

## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Michael Godfrey Sumner, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of the patients or any information that could disclose the identity of the patients 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 to a fine of not more than \$10,000 for a first offence and not more than \$20,000 for a subsequent offence.

**Indexed as:**

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

**IN THE MATTER OF** a Hearing directed  
by the Executive Committee of the College of Physicians  
and Surgeons of Ontario, pursuant to Section 36(2)  
of the *Health Professions Procedural Code*,  
being Schedule 2 to 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. MICHAEL GODFREY SUMNER**

**PANEL MEMBERS:**

DR. L. THURLING (CHAIR)  
DR. C.J. CLAPPERTON  
S. DAVIS  
DR. J. SCHILLINGER  
E. COLLINS

**Hearing Dates:** January 22, 2007  
**Decision Date:** January 22, 2007  
**Release of Written Reasons Date:** February 26, 2007

**Publication Ban**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the “Committee”) heard this matter at Toronto on January 22, 2007. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty order in writing, with written reasons to follow.

### **PUBLICATION BAN**

In response to a request by College counsel on behalf of the patients, the Committee ordered that no person shall publish the identity of the patients or any information that could disclose the identity of the patients pursuant to subsection 45(3) of the *Health Professions Procedural Code* (the “Code”), being Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended, having been satisfied that the desirability of avoiding public disclosure outweighs the desirability of adhering to the principle that the information should be available to the public.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Sumner had committed an act of professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he had failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Sumner is incompetent as defined by subsection 52(1) of the *Health Professions Procedural Code* (the “Code”), being Schedule 2 to the *Regulated Health Professions Act, 1991*, 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 practise or that his practice should be restricted.

### **RESPONSE TO THE ALLEGATIONS**

Dr. Sumner admitted that his care of patients constituted professional misconduct under paragraph 1(1)2 of O. Reg. 856/93 in that he failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence.

### **FACTS AND EVIDENCE**

The following Agreed Statement of Facts and Admission was filed as an exhibit and presented to the Committee:

## **PART I – FACTS**

### **Background**

1. Dr. Michael G. Sumner (“Dr. Sumner”) is a member of the College of Physicians and Surgeons of Ontario (the “College”) who received a certificate of registration authorizing independent practice in Ontario in 1985.
2. Dr. Sumner carries on practice as a neuropsychiatrist with a particular interest in treating patients suffering from chronic pain.
3. Up until January, 2006 Dr. Sumner practised in a private office in Greater Toronto, Ontario and at a pain management clinic in another part of the city.

### **The Letters of Concern**

4. In February, 2005 the College received two letters of concern in respect of Dr. Sumner. The first letter of concern was from a pharmacist who expressed concern over the quantity and combinations of medications being prescribed by Dr. Sumner.
5. The second letter of concern was received from a physician who also expressed concern about the quantity and combinations of medications prescribed by Dr. Sumner to two patients she encountered in her practice.
6. As a result of these letters of concern the College commenced an investigation into Dr. Sumner’s practice pursuant to section 75(a) of the *Health Professions Procedural Code*, being *Schedule II* to the *Regulated Health Professions Act* (the “Code”) on March 24, 2005 (the “Investigation”).

### **The Quality Assurance Committee**

7. On May 4, 2005, after a series of assessments, the Quality Assurance Committee of the College disclosed pursuant to s. 83(3) of the *Code* its opinion that Dr. Sumner was incompetent in his psychiatry practice.
8. As a result of the information from the Quality Assurance Committee, the Executive Committee initiated an investigation pursuant to section 75(b) of the *Code*. This

investigation was carried out in conjunction with the Investigation (collectively, the “Investigation”).

### **The Investigation and Referral**

9. During the course of the Investigation the College seized 21 patient charts from Dr. Sumner’s offices (the “Charts”). These charts reflected Dr. Sumner’s practice between 2000 and 2005.

10. The Charts were provided to two medical inspectors appointed by the College: Dr. Z and Dr. Y. Dr. Z is a psychiatrist and Dr. Y is a pain specialist.

11. Based upon conclusions reached in the reports of Drs. Y and Z, on December 20, 2005 the Executive Committee of the College referred specified allegations concerning Dr. Sumner to the Discipline Committee.

12. On January 26, 2006, effective January 30, 2006, the Executive Committee pursuant to section 37 of the *Code* imposed restrictions on Dr. Sumner’s Certificate of Registration pending the hearing before a panel of the Discipline Committee. A copy of the Order is attached as Schedule A [to the Agreed Statement of Facts and Admission]. The restrictions were as follows:

- i. Dr. Sumner shall close his private practice;
- ii. Dr. Sumner shall only practise medicine at his current pain clinic in Toronto;
- iii. Dr. Sumner shall not prescribe narcotics or controlled drugs and substances as defined in Schedules I to IV of the Controlled Drugs and Substances Act, unless the prescription has been co-signed by a physician approved by the College who has signed the Undertaking attached as Schedule “B” to this Order;
- iv. Dr. Sumner shall keep a photocopy of all co-signed prescriptions in individual patient charts.
- v. All expenses associated with the co-signing physician shall be at Dr. Sumner’s expense.
- vi. Dr. Sumner shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

**Patient A**

13. During the course of the Investigation the College received a complaint from one of Dr. Sumner's former patients, Patient A, about Dr. Sumner's care and treatment of Patient A.

14. The complaint of Patient A was considered by the Complaints Committee of the College and the issues in respect of Dr. Sumner's chronic pain management were referred to the Discipline Committee.

**Patient B**

15. In August, 2005 the College was contacted by Complainant 1 who expressed concerns about the death by suicide of his brother, Patient B, a patient of Dr. Sumner.

16. The College obtained the report of an autopsy conducted on the body of Patient B which concluded that the medication prescribed by Dr. Sumner did not cause Patient B's death. Dr. Sumner's care of Patient B was also referred by the Executive Committee to the Discipline Committee.

**The College's Expert Evidence**

17. Dr. Y was asked to comment on Dr. Sumner's care of patients as a chronic pain specialist. He found that in 18 of the Charts, Dr. Sumner was acting as a pain specialist. In 13 of these 18 charts, Dr. Y found that Dr. Sumner's care of patients fell below the standard of care expected of a chronic pain specialist, demonstrated a lack of knowledge, skill or judgement and exposed his patients to risk of harm. In particular, Dr. Y was concerned that Dr. Sumner failed to conduct or have conducted for him a targeted physical examination, and that he failed to perform adequate screening and management of addiction and diversion problems with respect to narcotics. Dr. Y also expressed concern about Dr. Sumner's failure to provide strict dosing instructions to patients for whom he prescribed controlled-release opioid analgesics to ensure they were taking the medications on a time-contingent basis rather than a pain-contingent basis. A copy of Dr. Y's report dated September 16, 2005 and an addendum dated October 28, 2005 are attached collectively as Schedule B [to the Agreed Statement of Facts and Admission].

18. Dr. Z was asked to comment on Dr. Sumner's psychiatric care of patients. He reviewed the Charts, and concluded that Dr. Sumner's care of patients fell below the standard of care expected of a psychiatrist and demonstrated a lack of knowledge, skill or judgment and exposed his patients to risk of harm. Among other things, Dr. Z raised concerns regarding

Dr. Sumner's assessment and diagnosis of psychiatric patients and his diagnosis of brain injury for many patients based solely on history without confirming objective evidence of brain damage, and his treatment of these patients.

19. Dr. Sumner's chart in respect of Patient A was also provided to Dr. Y. Dr. Y concluded that Dr. Sumner's care of Patient A fell below the standard of care of a chronic pain specialist, demonstrated a lack of knowledge, skill or judgement and exposed his patient to a risk of harm. A copy of Dr. Y's report dated July 6, 2006 is attached as Schedule C [to the Agreed Statement of Facts and Admission].

20. Dr. Sumner's medical chart in respect of Patient B was provided to the College by the Coroner's office. The College provided the chart to Dr. Y. Dr. Y upon reviewing the chart concluded that Dr. Sumner's care of Patient B fell below the standard of care of a chronic pain specialist, demonstrated a lack of knowledge, skill or judgement and exposed his patient to a risk of harm. A copy of Dr. Y's report dated August 16, 2006 is attached as Schedule D [to the Agreed Statement of Facts and Admission].

### **Dr. Sumner's expert evidence**

21. The Charts were provided to Dr. X. Dr. X is a physician licensed to practice medicine in Alberta with a specialty in palliative care and chronic pain. Dr. X disagreed with a number of the criticisms of Drs. Y and Z and concluded that the care provided by Dr. Sumner was appropriate and the difficult patient population treated by Dr. Sumner generally improved under his care.

### **Monitoring and Recent Practice**

22. In accordance with the Terms and Conditions imposed on Dr. Sumner's Certificate of Registration, Dr. W ("Dr. W") was approved by the College as an acceptable co-signor. From that time until the date of this hearing all prescriptions of narcotics and controlled substances listed in Schedules I to IV of the *Controlled Drugs and Substances Act* for Dr. Sumner's patients have been co-signed by Dr. W.

23. On January 15, 2007 Dr. W delivered his second monitoring report in respect of Dr. Sumner. In that report Dr. W concluded that Dr. Sumner's practice had changed in the 11 months he had been co-signing for him such that he believed Dr. Sumner was, as of the date of the report, competent to practice independently of the co-signing restriction imposed on

his Certificate of Registration. A copy of Dr. W's report dated January 13, 2007 is attached as Schedule E [to the Agreed Statement of Facts and Admission].

## **PART II – ADMISSION**

24. Dr. Sumner admits the facts in paragraphs 1 to 22 above and admits that his care of patients constituted professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O.Reg. 856/93") in that he failed to maintain the standard of practice of the profession.

## **FINDING**

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. The Committee further accepted that these facts provided a sufficient basis for a finding that Dr. Sumner's care of patients constituted professional misconduct. The Committee therefore accepted Dr. Sumner's admission and found that he committed an act of professional misconduct under paragraph 1(1)2 of O. Reg. 856/93 in that he failed to maintain the standard of practice of the profession.

## **PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs.

In deciding on the appropriate penalty, the Committee considered several factors. The evidence, and in particular the reports from Dr. Y and Dr. Z that were filed with the Agreed Statement of Facts, demonstrate that there were serious deficiencies in Dr. Sumner's prescribing habits and care and management of patients with chronic pain over a lengthy period, from 2000 to 2005, deficiencies that exposed his patients to risk of harm. This is mitigated to some extent by the fact that, according to Dr. W who has been supervising Dr. Sumner's prescribing of controlled substances since January 30, 2006, Dr. Sumner has made significant improvements to his quality of chronic pain care and prescribing. The Committee also considered the fact that Dr. Sumner has already faced significant sanction and expense, having been subject to onerous restrictions on his practice since January 2006 including being required to close his private practice and to have a co-signer appointed, at his own expense, of his prescriptions for narcotics or controlled drugs and substances. The Committee also took into consideration the fact that Dr. Sumner admitted to professional misconduct,

thus demonstrating that he recognizes the need to change his clinical practices and saving the College the time and expense associated with a lengthy hearing.

Taking the foregoing into account, the Committee concluded that the proposed penalty as set out in the joint submission was appropriate. It protects the public by requiring that Dr. Sumner practise only in a group practice that is approved by the College, and by ensuring that any prescribing by Dr. Sumner of narcotics and controlled substances will be subject to appropriate terms, conditions, restrictions, supervision and monitoring that are tailored to his level of knowledge, skill, judgment and regard for the welfare of his patients. The fact that Dr. Sumner has demonstrated over the last year that he has the ability to change his clinical practices provides additional support to the Committee for its conclusion that the proposed penalty will protect the public. In imposing a reprimand and restrictions on his practice, the proposed penalty meets the goal of specific deterrence of Dr. Sumner. It also sends the message to the membership of the College that conduct of the sort in which Dr. Sumner engaged is not acceptable, thus serving the goal of general deterrence. Accordingly, the Committee accepted the joint submission as to penalty made by the College and Dr. Sumner.

## **ORDER**

Therefore, the Discipline Committee ordered and directed that:

1. Dr. Sumner attend before the panel to be reprimanded, with the fact of the reprimand to be recorded on the register;
2. The Registrar impose the following terms and conditions on Dr. Sumner's Certificate of Registration for a period of 90 days following the date of this Order:
  - (i) Dr. Sumner shall not prescribe narcotics or controlled drugs and substances as defined in Schedules I to IV of the *Controlled Drugs and Substances Act*, unless the prescription has been co-signed by a physician approved by the College who has signed the Undertaking attached as Schedule "A" to this Order.
  - (ii) Dr. Sumner shall keep a photocopy of all co-signed prescriptions in individual patient charts.
  - (iii) All expenses associated with the co-signing physician shall be at Dr. Sumner's expense.
  - (iv) Dr. Sumner shall cooperate with unannounced inspections of his practice

and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

3. The Registrar impose the following additional term and condition on Dr. Sumner's Certificate of Registration for an indefinite period of time:

a. Dr. Sumner shall practice solely in a group practice at his current Pain Clinic in Toronto or another clinic approved by the College.

4. The Registrar impose the following additional terms, conditions and limitations on Dr. Sumner's certificate of registration for an indefinite period of time:

a. Within 90 days of the date of this Order, Dr. Sumner shall undergo an assessment of his practice to determine if his care meets the standard expected of the profession and if his care displays a lack of knowledge, skill or judgment or disregard for the welfare of his patients (the "Assessment"). The Assessment is to be carried out by Dr. Y or another assessor approved by the College ("The Assessor");

b. The Assessor shall report in writing to the College and to Dr. Sumner on the Assessment ("the Assessment Report");

**If Report Finds Standard of Care not met and Lack of Knowledge, Skill or Judgment**

c. If the Assessment Report or a report of a re-assessment done under the terms of this order concludes that Dr. Sumner's care does not meet the expected standard and displays a lack of knowledge, skill or judgment or disregard for the welfare of his patients the Assessor shall stipulate in writing the area or areas in which Dr. Sumner's care is deficient. Should the College receive such a report, the Registrar is directed to impose on Dr. Sumner's Certificate of Registration the following term and condition, which shall remain in effect until further Order of a panel of the Discipline Committee:

i. that Dr. Sumner be prohibited from prescribing those narcotics and controlled substances as set out in any or all of Schedules I to IV of the

*Controlled Drugs and Substances Act*, or any combination thereof, as stipulated by the Assessor.

**If Report Finds Standard of Care not met but no lack of Knowledge, Skill or Judgment**

- d. If an Assessment Report or a report of a re-assessment concludes that Dr. Sumner's care does not meet the expected standard but does not display a lack of knowledge, skill or judgment or disregard for the welfare of his patients;
  - i. the Registrar is directed to impose the following terms and conditions on Dr. Sumner's certificate of registration:
    1. Dr. Sumner shall not prescribe narcotics or controlled drugs and substances as defined in Schedules I to IV of the *Controlled Drugs and Substances Act*, unless the prescription has been co-signed by a physician approved by the College who has signed the Undertaking attached as Schedule "A" to this Order.
    2. Dr. Sumner shall keep a photocopy of all co-signed prescriptions in individual patient charts.
    3. All expenses associated with the co-signing physician shall be at Dr. Sumner's expense.
    4. Dr. Sumner shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order; and,
  - ii. Dr. Sumner can request a re-assessment by the Assessor, which is to be conducted no sooner than six months after the date of the last Assessment Report or report of a re-assessment.

**If Report Finds Standard of Care Met and No Lack of Knowledge, Skill or Judgement**

- e. If the Assessment Report or a report of a re-assessment concludes that Dr. Sumner's care meets the expected standard and does not display a lack of knowledge, skill or judgment or disregard for the welfare of his patients, the Registrar is directed to remove all terms and conditions on Dr. Sumner's Certificate of Registration, with the exception of the term in paragraph 3 of this order requiring that he practice solely in a group

setting approved by the College, and is directed to impose the following terms and conditions on his certificate of registration:

- i. Dr. Sumner shall arrange to have a clinical supervisor, approved by the College, with whom he shall meet as frequently as requested by the Supervisor, and no less frequently than once per month, to discuss his chronic pain management practice.
  - ii. Six months, 14 months, and 24 months after the date the conditions on Dr. Sumner's Certificate of Registration are removed under paragraph 4(e), an Assessor will re-assess Dr. Sumner's practice and will provide the College and Dr. Sumner with a copy of a report of the re-assessment.
- f. Dr. Sumner shall, within one year of the date of this Order and at his own expense, complete one course approved by the College in each of the following three areas, and will provide proof of attendance to the College:
  - i. Addiction medicine;
  - ii. Diagnosis and treatment of head injuries; and
  - iii. Psychiatric assessment and diagnosis.
5. Dr. Sumner shall be permitted to bring a motion before a panel of the Discipline Committee to vary this Order, but not earlier than 90 days after the date of this Order.
6. Dr. Sumner shall within 30 days pay the College its costs of this proceeding in the amount of \$2,500.00.

At the completion of then hearing, Dr. Sumner waived his right to appeal and the public reprimand was administered.

**Schedule "A"**

**UNDERTAKING OF DR. \_\_\_\_\_  
TO THE COLLEGE OF PHYSICIANS AND SURGEONS**

1. I am a practising member of the College of Physicians and Surgeons of Ontario (the "College").
2. I have read the Order of the Discipline Committee of the College of Physicians and Surgeons of Ontario dated January 22, 2007 regarding Dr. Michael Godfrey Sumner, and have read the Agreed Statement of Facts and Admission dated January 22, 2007 and the Schedules thereto.
3. I understand that Dr. Sumner may only practice medicine at the his current Pain Clinic in Toronto.
4. I understand that Dr. Sumner cannot prescribe narcotics or controlled drugs and substances as defined In Schedules I to IV of the *Controlled Drugs and Substances Act* unless the prescription has been co-signed by a physician approved by the College. I agree that commencing from the date I sign this Undertaking, I shall:
  - 3.1 review all of Dr. Sumner's prescriptions for narcotics and controlled drugs and substances, and discuss with him the clinical indications for such prescriptions;
  - 3.2 raise any concerns I have with Dr. Sumner regarding any of the prescriptions I have reviewed; and
  - 3.3 co-sign those prescriptions which I believe are appropriate in the circumstances of that patient.
4. I agree that if I am concerned that Dr. Sumner's prescribing may expose his patients to risk of harm or injury, I shall immediately notify the College. I also agree to report to the College every three months confirming that Dr. Sumner has been and continues to comply with the terms of the Order, and providing any other information I believe is relevant to Dr. Sumner's compliance with the Order.
6. I agree to immediately inform the College in writing if Dr. Sumner and I have terminated this relationship, or if I otherwise cannot fulfill the terms of my Undertaking.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_, 2007

\_\_\_\_\_  
Dr. \_\_\_\_\_  
Witness signature

print name: \_\_\_\_\_