches, since the wait to see her doctor was very long. He prescribed only 50 pills, but she came back and he renewed it again. He continued to do so. She would only take one a day or sometimes none at all. Dr. Lo testified he told her to get it from her family doctor. There is only one reference to this in the chart, in March 2005, and this is the last time he prescribed it.

Recently, she told him she still has headaches and uses plain Tylenol. Since 2007, she has been on 4 mg of Ativan a day and supportive psychotherapy. Dr. Lo admitted he should have contacted the family doctor.

Dr. Q testified that prescribing Tylenol #2 for so many years fell below the standard of care. Dr. Q testified that the abbreviations and cryptic notes in the first chart entry indicated the patient was suicidal and this was of great concern. During his interview with Dr. Lo, Dr. Q was informed this was a typographical error and that Dr. Lo meant to write "NOT suicidal." During that interview, a College investigator was also present, and during cross-examination her notes were put to Dr. Q. It was clear that Dr. Lo had said that Patient #9 was not suicidal at the first meeting. However, Dr. Q did not change his report to reflect this after the interview.

Dr. Q testified that because the chart did not indicate that when Dr. Lo prescribed Nardil, a potent antidepressant with potentially toxic and life threatening side effects, the patient was informed about which particular foods and over the counter medications to avoid, Dr. Lo fell below the standard of care. This was inconsistent with Dr. Lo's evidence that he did provide the Chinese food list to the patient. The Committee accepted Dr. Lo's evidence that the Chinese food list was provided to this patient. Dr. Q did interview Dr. Lo regarding this patient.

Dr. Z testified that the risk assessment could have been better on the first visit, but in 1986 psychiatrists didn't document these kinds of things. He testified that the profession has become more aware over the last ten to fifteen years. Based on his review of the chart, Dr. Z concluded that Dr. Lo continued the antidepressants and made a follow-up appointment for the patient. Dr. Z opined that the chart entries do not look like a plan for a suicidal patient.

In addition, Dr. Z indicated that in the 1980's, Xanax, a benzodiazepine, was introduced and touted as an antidepressant as well as an anxiolytic, though this quickly fell into disfavour. Dr. Z opined that Dr. Lo worked in earnest to help this patient and tried to

steer her to non-pharmaceutical therapies such as acupuncture and physiotherapy, and this was very appropriate.

Dr. Z is of the opinion that the prolonged prescription of Tylenol #2 for this patient was problematic, but not below the standard of care when the entire care of the patient is taken into account.

The Committee accepts Dr. Lo's evidence that he made a charting error on the first encounter with this patient regarding her mental status examination and risk assessment, when he failed to put a shorthand symbol in front of the word "suicidal." The Committee also accepts Dr. Z's evidence that the noted treatment plan was not consistent with that which one would use for a suicidal patient, thus supporting Dr. Lo's evidence on this point. Dr. Lo has cared for this patient since 1986 for depression, insomnia, and somatic complaints of pain with somatoform disorder. She has been a very difficult patient for Dr. Lo, who has tried in earnest to find a medication that will successfully treat her symptoms. Many medications have been tried but discontinued quickly due to side effects. Dr. Lo has managed this patient on benzodiazepines and Tylenol #2, and eventually supportive psychotherapy alone.

Dr. Lo admitted that, when the patient asked him to renew her Tylenol #2 prescription because it was a long wait to see her family doctor, he "quite unwisely" did and continued to renew the medication for years. It is noted that Dr. Lo did make a note in 2004 that the patient needed to get her Tylenol #2 prescription from someone other than him and his last prescription for her was in March of 2005. The Committee is concerned that Tylenol #2 was prescribed for such a lengthy period of time, but recognizes that this was a very complicated case.

The Committee accepts the expert evidence of Dr. Z and Dr. Q, that the use of benzodiazepines alone for depression is not standard. It is clear, however, that while Patient #9 was on benzodiazepines, Dr. Lo was trying to steer this patient to non-pharmacologic therapies, such as acupuncture, Qi Gong, and herbal medicine. As noted,

Dr. Lo testified this patient is no longer on medication and is managed with supportive psychotherapy alone. The Committee finds the allegation that Dr. Lo failed to maintain the standard of practice in his care and treatment of this patient is not proved.

The Committee finds Dr. Lo's record-keeping for this patient-failed to maintain the standard of practice of the profession, in that he did not adequately document important details of her long-term care.

(ii) Additional Recordkeeping

The Committee finds that Dr. Lo's record keeping fell below the standard of practice in all nine of the cases discussed above. The Committee finds that Dr. Lo's record keeping also fell below the standard of practice in five additional cases: Patient #10, Patient #11, Patient #12, Patient #13, and Patient #14.

Of the fifteen charts reviewed, fourteen (including the nine discussed above) were largely illegible and transcriptions were required for review. There was a general scantiness to the patient encounter entries, with wide use of abbreviations and symbols which were confusing. Most charts did not have an initial history, diagnosis and treatment plan charted with any detail. There was a general lack of pertinent negative findings, and mental status exams and risk assessments were not documented. Medication prescriptions and changes were often noted in the margin with abbreviations, which led to confusion both on expert review and when Dr. Lo was reading his own charts.

Although there were significant differences between Dr. Q and Dr. Z regarding the adequacy of the clinical records (with Dr. Z's criticisms being more limited and, in the Committee's view, more balanced and reliable than those of Dr. Q), there was sufficient agreement in the evidence for the Committee to conclude that Dr. Lo failed to maintain the standard of practice with regard to his record keeping in fourteen of the fifteen s.75 cases.

SUMMARY OF FINDINGS

The Committee finds that Dr. Hung-Tat Lo committed an act of professional misconduct under paragraph 27.21 of Ontario Regulation 448/80 and paragraph 29.22 of Ontario Regulation 548/90 made under the *Health Disciplines Act*, R.S.O. 1980 and paragraph 1(1)3 of Ontario Regulation 856/93 made under the *Medicine Act,* 1991, in that he failed to maintain the standard of practice of the profession in his care and treatment of and record keeping for Patient A, in his record keeping with respect to fourteen of the fifteen s.75 cases, and in his care and treatment with respect to two of the fifteen s.75 cases, as described above.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest opportunity.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Hung-Tat Lo, this is notice that the Discipline Committee ordered that there shall be a ban on the publication of the name or identity and any information that could disclose the name or identity of any patients whose name or identities are referred to at the hearing or in any documents 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.

Indexed as: Lo, H. (Re)

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

IN THE MATTER OF a Hearing directed
by the Complaints Committee and the Executive Committee
of the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) and Section 36(1) 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. HUNG-TAT LO

PANEL MEMBERS:

S. DAVIS (CHAIR)
DR. M. DAVIE
DR. P. CHART
DR. J. WATTS

Penalty Hearing Date: October 25, 2012
Penalty Decision Date: February 7, 2013
Release of Written Reasons: February 7, 2013

PUBLICATION BAN

PENALTY AND REASONS FOR PENALTY

On January 13, 2012, the Discipline Committee found that Dr. Hung-Tat Lo committed an act of professional misconduct under paragraph 27.21 of Ontario Regulation 448/80 and paragraph 29.22 of Ontario Regulation 548/90 made under the *Health Disciplines Act* R.S.O. 1980, and Paragraph 1(1)3 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991, in that he failed to maintain the standard of practice of the profession (i) in his care and treatment of and record keeping for Patient A; (ii) in his record keeping with respect to fourteen other patients; (iii) and in his care and treatment with respect to two of the fourteen patients.

The Committee heard evidence and submissions on penalty and costs on October 25, 2012, and reserved its decision.

EVIDENCE AND ANALYSIS

<u>Overview of Findings</u>

(i) Record Keeping

The Committee found that Dr. Lo's record keeping was deficient due to its illegibility; scant content; lack of detailed history, diagnoses and treatment plans; and the frequent use of abbreviations in all but one chart examined in the section 75 investigation into his practice. In addition, Dr. Lo was found to have failed to maintain the standard of practice of the profession with respect to record keeping in the index case of Patient A. It was admitted into evidence, on consent, that Dr. Lo had been referred to the Quality Assurance Committee by the Complaints Committee of the College in July 2001 regarding his record keeping. Dr. Lo testified at the hearing that he had taken the College's record keeping course twice, once in 2008 and previously in 2002. As well, the Committee received into evidence a report from the Inquiries, Complaints and Reports Committee, from October 2010, regarding a caution issued to Dr. Lo following an independent review of a complaint. Review of that complaint revealed incomplete record keeping and limited collateral information gathering.

(ii) Patient Care and Treatment

The Committee found that Dr. Lo failed to maintain the standard of practice of the profession in his care and treatment of Patient A in two areas; firstly, with respect to his lack of follow-up when medication changes were made, specifically on the last visit when a new medication was prescribed but no follow-up appointment was made before the patient left Dr. Lo's office; and secondly, with respect to collateral information gathering from the patient's family and the patient's family physician.

Dr. Lo admitted to inadequate monitoring of serum Lithium levels in Patient #2 and to being unaware of her significant past medical history of thyroid cancer and her long-term medication of Thyroxine. Consequently, the Committee found that Dr. Lo failed to maintain the standard of practice of the profession in his care and treatment of Patient #2. Counsel for Dr. Lo entered into evidence at the penalty hearing a Lithium monitoring flow sheet, which Dr. Lo has implemented into his practice to avoid making the same mistakes in the future.

Finally, the Committee found that Dr. Lo failed to maintain the standard of practice of the profession in his care and treatment of Patient #8's comorbid alcoholism and prescription of antabuse and benzodiazipines. Dr. Lo admitted to not having managed this patient adequately. Dr. Lo testified that he will not treat alcoholism in the future and will refer such patients to other specialists for treatment of their alcoholism.

<u>Position of the College</u>

College counsel submitted that these failures to maintain the standard of practice were severe. The College submitted a proposed penalty consisting of:

1. six months preceptorship of Dr. Lo's practice, specifically in the areas of psychosis, alcohol addiction, Lithium monitoring and shared-care;
2. re-assessment following the preceptorship, with Dr. Lo abiding by whatever recommendations the re-assessment sets out;
3. a public reprimand; and

4. costs for 13 of the 20 hearing days at the tariff rate of $3,650.00 per diem, totalling $47, 450.00.

Dr. Lo's Position

Counsel for Dr. Lo proposed no penalty or, at most, a reprimand. He argued that the College had substantially failed to prove allegations which had not already been admitted. Dr. Lo admitted at the outset of the hearing to poor record keeping and to poor management of a long-term alcoholic patient, Patient #8. During the hearing, Dr. Lo also admitted to other areas where his management of medication monitoring was lacking.

Dr. Lo's counsel drew the Committee's attention to the significant practice monitoring that Dr. Lo has been under since the filing of the complaint regarding Patient A and the section 75 investigation, and since the expert opinion of Dr. Q was released on January 3, 2008. At that time, Dr. Lo entered into an undertaking with the College. Dr. Lo undertook to arrange, at his own expense, a College approved practice monitor to review his charts and patient care every two weeks. This undertaking has been in place and abided by for slightly more than four years. The practice monitor has reviewed 1163 charts with Dr. Lo. Monitoring, with College approval, came to an end on June 12, 2012. The practice monitor, Dr. M, appeared before the Committee at Dr. Lo's hearing and testified that there has been much improvement in Dr. Lo's charting and that he has no concerns about Dr. Lo's patient care and management.

DECISION

In crafting an appropriate penalty, the Committee must consider well recognized penalty principles. A penalty should express the abhorrence of the profession for the professional misconduct and serve to uphold the honour and reputation of the profession. A penalty should provide specific deterrence for the member and general deterrence for the profession. To whatever extent possible, the penalty should serve to rehabilitate the member. Foremost, the penalty should protect the public from any future misconduct or harm. The specifics of the case must be considered, including any mitigating or aggravating factors.

A significant mitigating factor in this case is the absence of previous discipline findings against Dr. Lo. The Committee also placed significant weight on Dr. Lo's long history of community service. Dr. Lo has made a substantial contribution to the psychiatric health of many very ill patients over many years in a very busy culturally sensitive urban practice. Dr. Lo cooperated with the College investigators and, at the outset of the hearing, admitted his shortcomings and failings in his record keeping practices. As the hearing proceeded and evidence revealed deficiencies in collateral information gathering, medication monitoring and the treatment of comorbid alcoholism, Dr. Lo readily admitted these deficiencies. The Committee was also told of his voluntary completion of the College prescribing course in 2011. Counsel for Dr. Lo informed the Committee that Dr. Lo will no longer operate a 'door-ajar policy', which Dr. Lo had explained to the Committee during his testimony. This practice policy allowed patients to return to see him after long absences, on their own accord, necessitating that Dr. Lo rely solely on the patient for relaying significant interim history. Instead of this "door-ajar policy", the Committee was told at the penalty hearing that Dr. Lo now sees patients who come to see him after a year has passed since their last visit only with a family doctor referral. He then generates a consultation report back to the patient's family physician, therefore ensuring more communication between Dr. Lo and his patients' primary care physicians. In addition, as mentioned above, his practice has been monitored closely, pursuant to his 2008 undertaking with the College, and significant improvements have been noted.

The Committee must also consider any aggravating factors when determining the appropriate penalty in any case. To learn, at the penalty phase, of two previous complaints against Dr. Lo for similar deficiencies in record keeping and collateral information gathering is concerning to the Committee. The Committee is aware that the extensive long-term practice monitoring has led to improvements in the areas of concern. The Committee expects Dr. Lo to continue to improve his record keeping practices. As he now maintains electronic medical records, his records will be legible, but the content must be detailed enough to, for example, allow a third party to be able to follow the history of the patient or for Dr. Lo to be able to readily monitor a patient's progress, medication changes and/or side effects appropriately. The records which were the subject

of the hearing did not meet these criteria. A re-assessment of Dr. Lo's practice within 12 months' time will ensure that the gains that he has made continue and that the public is protected. Given the long standing monitoring Dr. Lo has already undertaken, the Committee is of the opinion, however, that ongoing monitoring is unwarranted. Dr. Lo's practice consists of many very complicated patients who have been successfully managed long-term in the community under his care, and for that he is commended.

The Committee is of the view that a public reprimand is appropriate. It should send a message to the membership and the public that record keeping is a vital part of patient care. It will also reinforce to Dr. Lo that his failure to maintain the standard of practice of the profession is a serious finding. Dr. Lo's deficits in record-keeping were serious and multiple and thus merit the public denunciation of a reprimand.

With respect to costs, the Committee awards the College the cost of a one day hearing at the tariff rate of $3,650.00, to be paid within 30 days of the release of this decision. The hearing on the allegations and penalty took more than 20 days. However, many of the allegations against Dr. Lo were not proved on the evidence. As previously stated in its decision on finding, the Committee did not find Dr. Q's evidence to be of much assistance for the reasons given. The careful selection of experts and care in the preparation of expert reports are critical aspects of a discipline hearing. There were significant deficiencies in the report and testimony of Dr. Q, and his alarmist and incomplete assessment of Dr. Lo's care and treatment of many of the fifteen patients reviewed made for a lengthier than necessary hearing.

ORDER

The Discipline Committee therefore orders and directs that:

1. the Registrar impose the following terms, conditions and limitations on Dr. Lo's certificate of registration:

   a) Dr Lo shall undergo, at his own expense, a re-assessment of his practice within 12 months of the date of this order by an assessor acceptable to the College ("the

Assessor"). The re-assessment shall include a review of Dr. Lo's documentation and record keeping, his appropriate prescription and monitoring of Lithium in clinical practice, his communications with family members and family physicians, and his identification and referral to specialists of patients in his care with comorbid alcoholism; and

b) Dr. Lo shall abide by all recommendations provided by the Assessor.

2. Dr. Lo shall attend before the Committee to be reprimanded, on a date to be fixed by the Committee which shall be no later than three (3) months from the date that this Order becomes final;

3. Dr. Lo shall pay costs to the College in the amount of $3,650.00 within 30 days of the date of this Order.