Indexed as: Arnold (Re)

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 60(6) of the **Health Disciplines Act**, R.S.O. 1990, C.H. 4

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ROSEMARY JOAN ARNOLD

PANEL MEMBERS: DR. J. CURTIS (Chair)
DR. J. THOMPSON
DR. M. GOODMAN
F. HOSHIZAKI

HEARING DATE: SEPTEMBER 19-23, 1994
FEBRUARY 1-2, 1995
FEBRUARY 9, 1995
APRIL 3-6, 1995

DECISION/RELEASED DATE:

DECEMBER 19, 1995

DECISION AND REASONS FOR DECISION

This matter came on for hearing at the College of Physicians and Surgeons of Ontario at Toronto September 19-23, 1994 and at the offices of Fasken Campbell Godfrey, February 1, 2, 9, and April 3, 4, 5, 6, and 17, 1995.

In the Notice of Hearing it was alleged that Rosemary Joan Arnold is guilty of professional misconduct or incompetence, the particulars of which are as follows:

1) It is alleged that Dr. Rosemary Joan Arnold is guilty of professional misconduct contrary to subsections 27(3), (16), (20), (21), (26), and (32) of Ontario Regulation 448/80 as amended.

2) It is further alleged that Dr. Rosemary Joan Arnold is incompetent in that she has displayed in her professional care of a patient a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates she is unfit to continue in practice, contrary to subsection 61(4) of the **Health Disciplines Act**, R.S.O., 1990, c. H.4.

FIRST MATTER (RECORDS FAILURE) - SUBSECTION 27(3)

3) Dr. Arnold failed to maintain the records that a member is required to keep in respect of the patients listed in Appendix "B".

4) Particulars of the records failure include failure to adequately document (or record), or document (record) at all (in some cases) patient history, particulars of physical examinations, investigations (and their results), diagnoses, and treatment.

5) The records that a member is required to maintain are set out in section 29(1) of Ontario Regulation 448/80 as amended.

SECOND MATTER (FALSIFYING RECORD) - SUBSECTION 27(16)

6) On or about February 20, 1988, Mr. PEP sustained an injury to his left hand, and subsequently consulted Dr. Arnold on or about February 24, 1988 for its treatment. The injury was not work-related.

7) Dr. Arnold was consulted again by Mr. PEP on or about April 21, 1988, for an injury to the left hand (same digit) sustained on or about April 15, 1988, and Dr. Arnold submitted a report to the Workers' Compensation Board (WCB) dated May 18, 1988.

8) Section 10 of the WCB Form submitted by Dr. Arnold requested particulars of any "prior history of similar condition and any physical defect". No record of Mr. PEP s prior history involving this hand (and digit) was made by Dr. Arnold in this section, nor was there any record elsewhere contained in the submitted report in respect to his prior history.

THIRD MATTER (CONTRAVENING LAW) - SUBSECTION 27(20)

9) Dr. Arnold submitted a false report to the WCB in respect to the injuries to the left hand (and digit) sustained by Mr. PEP in February and April 1988.

10) Dr. Arnold is required by law to submit a report on request to the WCB pursuant to Section 53 of the **Workers' Compensation Act**, R.S.O. 1990, C. W.11.

11) This matter is alleged in the alternative to the second matter (i.e. paragraphs 6 to 8 above).

FOURTH MATTER (STANDARDS FAILURE) - SUBSECTION 27(21)

12) In respect to the patients listed in Appendix "B", Dr. Arnold failed to maintain

the standard of practice of the profession.

13) Particulars of the standards failure are as follows:

(a) Dr. Arnold treated her patients with excessive quantities of narcotics and other drugs having habit-forming potential;

(b) Dr. Arnold failed to monitor adequately, or at all, the condition of her patients and/or their use of the drugs Dr. Arnold prescribed or administered to them;

(c) Dr. Arnold failed, or neglected, to recognize the drug seeking behaviour of her patients, took no (or insufficient) steps to investigate the possible causes of these patients' behaviour, and to treat these patients appropriately;

(d) Dr. Arnold failed to treat or deal adequately with the drug dependency of her patients;

(e) in the alternative to the first matter (i.e. paragraphs 3 to 5 above), Dr. Arnold failed to maintain the records that ought reasonably to have been maintained respecting her patients. Such records should have included indications for the use and continued use for narcotics and other habit-forming drugs prescribed and/or administered by Dr. Arnold, periodic assessments of the patients, investigations conducted, results of those investigations and diagnoses and treatment.

FIFTH MATTER (IMPROPER PRESCRIBING) - SUBSECTION 27(26)

14) Dr. Arnold improperly used her authority as a member to prescribe narcotics and other drugs having habit-forming potential to the patients listed in Appendix "B".

15) Dr. Arnold knew, or ought reasonably to have known, that the patients listed in Appendix "B" were drug seeking individuals. Dr. Arnold accommodated and/or facilitated her patients' requests, and sometimes addictive need, for more narcotics or other habit-forming drugs, without acceptable medical reasons. In circumstances where Dr. Arnold was not initially aware of the drug seeking behaviour of the patients, she did become aware, or ought reasonably to have become aware, of that behaviour during her treatment of these patients, and she should have responded appropriately. Dr. Arnold did not.

SIXTH MATTER (DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT) -SUBSECTION 27(32)

16) In the alternative to the fifth matter, Dr. Arnold conducted herself in an unprofessional manner in consistently prescribing narcotic and other habit-forming medications to the patients listed in Appendix "B" when she knew, or ought reasonably to have known, that her patients were drug seeking individuals.

SEVENTH MATTER (INCOMPETENCE) - SUBSECTION 60(4) HDA

17) The conduct alleged in the above matters displays in Dr. Arnold's professional care of a patient a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates she is unfit to continue in practice, which is incompetence as defined in subsection 60(4) of the **Health Disciplines Act**.

At the hearing two prosecution expert witnesses, Drs. Harold Barnett and Howard Rudner, testified regarding Dr. Arnold's case on the basis of chart reviews for eleven patients. A physician, Dr. FDR, who functioned as a locum tenens for Dr. Arnold for

two months in 1989, testified regarding nine of the eleven patients. Dr. Arnold testified in her own defence. Dr. Lorne Martin gave evidence as a defence expert witness. In addition, three of the eleven patients, a colleague, a pharmacist, and Dr. Arnold's secretary testified. A number of testimonial letters from colleagues and patients were presented.

Prosecution Experts

Dr. Harold Barnett

Dr. Harold Barnett was accepted by the defence as an expert in general practice. Dr. Barnett was asked by the College, to review 62 patient charts of Dr. Arnold along with Bureau of Dangerous Drug (BDD) profiles of patients who received narcotics or other controlled substances from the physician. He graded the level of care provided by Dr. Arnold and of the 62 patients and found 11 cases where her care was substandard.

On cross-examination of Dr. Barnett, the defence counsel elicited testimony that Dr. Barnett's practice was dissimilar to that of Dr. Arnold in that his experience with those on welfare, the working poor and those with chronic pain is limited.

Dr. Barnett assumed that if a history and physical examination were not recorded, they were not performed. However, he was uncertain when there was no recorded indication for treatment whether such treatment was inappropriate.

In circumstances of chronic pain without a definitive diagnosis, but with some specialist support, Dr. Barnett said that he would be very circumspect with regard to the use of narcotic analgesics. He would develop a treatment plan starting with non-pharmacological approaches, and if necessary, move on to non-narcotic drugs. If there was still an inadequate response to treatment, more potent narcotic analgesic drugs could be considered, but such use and the underlying diagnosis he said must be repeatedly re-examined.

Dr. Howard Rudner

Dr. Howard Rudner was also accepted as an expert in general practice. Dr. Rudner reviewed the 11 charts and submitted a report of some 40 pages outlining the assessments done and treatments prescribed by Dr. Arnold. He commented on her management and noted where he said Dr. Arnold fell below the standard.

Dr. Rudner's time is divided between his practice and teaching responsibilities. His practice load is small and consists of mostly "white collar" middle-class patients. Chronic pain is an interest in his practice and in teaching. He has ready access to specialists and support services. Narcotic analgesics, in his opinion, should be used as a last resort in a very select group of patients and great caution must be exercised. He acknowledged that chronic pain may exist without significant clinical findings, but many other factors are considered when deciding upon the management. He said that drug seeking behaviour would be a warning sign regarding the use of narcotic analgesics. If these drugs are prescribed, monitoring and reassessment is mandatory, and documentation provides evidence that this was done.

He described a continuum from therapeutic dependency to psychic dependency to addiction. Dr. Rudner acknowledged that some monitoring was done by Dr. Arnold in that visits were regular and sometimes the quantities of pills given were noted. There were many notations of counselling and counselling regarding excessive use of drugs. He acknowledged that virtually no organic disease was left untreated, but he suggested that psychopathology was not dealt with.

Prosecution Witness

Dr.FDR

Dr.FDR worked as a locum tenens for Dr. R.J. Arnold in July and August 1989. He acknowledged that although Dr. Arnold has had locum tenens physicians each summer between 1986 and 1992, he was the only one who deemed these patients drug seekers and the only one who denied the patients medication. He also agreed that he did not have time to review in detail the record of each patient. These patients were not the type he sees in his own practice.

Dr. FDR agreed that while his approach to pain management is extremely careful, in highly selected patients chronic narcotic therapy could be acceptable.

Defence Witnesses

Dr. Arnold

Dr. Arnold, presently 52 years of age, has practised with her husband since 1971. They have 12,000 patients between them. She works 48 hours per week for 10 months each year. She sees in her practise mostly women and children but also she deals with work related injuries and injuries after motor vehicle accidents on behalf of insurance companies.

She said she has found a number of difficulties practising in her community. Records are rarely provided by previous physicians. Communication and consultation with psychiatrists has been particularly problematic. Referrals to specialists have often been very difficult and waiting periods have been lengthy. For example, it takes six months to see the local neurologist, 12 months to be seen at the physiotherapy department and 18 to 24 months to be assessed at a pain clinic in Hamilton. Despite these lengthy periods Dr. Arnold has felt obliged to obtain the approval of a specialist before prescribing narcotics for back pain or migraine headaches.

She described the extent of the history and physical examination that she said she does for a general and intermediate assessment and her assessment and management of lumbosacral pain and migraine. Dr. Arnold had to be reminded of a sensory examination, and motor power and reflex assessment for the purposes of assessing back pain. However, she said she does perform these examinations, as well as a range of motion assessment, straight-leg raising and palpation at every examination.

Dr. Arnold acknowledged problems with her records and she said she now recognizes the need to be more complete for the purposes of locum tenens physicians and for litigation. She did say however, that the 11 charts reviewed at this hearing are not representative of her practice. She has developed printed sheets which she now uses for general assessments and office visits. Previously, she testified, the findings were subsumed in the diagnosis and, second, negative findings were not noted.

Dr. Arnold said that she monitored narcotic use by having the patient return to her office on a regular basis. She has not recognized drug seekers.

On questioning by a panel member, Dr. Arnold distinguished the concepts of therapeutic dependency and addiction. In the former, a person may require narcotics for an organic problem and does not take narcotics for their psychic effect.

Dr. Arnold was questioned intensively regarding "black books" in which she kept

information regarding the findings of motor vehicle accident victims for the purpose of drafting a medical/legal letter. She said these books were destroyed when no fault insurance came into effect. The only permanent record of these examinations is the summary letter to the lawyer. No entries were made regarding these findings in the patients chart. Dr. Arnold acknowledged that she had no knowledge regarding whether this charting system and the destruction of the original document was acceptable to the authorities.

Dr. Arnold acknowledged contact with the BDD a few years ago prior to the College investigation which was commenced in 1990. Information regarding narcotic use in certain patients was requested by the BDD. She responded and apparently complied with their regulations regarding narcotic use. Subsequently she was called before the Medical Review Committee of the College of Physicians and Surgeons of Ontario in 1975 but no problem was found.

Dr. Arnold does not prescribe narcotics for functional pain. She stated that benzodiazepines were widely used in the 1980's and were safe if carefully monitored. Barbiturates were used rarely and were used only for short periods of time. She said that she did not use Tylenol #3 as a first line drug as it appears in her records. These patients would have used Tylenol #1, obtained without prescription before consulting her but this was not charted. Failure to relieve the symptoms led to her use of the more potent narcotics. Similarly, non-steroidal anti-inflammatory drugs (NSAID) use, whether purchased over the counter or prescribed by her, were not charted. She volunteered that she is the largest user of NSAIDs in her area. Medicolegal cases were more detailed and the files were kept separately. She said these records were destroyed with the advent of no fault insurance.

Since the investigation leading to the present hearing was started she has altered her practice habits. She no longer sees chronic pain patients and rarely prescribes narcotics. Her charting is now assisted by forms she has devised. More information is recorded and she includes a treatment plan.

Dr. Lorne Martin - Defence Expert

Dr. Martin testified as an expert for the defence. He has been a family practitioner and has been a locum tenens physician on a number of occasions. He now works in an emergency department and is Chief of Staff at his hospital. He has reviewed the 11 charts and has heard the testimony of the prosecution experts and Dr. Arnold. He did not claim to have any expertise in substance abuse, chronic pain or opioid management of chronic pain. He has, however, attended courses on pain management.

His views regarding the use of narcotic analgesics were at variance with those of Doctors Barnett and Rudner. Dr. Martin believes that his primary role is to relieve suffering. His first inclination is to believe patients when they say they are having pain, unless there is evidence to the contrary. He has often noted the minimal use of narcotic analgesics in situations of real pain.

He testified that there are more dangerous drugs than narcotic analgesics and emphasized that judgment is a more appropriate word than caution in describing the proper approach to the use of these drugs. Even if there is no evidence of organic pain, these drugs may be properly prescribed if it is the judgment of the physician that such medications are necessary. Dr. Martin said that he would be very reluctant to believe a patient was lying about pain or his or her use of drugs without definite evidence. He was aware, however, of all of the warning signs of drug seeking behaviour. His approach is to largely accept what the patient says as true unless proven otherwise. He agreed with Dr. Barnett's approach in circumstances where addiction is detected.

He differed from the prosecution experts in other regards. He has no reservations about using narcotic analgesics stronger than Tylenol #3. His reliance on specialists is much less. He took issue with the prosecution experts' emphasis on features of drug

seeking behaviour such as asking for a specific drug, begging for drugs and emergency room lists of drug seekers. He defined addiction as physical dependence on a drug as exemplified by withdrawal reactions and tolerance and a motivation to obtain drugs at the expense of their own well being. Addiction is a less relevant concern when there is a painful condition being treated. Dr. Martin was not aware of the term "therapeutic dependency". He believed that Dr. Arnold's belief that her patients had significant pain was of great importance. Objective evidence of pain would also be helpful.

A College of Physicians and Surgeons of British Columbia (CPSBC) document entitled, "Guidelines for the Management of Chronic Non-malignant Pain", February 1993, was discussed. Dr. Martin emphasized that patients with idiopathic pain should not be denied narcotic analgesics when indicated. Pain is always a subjective complaint and these patients should not be disregarded. Dr. Martin generally agreed with the document but he would have some slight reservations regarding some inflexibility of the approaches. He suggested that the use of narcotic analgesics is becoming more liberal. He acknowledged that many physicians would not agree with his approaches. He was unable to be categorical regarding the standard of practice with regard to the use of narcotic analgesics for chronic pain.

Dr. Arnold's patients, he observed, were extremely difficult patients, patients that many doctors would refuse to deal with. For this reason he said that she should not be held to the same standard of practice as others with a more usual practise.

Dr. Martin's opinion was that Dr. Arnold prescribed narcotic analgesics appropriately on the basis of her evidence in that there was always an organic diagnosis. The level of certainty of Doctors Barnett and Rudner regarding these patients being drug seekers was, in his view, unfounded. On reviewing the records, Dr. Martin was much less certain in this regard.

Dr. Martin stated that the use of street drugs by patients with chronic pain does not mean the patient is a drug seeker.

Dr. Arnold behaved appropriately in terminating the therapeutic relationship when she felt uncomfortable dealing with these patients' use of drugs.

He said that in none of the eleven patients did Dr. Arnold prescribe narcotic analgesics in greater than permissible doses nor was there evidence of escalating doses except for short periods of time.

On the basis of Dr. Arnold's testimony, Dr. Martin believed that her general assessment and routine clinical assessment were adequate. He would not insist on a physician obtaining records of previous physicians as, in practice, this is often problematic. He believed that her use of investigations and referrals was appropriate. Her general approach to treatment, follow-up and monitoring was appropriate. He did not deny the possibility that some patients may have become addicted to drugs while under Dr. Arnold's care.

He did concede that Dr. Arnold's records were below the standard according to 1983 College guidelines in many regards. He agreed that findings supportive of a diagnosis were often not recorded, and that no history or physical examination was recorded for many patients. He also conceded that Dr. Arnold failed to satisfy the requirements with regard to records for a general assessment, counselling and psychotherapy.

Chart 3.1 - IPA

Prosecution

This woman, born in 1944, had a long history of severe psychiatric problems, psychosocial problems, substance abuse and drug dependency before becoming a patient in Dr. Arnold's practice. She also complained of headaches, neck pain and pain in the feet. When she first saw Dr. Arnold in June 1987 she was already taking regular quantities (six per day) of Tylenol #3 as well as Valium and Dalmane. Dr.

Arnold added Fiorinal C 1/2.

There was some evidence of investigation and referral and some evidence of organic disease (on lumbosacral spine x-ray) but the College's witnesses believed there was no significant evidence of any acute organic problem that would justify prescriptions of large doses of narcotics. These consultants did not believe there was a significant organic problem and one commented on the excessive drug usage. Despite recognizing that the patient was using too much codeine, in December 1987, Dr. Arnold continued to prescribe drugs containing codeine. Dr. Rudner expressed concern that she failed to confront the patient regarding drug dependency.

Drug dependency was noted by another physician later in December 1987 and significant attempts were made in the summer of 1989 by the locum tenens physician, Dr. FDR, to restrict her narcotics and to refer her to a pain clinic or a rehabilitation clinic. However, the patient refused. Dr. FDR was distressed by the fact that she was taking both Tylenol #3 and Fiorinal C 1/2 and also Valium and/or Dalmane. He believed that the patient did not complain of pain but went to the doctor for medications. The patient acknowledged her addiction after Dr. FDR refused to comply with her request for the usual amount of medications. The patient forged a prescription and was subsequently arrested.

After Dr. Arnold's return from her holidays her records indicated acknowledgement and agreement with Dr. FDR's approach but within 48 hours Dr. Arnold was prescribing the same drugs. Despite a drug overdose Emergency Assessment Unit Report in September 1989 which clearly stated that the patient was taking pills in order to cope, and another admission in January 1990 because of a drug overdose, Dr. Arnold continued to prescribe narcotics.

Dr. Barnett testified that the charting was clearly inadequate. There was scant evidence of physical examinations or inquiry regarding her problems, excessive narcotics were prescribed, there was no monitoring of her progress, she improperly exercised her authority to prescribe restricted drugs and did not display a competent level of skill, knowledge or judgment.

The defence elicited agreement that there was some evidence of organic back disease on X-ray but the extent to which this was responsible for her complaints remained in question in the minds of the prosecution experts.

On cross-examination Dr. Rudner admitted that the patient had already been taking codeine for a number of years when Dr. Arnold first attended her but he believed that Dr. Arnold initiated Fiorinal C1/2 and Librium. He also allowed that there was some X-ray evidence to indicate that her neck and back pain was organic in origin but his impression was that the consultants did not believe that the pain was organic. He stressed that X-rays must be judged in context with the rest of the assessment. Dr. Arnold prescribed these drugs without obtaining any old records, without knowing her previous pattern of drug use, and without ongoing assessments. He appreciated that the patient presented a very difficult management problem but he testified that Dr. Arnold failed to deal with the problems in a meaningful way and that she never discussed this woman's drug problems with her.

Defence Case

In her testimony, Dr. Arnold described the patient's extremely troubled psychiatric history. Previous physicians had tried to wean her from narcotics unsuccessfully. Her previous physicians refused to forward to Dr. Arnold the patient's medical records. Dr. Arnold, however, said she obtained a list of the patient's drugs, as she does with all other patients, from the pharmacist. Although it was not recorded in her chart, Dr. Arnold said she did a complete assessment of the patient's back.

She acknowledged that Drs. OPE, TEK, and HPV could find little evidence of organic disease and concentrated on her psychiatric problem. However, Dr. Arnold believed that the X-rays demonstrated an organic problem.

Throughout most of the time she cared for IPA, Dr. Arnold had great difficulty in communicating with the treating psychiatrist and she attributed part of the patient's problems to his poor management.

She acknowledged prescribing an average of eight and a maximum of twelve codeine containing pills per day (amounting to 240-480 mg. of codeine per day) as well as Librium and/or Valium. Dr. Arnold believed that the patient had chronic organic pain in her back and neck and testified that she also had injuries periodically inflicted on her by her spouse that required the narcotic analgesics.

Dr. Arnold testified that she monitored the patient adequately by seeing her frequently, by giving her prescriptions for only two weeks at a time, by examining her regularly and by counselling her regarding drug use.

Dr. Arnold said she resumed prescribing the drugs which Dr. FDR refused because she knew that there was no prospect of this patient attending Homewood and it was very unlikely that with the long history of codeine use that she would be able to stop the medications because of organic pain.

Finally, in March 1990 Dr. Arnold became suspicious of double doctoring. By the next month she refused to treat her further.

On cross-examination, Dr. Arnold admitted she had no information about the patient from other doctors when she first accepted IPA into her practice. She learned what she knew from the pill bottles, the pharmacist and the patient who kept records. She did obtain a 1981 letter from Dr. OPE at some point between 1986 and 1988. There was no record of requests for records to other doctors.

Although very little information was recorded under the heading General Assessment, Dr. Arnold claimed to have fulfilled the requirements for a General Assessment according to the General Preamble of the Schedule of Benefits. Initially her diagnosis was headache but later her diagnosis was migraine. Lumbosacral spasm was also a common diagnosis. No findings were documented to support this diagnosis but Dr. Arnold felt the findings were implicit in the diagnosis. She admitted her records were poor.

Prosecution counsel tallied the drugs that this patient received for a five-month period and a second three-month period. Dr. Arnold agreed that she had prescribed 1640 tablets of medications containing 30 mg. of codeine over a five-month period in 1987-88 (8580 mg. per month) and 14,400 mg. per month in the three-month period after she refused to be admitted to Homewood.

Dr. Arnold believed that the patient had organic pain but became aware as time went on that the patient exaggerated her complaints. She acknowledged that the patient was "therapeutically dependant" on codeine but denied that she exhibited any drug seeking behaviour.

Dr. Arnold advised the prosecution counsel that she was aware of College Notices published over the course of several years regarding the prescription of narcotics. She was aware that prescription of narcotic drugs is not approved for treatment of narcotic habituation or addiction; that long-term management of addiction with narcotics except with Methadone, which is used only by permission, is below the standard; and that there are recognized behaviours of drug seekers.

Dr. Arnold admitted that she was excited on her return to the office from holidays by the prospect of the patient's admission to Homewood as arranged by Dr. FDR. When Dr. Arnold refused narcotic medications, IPA became very upset and ran out of the office to be brought back later by the police.

The refusal to treat her further followed her receipt of information from BDD indicating that the patient may have been double-doctoring.

Dr. Martin, the defence expert, also testified regarding this woman. He asserted that bearing in mind the starting point with this patient, Dr. Arnold should not be held accountable for all the difficulties she experienced. He insisted that Dr. Arnold was qualified to treat such a patient despite the complexity. He believed that narcotic analgesics were used because of pain. On reviewing the quantities he did not see a substantial escalation over the period of time that Dr. Arnold was treating her.

Chart 3.2 - LWP

Prosecution Case

Dr. Arnold's records for June 1987 to September 1990 (510 pages) for this unfortunate woman, born in March 1963, were reviewed by the two prosecution experts.

In their opinions her records never indicated any more than the most cursory of examinations. Despite numerous consultants clearly indicating there was an inadequate organic basis for her complaints, despite their diagnoses of drug dependency and habituation and despite their recommendations that no narcotics be given, Dr. Arnold persisted in prescribing excessive narcotics in the form of Robidone, Tylenol #3 and Tylenol #4, Fiorinal C 1/2, intra-muscular Demerol, Valium, Amytal, Rivotril, Percodan as well as other drugs. At one point in January 1990 she was taking 17 different drugs.

Dr. FDR saw her four times in the summer of 1989. His initial diagnosis was drug dependant behaviour. He was horrified by her drug ingestion and concomitant use of Tylenol #4 and Fiorinal C 1/2, five to six tablets each per day. He believes she was

using potent narcotics for relatively minor complaints.

This woman demonstrated drug seeking behaviour such as going to the emergency department for narcotics because she claimed to have lost her Demerol, requesting narcotics of a family doctor and a long history of numerous complaints, many minor, and all requiring, in her mind, narcotics. Dr. Arnold's diagnosis was usually lumbosacral strain.

Dr. Arnold wrote an insurance report in September 1988 saying she had examined the patient in October 1987 but there was no record of such an examination in her chart.

On cross-examination Dr. Rudner was critical of the chronic use of oral Demerol and the use of excessive doses of narcotic analgesics especially after LWP had been assessed at a Pain Clinic at which time recommendations regarding restriction of narcotics were not followed. There may have been some organic pain but he believed it was not severe enough to require narcotics.

Defence Case

Dr. Arnold described the extremely complex psychosocial and physical problems plaguing this woman. On entering her practice LWP was consuming 10 to 12 Tylenol #3's per day. Dr. Arnold was convinced that she needed the drugs prescribed because "she was in agony" and "cried out at night" because of severe muscle spasm producing migraine headaches. Dr. Arnold exclaimed "It was dreadful to see her." The patient had severe muscle spasm in the neck and back associated with fluctuating neurological symptoms and, for a time was forced to resort to a wheelchair because of paraplegia. Because the pain was so intense she suspected some kind of "central pain, not yet diagnosed". Dr. Arnold found no evidence that she was abusing drugs.

After her premature discharge from a Rehabilitation Unit sDr. Arnold learned of some duplicity on LWP's part regarding the circumstances at the time of the discharge. Dr.

GLU's regime included Tylenol #2 up to 6 per day and LWP agreed with this plan. However, she required more narcotics within a short time because of severe pain.

LWP was seen frequently by specialists, including a psychiatrist, a neurosurgeon, and two neurologists. In 1992 she was seen at another pain clinic where a diagnosis of fibromyalgia was made. Her narcotics were "traded" for Prednisone.

Dr. Arnold believed that her patient had true, severe organic pain including migraine, severe muscle spasm and fibromyalgia. All modalities of treatment were tried in conjunction with the narcotics. The quantities of the narcotics were not excessive and were given in relation to the patient's pain, which is subjective. Dr. Arnold said that monitoring of the patient's drug use and her condition was effected by regular, prolonged office visits. She also referred LWP liberally to specialists.

On cross-examination, Dr. Arnold testified that she did discuss the circumstances of this patient's premature discharge from Dr. GLU's rehabilitation unit with LWP but there is no record of such a discussion. Dr. Arnold did not clearly respond to questions regarding whether she discussed the patient's duplicity. Dr. Arnold did not make contact with Dr. GLU but she did receive a letter from him approximately two months after the patient's discharge. The patient was discharged on Tylenol #2 and it was not until later that more potent narcotic analgesics were prescribed.

The defence expert suggested that Dr. GLU's and Dr. FDR's prescribing of narcotic analgesics for this woman, despite their diagnosis of probable non-organic pain, confirmed their uncertainty that the patient did not have organic pain. Other specialists he said were similarly uncertain. That she had pain that awakened her, Dr. Martin proffered, is good evidence of true organic pain.

Chart 3.3 - QAE

Prosecution Case

Records regarding this man born in November 1954, for the period September 1984 to September 1990 were reviewed. He complained usually of low back pain and cough and was treated with various types of narcotics such as Tylenol #3 or Tylenol #4, or Percocet. In September 1989 the patient went to the emergency department regarding his addiction. Subsequently Dr. Arnold continued to prescribe narcotics. In November 1989 he was admitted with an overdose of Valium.

There was an injury to QAE's finger at home in February 1988 and a chip fracture was reported on an X-ray. Dr. Arnold reported a work related injury to the same digit in April of 1988 and neglected to mention the original injury. Dr. Barnett was troubled by this report which he deemed false. Dr. Barnett did not suggest there was collusion. Further, it was evident from the chart that a report had already been made to the Workers' Compensation Board and Mr. QAE missed only two days of work.

On cross-examination, Dr. Rudner said that narcotics may properly be used for chronic pain only if other means of treatment were not effective, and in this case there was no evidence of such trials. He acknowledged that at the time of the Valium overdose there was no acetaminophen detected in QAE's blood indicating that at least at that time he was not abusing Tylenol #3 or #4. He advised that Dr. Arnold should have entered into a contract with her patient regarding drug use.

Defence Case

Dr. Arnold testified that this man was afflicted with a back problem. She said that an examination revealed muscle spasm and scoliosis. She said the usual conservative modalities of treatment were not effective and narcotic analgesics were necessary especially after work and to allow sleep at night. There were also numerous injuries intermittently requiring narcotic analgesics. She said he also needed narcotic-containing cough medicine because of a chronic smoker's cough.

When Dr. Arnold was completing the WCB report regarding the hand injury and failed to mention the previous injury, she said there was no intention to deceive. She had merely forgotten about the injury three months previously. She said there would have been no benefit to the patient.

Dr. Arnold claimed she did monitor the use of the drugs through discussions with the patient and his wife. Finally, in 1990, when it was evident that he was not sticking to their plan, she refused to prescribe narcotics. Shortly thereafter, when he refused a referral to Dr. OPE she terminated the relationship.

The Valium overdose was not a suicidal attempt but an hysterical gesture because of anger, according to her testimony.

She denied that the quantities of narcotics were excessive. The drugs were prescribed for organic problems, and monitored and were never prescribed at the patient's request.

On cross-examination Dr. Arnold insisted that the WCB's reason for the question on the report regarding previous injury was not to determine whether the current injury is related to a previous injury but to determine "how long the claim would be extended". She said that in this particular case a claim would not be successful because he had been fired. She said she may have left the box in question blank because she did not have an x-ray report at the time that she completed the form. She agreed that the radiologist made a mistake in identifying the fifth finger rather than the fourth finger as the injured digit.

She agreed that this man was not addicted to drugs when she first took him on as a patient. She became aware that he was getting drugs she was not prescribing at the time of his drug overdose but she did not confront him about this. She acknowledged that he was abusing street drugs by the time she terminated the relationship.

Dr. Martin was sympathetic to Dr. Arnold's oversight in failing to complete the WCB

form.

This man's benzodiazepine overdose did not involve a drug prescribed by Dr. Arnold. She said she only gave him regular doses of narcotic analgesics for back pain on a reasonable basis.

Prosecution counsel reviewed Dr. Arnold's stated reason for discharging the patient from her practice - that she doubted the veracity of his complaints and he refused to cooperate in that he refused a CT scan. Dr. Martin was unable to give an opinion regarding whether this patient had a drug related problem.

Chart 3.4 - NZV

Prosecution Case

Born in October 1952, this man was a patient of Dr. Arnold's between March 1986 and December 1990, and according to his review of the records, Dr. Barnett was of the view that this patient had an established chronic pain pattern and consumed large quantities of codeine before being cared for by Dr. Arnold. His initial visit to Dr. Arnold was for Percocet but she advised Tylenol #4 but gave prescriptions for both for "lumbosacral spasm". She continued to prescribe narcotics without ever demonstrating evidence of a physical examination in the record.

Later that year the records indicated Dr. Arnold counselled the patient regarding drug addiction and proposed a pain clinic referral. However, she continued to prescribe narcotics regularly. The patient finally attended the pain clinic two years later.

Narcotics of various forms were prescribed at virtually every visit.

On cross-examination of Dr. Barnett there was dispute regarding specialists' opinions that were recorded in the chart. Defence counsel pointed out that there was some evidence of organicity but Dr. Barnett insisted that while there was some "lingering doubt" in his mind about organic cause for the pain there was no doubt that the patient was using and given large quantities of narcotics and clearly demonstrated drug seeking behaviour.

Dr. FDR's office notes from July and August 1989 clearly described drug seeking behaviour and his efforts to reduce their use. This doctor also recommended a drug rehabilitation program. According to Dr. Barnett, Dr. Arnold ignored these notes.

There is a note from a medical clinic dated August 1989 where the patient appeared requesting Percocet. He was on the "narcotics list" and therefore no narcotics were given.

Dr. Rudner, on cross-examination, admitted that there was some evidence that this man had organic pain, and that other non-narcotic modes of treatment were tried, but he insisted there was clear evidence that he was a drug-seeker and he should have been dealt with differently.

Defence Case

In her testimony, Dr. Arnold told the Committee that this man was a heavy steel worker and had been investigated previously for acute followed by chronic low back pain. Although a myelogram was negative, his plain X-rays showed osteophytes with narrowing of the neural foramina. He had been seen by specialists and since all the usual modes of therapy had been unsuccessful he was on significant doses of codeine.

When Dr. Arnold first saw him she reviewed the previous investigation and treatment and did a complete back examination. Despite some indications from an orthopedist that the pain was largely "functional", she believed that there was definitely an organic basis for the pain and prescribed Percodan, Tylenol #4 and Valium. The drugs were to be taken at the end of the day and at night to enable the patient to continue to work. His complaint was always the same.

In 1987 she referred NZV to a pain clinic but because of domestic difficulties, he was not seen there for over two years. Finally, when he was assessed at a pain clinic in 1990 there was no mention of a drug problem. Dr. Arnold also pointed out that she referred him to an orthopedic surgeon and a neurosurgeon.

Dr. Arnold prescribed the narcotic analgesics, Imodium, and Robidone at various times all for appropriate indications. In her opinion, the patient never demonstrated drug seeking behaviour. Dr. Arnold maintained that the amounts of narcotics used were never excessive in view of the indications and she believed her monitoring was adequate.

On cross-examination Dr. Arnold testified that contrary to the BDD claim that this man was double-doctoring he had obtained drugs from other doctors at her office in her absence. She accepted the BDD position that Fiorinal and Robidon were not justified but she continued to prescribe Valium and Percocet for his back pain.

Again, she claimed that the physical findings could be inferred from the diagnosis of lumbosacral spasm. She agreed that her notes were inadequate.

She also admitted that her letter of referral to the pain clinic did not mention addiction although she counselled him in this regard. She did not follow up the failure of the pain clinic appointment and it was another two years before she referred him again, prescribing narcotic analgesics in the meantime.

She was aware of Dr. FDR's opinion regarding drug addiction and the walk-in clinic designation of the patient as a "narcotic seeker" but she did not see him as a drug seeker as she said he was always truthful about his drug use and he did have pain.

The record shows that between 1983 and 1988 he had more or less chronic diarrhea but she did not investigate this problem. She did send him to an allergist because of the possibility of lactose intolerance.

The defence expert found that there was evidence to support an organic diagnosis for this man's back pain and he did not presume, like Dr. FDR, that the patient had no pain. The pain clinic said he was "disabled by back pain" and was not critical of Dr. Arnold's management. Further, her management of his chronic diarrhea was appropriate. He believed the diagnosis to be irritable bowel syndrome.

Chart 3.5 - WLK

Prosecution Case

Born in 1965, this man attended Dr. Arnold from June 1984 and records were reviewed to August 1990. Diagnoses were back pain, bronchitis and headaches. Narcotics were freely prescribed after April 1989 with only extremely scanty evidence of a physical examination.

Dr. Carulei identified him as a drug seeker on the first visit but prescribed Tylenol #3 and referred the patient to a neurologist because of headaches on the second visit.

Dr. Arnold counselled him about drug addiction in November 1989 and refused to prescribe Percocet but she did prescribe Tylenol #3, Tylenol #4 and Fiorinal C 1/2 regularly until the last visit which was in August 1990 when she refused all medication.

Dr. Barnett's criticism of her management of this man revolved around the lack of a proper assessment of his complaints and the absence of other modalities of therapy not involving the use of narcotics.

Dr. Rudner was struck with Dr. Arnold's lack of resolve in that she had knowledge of the patient's drug seeking behaviour after Dr. FDR so noted in June and July 1989 and she refused narcotics at first but shortly thereafter she relented. This lack of resolve was demonstrated later as well. Finally, she refused to prescribe narcotics and he was not seen again after August 1990.

On cross-examination, Dr. Rudner accepted that there may have been an organic basis for prescribing narcotics but not on a chronic basis. He also acknowledged that the patient's use of narcotics did not increase and that Dr. Arnold made some effort to restrict the amounts However, in his opinion, she knew or ought to have known the patient was a drug-seeker by August 1989, but Dr. Arnold continued to prescribe the drugs.

Defence Case

In her testimony, Dr. Arnold described this young man as unemployed, very anxious and plagued by migraine headaches for a number of years. The headaches had previously been investigated in Timmins. Regular prescription of narcotics began in April 1989. She was unaware of a walk-in clinic visit in April 1989 at which time he was complaining of migraine. She stated that she would not have prescribed further narcotics if she had known the she could not enlist his cooperation. In May 1989 she gave him Tylenol #4 for migraine. He then complained of back pain and she gave him a further prescription for Tylenol #4 for both problems.

In October 1989 she confronted him regarding his failure to attend a headache clinic, although she recognized that he had difficulties travelling. She withheld drugs on that occasion. She arranged for Dr. OPE to see him. A diagnosis of migraine was confirmed and a CT scan was arranged but no treatment recommendations were made. Subsequently, Dr. Arnold again withheld drugs when the patient failed to appear for the CT scan. She made intermittent efforts to have the patient control his medication intake, later refused to give further prescriptions and refused to see him again in August 1990 when she learned of excessive quantities of narcotics having been prescribed by a locum tenens at her office.

On cross-examination, Dr. Arnold acknowledged that she did not receive information from other physicians who might have seen this potentially dangerous man. She surmised that in April 1986 after a motor vehicle accident other information which was not on her chart might have been contained on a welfare form, a copy of which would not ordinarily be in her file. Similarly, it was not clear that there was information about this accident in the black book. On that occasion she treated him with 282 Mep because of cervical muscle spasm. The same month she did a general assessment although there is no record of a physical examination. She asserted that this was always done.

After a three-year hiatus he returned in April 1989 complaining of headache. She admitted that no documents pertaining to the intervening years were obtained. Because of the headache she prescribed Tylenol #3 and later Tylenol #4. Robidone was given for a smoker's cough although this was not noted. No further investigation was done for his headaches, this having been done in Timmins at the age of 13. By June 1989 Dr. FDR made a diagnosis of drug seeking behaviour. Dr. Arnold was critical of Dr. FDR for his failing to listen to his patients and because she thought he believed that lower class patients should put up with pain. Although Dr. FDR initially refused narcotics he eventually did prescribe a limited amount of Tylenol #3. Dr. Arnold resumed the previous medications and dosages when she returned from her holiday. By October 1989 she was refusing to prescribe medications. She faltered in

February 1990. In April 1990 she was counselling regarding drug abuse and refusing narcotics but she was prescribing narcotics again within two months. Finally she refused to see him again in August 1990 after he had obtained medication from a locum tenens physician.

She said she had difficulty knowing whether this man had true pain. Finally, she reluctantly agreed that he was abusing drugs in that he obtained drugs from a locum tenens contrary to her advice in December 1990. She was not certain whether he took narcotics for their psychic effect but she believed that he refused to tolerate any pain.

There was one psychiatric consultation in 1985 and a consultation with Dr. OPE in 1989 but generally he refused referrals.

Dr. Arnold maintained that she monitored this man's drug usage through his mother and the pharmacy and by controlling the amount of medication the patient was given on each occasion.

Dr. Martin supported the use of non-escalating doses of narcotic analgesics for this man because of migraine and at times for a superimposed musculo-skeletal injury.

On cross-examination Dr. Martin had difficulty answering questions regarding the appropriateness of Dr. Arnold's treatment based on the charts since they were generally inadequate. On the basis of Dr. Arnold's testimony he said he found the quality of Dr. Arnold's care adequate.

Dr. Martin did acknowledge that the concomitant use of Tylenol #4 and Fiorinal C 1/2, apparently both for migraine, was an unusual practice, without obvious rationale but without serious consequence.

Chart 3.6 - OCD

Prosecution Case

Born in 1953, this woman was treated for anxiety, cough and fibromyalgia with repeated prescriptions for Talwin, Percodan, Valium, Robidone, Tuinal and Halcion between October 1986 and September 1990. Expert advice was given that these drugs be tapered and stopped but Dr. Arnold ignored this advice.

Dr. Arnold counselled the patient regarding her use of medications but nevertheless continued to prescribe the drugs. No record of any assessments was seen on the record.

Dr. FDR identified the drug problem and recorded advice regarding tapering and stopping the drugs but Dr. Arnold continued to prescribe these drugs without apparent heed to this written advice.

Dr. Rudner, on cross-examination, expressed disapproval of an approach by a pain specialist who saw this woman in 1991 and recommended narcotic analgesics such as Leritine and then Dilaudid, even though she was not taking narcotics at the time. Notwithstanding this consultation letter which defence counsel characterized as validating Dr. Arnold's previous management, Dr. Rudner was clear that the drugs were prescribed in excessive amounts, for no valid reason, and the use of these drugs was not monitored properly.

Defence Case

In her testimony, Dr. Arnold said that this obese, working mother was complaining of pain as a result of a motor vehicle accident several years previously as well as headaches, when she began caring for her in 1986. The patient had been off and on Leritine since the accident. To keep her mobile which enabled her to work and care for her daughter she required Talwin or Percodan, Valium, sometimes sedation at

night, and sometimes Fiorinol C 1/2. Dr. Arnold was not concerned about the patient abusing these drugs, and did monitor their use by frequent visits, and contact with the pharmacist. In 1988 a diagnosis of fibromyalgia was made by a pain specialist. He recommended weaning her from the narcotics. Some effort was then made to diminish the use of these narcotics.

Dr. Arnold defended her use of Ionamin for obesity.

The patient no longer works, having obtained a settlement for injuries sustained in a second accident in September 1988.

Dr. Arnold did not comply with the recommendation of the pain specialist who recommended Leritine and the Dilaudid because of her lack of familiarity with these medications.

Dr. Arnold claimed to "always" examine this woman, and denied prescribing excessive amounts of narcotics, and did monitor drug use. There was never any evidence of drug abuse.

On cross-examination some minor inaccuracies in Dr. Arnold's letter to the BDD regarding this woman were reviewed. Dr. Arnold testified that she monitored the narcotics for this woman through her daughter and through the patient herself. She knew the patient well and considered drug ingestion was not a particular problem. Before she became Dr. Arnold's patient this woman was accused of selling illegal drugs but she was found not guilty. Apparently her boyfriend was the guilty party. In addition it was revealed that this woman's daughter was known to be heavily involved in drug addiction.

Dr. Martin vehemently disagreed with the advice this patient was given in 1988 to stop all analgesics, since he thought she did have pain. He supported Dr. Arnold's practice of prescribing analgesics saying they maintained the patient's ability to work.

Chart 3.7 - CGR

Prosecution Case

Born in 1951, this man saw Dr. Arnold somewhat sporadically starting in May 1983. Her initial assessment was considered quite incomplete by Dr. Barnett and Dr. Rudner. Subsequent notes did not indicate any adequate examination or assessment of his problems and a variety of narcotics and narcotic containing medications and benzodiazepines were prescribed for back pain, migraine and shoulder pain. There was a drug overdose in 1983. By 1987 Dr. Arnold was aware of his use of intravenous cocaine. She recognized he was addicted to narcotics but she continued to prescribe these medications. There is repeated evidence of drug seeking behaviour and in an emergency record of February 1988 he was noted to be a "known drug abuser".

The locum tenens, Dr. FDR, in 1989 was critical of the concomitant use of Talwin, Fiorinal and Valium. He refused to give a further prescription for Percocet, but on Dr. Arnold's return she again prescribed narcotic containing drugs. Later an orthopaedic surgeon advised that the problem was psychogenic but Dr. Arnold continued to prescribe narcotics. She did, at times, limit the prescriptions but this was not done consistently. In 1990 she referred him to a rehabilitation program but on his return she prescribed narcotics and benzodiazepines and there was no follow-up regarding the addiction problem.

On cross-examination, Dr. Barnett allowed that there was some evidence for organicity and that evidence of his use of street drugs and his addiction evolved over a few years. Furthermore, he agreed that, despite the evidence of drug problems mentioned above, prudent administration of narcotic analgesics for a legitimate problem must be considered, albeit very cautiously.

In his cross-examination Dr. Rudner was steadfast in his belief that Dr. Arnold's

management was below the accepted standard of practise. He was concerned with the amounts of the medications used, the lack of an indication for narcotics over an extended period of time, without evidence of a proper assessment or management plan for a man who demonstrated increasing evidence of drug seeking behaviour and who was known to be using intravenous cocaine in April 1989. Despite this knowledge, Dr. Arnold continued to prescribe narcotics. Dr. Rudner acknowledged that there may have been some organic disease but he believed that narcotics should not have been used in the fashion they were.

Defence Case

Dr. Arnold reviewed this man's story of chronic intermittent neck and low back pain and migraine headaches. She believed that he had significant neck pathology in view of an x-ray report of 1983 which showed disc space narrowing and osteophytes encroaching on the neural foramina. She believed that he was unable to work as a painter without narcotics. She never considered that he used narcotics for a reason other than pain relief.

She knew that he used cocaine recreationally but she did not think that he was addicted or that such use would interfere with her management. She said she monitored his drug use by reviewing his situation at each visit, discussing his problems with his spouse and the pharmacist and dispensing his drugs monthly.

This man would have been unable to go to a pain clinic since he did not drive a vehicle. He did, however, see Dr. OPE because of migraine headaches. Dr. Arnold did not accept Dr. TEK's diagnosis of psychogenic pain in November 1988, but she did accept the diagnosis of cervical spondylosis in 1990 made by Dr. HFO.

She attempted to taper his drugs in 1989 to a level which would allow him to function relatively pain free. The amounts of the drugs prescribed, she testified, were never out of proportion to the severity of his pain. Valium was used chronically to prevent violent outbursts and barbiturates were used for sleep at times.

On cross-examination, Dr. Arnold recounted some details of this man's 17 year history of migraine requiring narcotic analgesics. She did not attempt to verify the history by obtaining previous records. She acknowledged knowing he was given Demerol injections several times in emergency departments. He took an overdose of Fiorinal C 1/2 that she had prescribed but she believed it to be an hysterical gesture. She was aware that this man used intravenous cocaine and Dr. Arnold believed that the patient was a drug abuser but she testified that his abuse of drugs was for the purpose of pain relief.

Dr. Arnold was cognizant of Dr. FDR's concern regarding drug addiction but she continued to prescribe these drugs because she believed she knew the patient better. When confronted with information in this man's office record, including repeated HIV tests because of intravenous drug use, notes from other physicians saying "known drug abuser," "buys Talwin and other drugs and injects IV", "very suspicious for drug seeking behaviour" and other references to intravenous cocaine use, Dr. Arnold was steadfast in her assertion that this man was not a drug seeker but needed narcotics because his pain either from headache or cervical spondylosis required them. She prescribed Valium in 1986 because she had noted that patients coming out of drug rehabilitation programs were often given Valium. It was also used for sleep and to control anger. She said there was no need for a psychiatric referral. In 1989 Dr. SYS said his pain was psychogenic but she rejected that impression. Finally, however, she did admit that he was a cocaine addict in August 1990.

She surmised that the lack of any evidence of a physical examination after a motor vehicle accident in 1987 represented that absence of physical findings.

Dr. Martin again found evidence of the uncertainty of physicians in assessing the subjective complaint of pain with this patient. Many other physicians were suspicious that he was a drug seeker but nevertheless prescribed narcotic analgesics. He thought Dr. Arnold was in a better position than anyone else to assess his pain. He said this man had organic pain (left shoulder tendonitis and migraine) and treatment with narcotic analgesics and other agents was appropriate. That he was a street drug user, he said, should not preclude appropriate pain management.

Chart 3.8 - VAN

Prosecution Case

The chart (from October 1989 to June 1990) for this woman, born in 1948, was reviewed. The patient was given Fiorinal C 1/2 for migraine without any evidence of adequate assessment. There was some evidence of drug seeking behaviour. Eventually Dr. Arnold stopped seeing her when she was informed by the RCMP that the patient was double-doctoring.

Dr. Rudner believed that Dr. Arnold exercised poor judgement on the basis of the lack of a satisfactory explanation for her management in the medical record. He stated that this case represented professional misconduct because it demonstrated that Dr. Arnold was following a pattern of being duped by drug seekers.

Defence Case

Dr. Arnold testified that this woman came to her on the recommendation of a pharmacist for Fiorinal C1/4 because her family doctor would not prescribe this drug for migraine. The patient had established migraine and had been seen by a neurologist whom Dr. Arnold attempted to contact. Dr. Arnold "totally believed" this patient who had a typical story. She prescribed six Fiorinal C 1/2 for each headache approximately monthly. She was astounded to find that this woman had used about ten doctors to

obtain a supply of medication.

On cross-examination, Dr. Arnold revealed that she did not contact the family doctor at the request of the patient and that she did not contact a neurologist who had seen the patient, and she did not contact the pharmacist. Dr. Arnold was unwilling to acknowledge that she *concealed* information from the family doctor. She did acknowledge, however, being totally duped by this woman because of her standing in the community. According to her understanding of the concept of drug seekers, she believed that VAN was the only one of eleven patients who demonstrated such behaviour.

Dr. Martin testified that be believed that Dr. Arnold's management of this woman was appropriate both with regard to the amounts of analgesic given and the indication. Furthermore, he found no problem with her not contacting the family physician because the patient would not consent. The patient imposed terms on her treatment and the doctor accepted these terms. He said that Dr. Arnold did not fall below the standard. Dr. Martin found it acceptable to take on partial care of a patient such as in this situation.

Chart 3.9 - XCB

Prosecution Evidence

Chart entries for January 1985 to November 1989 were reviewed for this man who was born in 1958. He was treated for back pain for which Dr. Barnett acknowledged there was some possible organic basis, with Fiorinal C 1/2, Talwin, Percodan and Tylenol #4. Dr. Barnett hesitatingly admitted the records were probably not below the standard but was clear that the choice of medications and the quantities given were not appropriate. He said that Dr. Arnold failed to respond to warning signs of abuse and drug seeking behaviour, such as an emergency room report which indicated "does barbiturates, benzodiazepines daily, plus or minus alcohol recently" with the diagnoses

of seizure disorder, street drug and alcohol abuse in 1986. Dr. Barnett testified that her monitoring of the response to the drugs and the progress of his condition was substandard.

Dr. Rudner acknowledged, on cross examination, that there was some organic basis for this man's pain as reflected in two specialists' reports, but he said that potent drugs must be used only when other approaches have failed. Secondly, the amount of drug given must be tailored according to the severity of the pain. Narcotics should be used only for short term treatment.

He testified that it was clear that he was a drug seeker at the latest in June 1986 when he was admitted with a seizure. Subsequently, Dr. Arnold counselled the patient regarding his taking too many pills but she continued to prescribe Talwin.

Defence Evidence

Dr. Arnold testified that this man who was a carpet layer already had established chronic low back pain before she assumed his care. She believed that there was an organic basis for his pain because a 10% scoliosis presumably due to muscle spasm was described on an X-ray. She prescribed Talwin with instructions to use the drug sparingly (one or at the most two per day). The patient was assessed by specialists, and other modalities of treatment were tried. Although there was scant evidence in the medical record of a physical examination, these were done routinely according to Dr. Arnold's testimony.

On his release from jail in 1986, he requested a prescription for Percodan, which she gave him because he said it had been helping.

Dr. Arnold reviewed the history after XCB was admitted because of a seizure. She believed that he had not had a seizure but that the problem resulted from a fight with his girlfriend. She had not prescribed the benzodiazepine or the barbiturate described

in the emergency note. The patient denied using street drugs.

On his release from jail a second time, she complied with the patient's request for Talwin.

Finally, she terminated the relationship when she read in a newspaper that he had broken into a pharmacy.
She complied with his requests for Percodan and later Talwin on his discharge from jail without seeking medical records. She did not obtain records from his previous physician.

After the admission because of a seizure in 1986 she disagreed with the emergency record note indicating "street drug and alcohol abuse". Although there is no mention of a confrontation with XCB in her record she did recall such a discussion. She concluded from this discussion that he was not abusing drugs. That he was polite, well dressed and never demanded drugs contributed to this belief.

Dr. Martin asserted that Dr. Arnold's management including investigation referrals and treatment of this patient was appropriate and acceptable. His jail experiences do not constitute a contraindication to narcotic analgesics. That he attended a chiropractor is support for the fact that the patient did have pain since these practitioners do not prescribe drugs.

Chart 3.10 - QIP

Prosecution Evidence

Dr. Arnold's office records on this man born in 1960, from 1985 to September 1990 were reviewed by Dr. Barnett. During this interval there were periods of time when Dr. Arnold saw him frequently for a variety of complaints. Benzodiazepines were prescribed for anxiety. Narcotics, sometimes two at a time, were prescribed for no apparent reason and at other times for inappropriate reasons. Another physician diagnosed benzodiazepine addiction in 1987. These drugs continued to be prescribed by Dr. Arnold subsequently. In July 1988, another locum tenens diagnosed drug addiction and developed a plan to stop the drugs but, shortly thereafter, Dr. Arnold prescribed Talwin, Valium, Fiorinal C 1/2. In 1989 Dr. Arnold became aware that another doctor had been prescribing medications and she counselled him with regards to "too many pills". However, she continued to prescribe the medications regularly, albeit with some control, without any investigation regarding their need and without any apparent medical foundation.

On cross-examination Dr. Barnett allowed that there was some recognition of a problem and some effort on Dr. Arnold's part to restrict and control the drugs this man was given.

Dr. Rudner found no documentation to suggest a chronic problem requiring narcotic analgesics. Acute lumbosacral sprain diagnosed by Dr. OPE does not justify long-term treatment. There is a discharge summary in Dr. Arnold's file dated July 1988 at which time Talwin abuse was suggested but there is no evidence that she discussed this matter with the patient. After this admission she continued to prescribe a combination of three potent and addicting drugs at the same time. There was no effort to seek specialist help.

Defence Evidence

In her testimony, Dr. Arnold acknowledged having seen this man many times due to neck and back pain as a result of two motor vehicle accidents and aggravated by his work as a truck driver, a painter or garbage collector. He required narcotics (Fiorinal C 1/2, Talwin and Darvon) in order to work. He took Valium, 30 mg. per day chronically

after he had been weaned from cocaine several years earlier.

In 1989 a locum tenens physician diagnosed benzodiazepine addiction and weaned him from Valium. The patient developed an abnormal heart beat and Dr. Arnold re-prescribed Valium. She was not concerned about addiction and believed he needed Valium and that he was using the drug responsibly.

In November 1987 Dr. Arnold began prescribing Talwin Compound for back pain which was continued until he was admitted because of a seizure in July 1988. In hospital on no medications, back pain was not a problem. She surmised that the absence of pain was because he was not working. The possibility of Talwin abuse was mentioned in the discharge note by a locum tenens. This physician discussed tapering the drugs after discharge and arrived at a plan with the patient. However, Valium and Talwin Compound were prescribed again when Dr. Arnold returned to her practice apparently because the patient had started work as a garbage collector and needed the medication in order to work.

In January 1989 he asked for Dilaudid but Dr. Arnold refused. She was giving prescriptions on a weekly basis. Shortly thereafter she added Fiorinal C 1/2. By the fall of 1989 she was urging this patient to reduce and later stop his narcotic medications which at that time included narcotic and benzodiazapine medications amounting to Valium 40 mg. per day, Talwin, 200 mg. per day and Codeine, 120 mg. per day in the form of Fiorinal C 1/2.

In January 1990 he went to the emergency department seeking drugs and was identified as demonstrating "likely drug seeking behaviour". Dr. Arnold, however, testified that he was not a drug seeker, that he needed the drugs in order to work. He had agreed to diminish his use of narcotics. She continued to prescribe narcotics and told him she would stop prescribing these medications if he sought drugs elsewhere. This, in fact, occurred in September 1990 and she refused to deal with him further at that time.

On cross-examination, Dr. Arnold acknowledged that she would have been cautious with this man with regard to addicting drugs in view of his previous history of cocaine addiction. However, she said she found it necessary to prescribe these medications for injuries in order to keep him working. She did discuss the problem with him on occasion. She pointed to one entry, September 7, 1988 where she noted that there was "a long discussion regarding pain and treatment". She denied he was addicted to benzodiazapines.

Although he was not a drug seeker at the beginning of his involvement with Dr. Arnold, she agreed that he was a drug seeker by the time she terminated the relationship.

Dr. Martin testified that this man had both low back pain with some evidence of nerve root irritation and headache. The patient's use of analgesics was not excessive (within his limit of 12 per day). There are a number of instances when Dr. Arnold refused the medication and counselled him regarding drug abuse.

Chart 3.11 - PPE.

Prosecution Evidence

Chart entries from February 1986 to August 1990 were reviewed for this woman. Starting in January 1989 the patient was given Percocet regularly for back, neck and abdominal pain with no specific diagnosis or attempt to discover a diagnosis until March 1990 when for unknown reasons the drug was no longer prescribed. In 1992 she was diagnosed as having thoracic outlet syndrome but Dr. Barnett was not deterred from his belief that the assessments were inadequate and there was no documented indication for prescribing Percocet.

Dr. Rudner believed, on the basis of the clinical record, that this woman was given

Percocet for abdominal pain for which there was no organic diagnosis as well as back pain. He said that the dose was not excessive but that the history and physical examination were inadequate and that treatment with a narcotic before trying other types of treatment was inappropriate. He recognized that the patient was ultimately operated on in 1992 because of the shoulder pain but this did not appear to be the reason for prescribing Percocet.

Defence Evidence

In her testimony, Dr. Arnold maintained that this woman needed the small doses of Percocet in order to work as she was the sole breadwinner in the family. Her problems were shoulder and low back pain and lower abdominal pain. Dr. Arnold was reluctant to refer her to a specialist in Kitchener because she predicted that this specialist would advise her not to work because of the overuse syndrome. Codeine caused gastric upset but the patient eventually found that Percocet was tolerated at a dose of three per day all of which were taken after work.

Other modalities of therapy were either tried and abandoned or ongoing. By August 1990 the patient was not taking Percocet. Subsequently she referred the patient to a local orthopedist whose treatment was ineffective. Because she thought the patient had thoracic outlet syndrome she referred the patient to another out-of-town specialist who concurred and an operation was subsequently successfully performed.

Dr. Martin pointed out that this woman represents another example of an apparent drug seeking individual who eventually was found to have an organic diagnosis. The patient required narcotic analgesics in order to work and she is now pain free. He concluded that Dr. Arnold's management was appropriate.

Defence Witnesses

1) A colleague of Dr. Arnold's who is an uncertified obstetrician praised Dr.

Arnold's practice of medicine, her diagnostic work-ups, and the appropriateness of referrals. He was impressed with her popularity with her patients.

2) A pharmacist who has a pharmacy in the same building as Dr. Arnold testified that she writes approximately 30 prescriptions a day, accounting for 20 percent of his prescription business. He said her use of narcotic analgesics would be considered normal. She restricts quantities and doses and is generally more cautious than the average physician. She is not an over-prescriber, in his opinion. He has frequent communications with her.

On cross-examination, prosecution counsel established a previous business relationship between the pharmacist and Dr. Arnold and her husband. Subsequently both the pharmacist and the Arnolds moved to another building across the street.

3) BPU, a long-term patient of Dr. Arnold's testified as to Dr. Arnold's care. Dr. Arnold has been cautious with regard to narcotic analgesic drugs and advises other modalities of therapy initially. When narcotic analgesics are necessary, Dr. Arnold monitors these drugs carefully.

4) PPE (formerly S.W. 3.11). This woman testified regarding her work related injury. She told the Committee that Dr. Arnold identified work as the cause of her pain and arranged for restricted activities at work. Eventually, after PPE determined that her husband's Percocet was effective she was given Percocet by Dr. Arnold. This enabled her to continue to work. Eventually, however, she had to stop working and ultimately she underwent successful surgery. Dr. Arnold has been attentive and not hurried and has examined her every two weeks.

5) NZV 3.4. This man testified regarding his 15 year history of low back pain

related to injuries. He reviewed the various modalities of treatment which have been used. He requires Percocet t.i.d. and Valium, 10 mg. t.i.d. to make the pain tolerable. He acknowledged that some specialists have advised him to use less medication. The Pain Clinic however, did not advise him to diminish his use of narcotic analgesics. This patient has been seen by Dr. Arnold weekly over the past 12 years. Approximately every three to four weeks, he said Dr. Arnold does a physical examination of his back including range of motion, a sensory examination and an assessment of reflexes. He said she has discussed the careful and prudent use of the medications with him on numerous occasions.

6) QSW, a secretary in Dr. Arnold's office testified that on occasion she has entered various measurements into the black book for patients of Dr. Arnold's where there is a medicolegal issue. No other information was recorded in the book. Dr. Arnold used this information to draft letters to lawyers. These black books could not be found.

7) A book of solicited and unsolicited letters of reference from patients and colleagues was submitted by defence counsel.

PROSECUTION ARGUMENT

Prosecution counsel submitted that Dr. Arnold was guilty of all of the allegations. He suggested that her responses to these allegations were excuses, half truths, fanciful recollections and intentional deceptions. He submitted that Dr. Arnold repeatedly tailored her evidence according to the circumstances. Her practise has all the hallmarks of a practise involving unacceptable use of narcotics with an additional "commercial element."

Records Failure

Prosecution counsel submitted that Dr. Arnold claimed to have been unaware of the obligation and purpose of medical record keeping, although she claimed to have read the College Notices in this regard. At the hearing it became evident she was unaware of their meaning.

He submitted that she failed in several areas with regard to record keeping: there was no evidence of a history or physical examination or of a diagnosis supportive of the use of narcotic analgesics; there were scanty or non-existent cumulative profiles of the patients' problems or of their drug treatment; there was no treatment plan; and, there was no attempt to produce continuity by obtaining previous physicians records.

All of the experts agreed that her records were deficient.
The use of the black books, a record separate from her medical file is unacceptable, as is their destruction before the mandatory period has elapsed.

Falsifying Record, Contravening Law

Prosecution counsel submitted that the evidence in support of this allegation is incontrovertible. Dr. Arnold, having seen the patient on five previous occasions within a short period, could not have forgotten or overlooked the previous injury and she was quite accustomed to completing these forms. Clearly, he submitted, she either submitted a false report or contravened the law.

Standards Failure

Prosecution counsel submitted that there can be little doubt that the care provided by Dr. Arnold is substandard. With regard to patient VAN, 3.8, he characterized her taking on this patient and agreeing to conceal the information from her family doctor as a "breathtaking disregard for proper professional conduct. Unacceptable and discreditable". Dr. Martin's support for this behaviour undermines his credibility and his opinion regarding the standard of practice.

Prosecution counsel reminded the Committee of the CPSBC guidelines which indicate that if narcotic analgesics are chosen for the management of chronic non-malignant pain their use must be careful and prudent with staging and goals. This approach was clearly not taken by Dr. Arnold.

Improper Prescribing or Disgraceful, Dishonourable or Unprofessional Conduct

Prosecution counsel admitted that these allegations overlap, to some extent, with the standards allegation. He submitted that Dr. Arnold made no attempt to treat with non-narcotic antitussive agents. Narcotics seemed to have been prescribed as first line drugs and for prolonged periods. There was no monitoring. There was usually no attempt to deal with drug seeking or if efforts were made to reduce the dose they were half-hearted and inconsistent. Documented third party concerns regarding drug use were ignored.

He submitted that the statement, "I believed my patient" was repeated like a mantra as an explanation for prescribing these drugs. There is clear evidence of the totally unrestricted prescription of narcotics and abuse of her authority conferred by the legislation to prescribe these drugs.

Incompetence

Prosecution counsel submitted that there is evidence of incompetence on the basis of the practice pattern of Dr. Arnold in prescribing narcotic analgesics and other habit forming drugs.

DEFENCE ARGUMENT

At the outset of his closing submissions defence counsel attempted to put these eleven cases in context. Sixty-two charts were selected from the BDD list and only

eleven were said to have fallen below the standard by the prosecution experts. He said these eleven cases are not representative of her 6,000 patient practice. They were exceedingly difficult patients. Furthermore, none complained to the College and there is no evidence of any harm.

He submitted that there were no obvious drug seekers among this group and only one of the eleven patients clearly abused drugs. To make a finding against Dr. Arnold, he submitted that the Committee must conclude that she had wilfully or blindly catered to drug seekers. The Committee must avoid easy inferences and retrospective reviews. He said whether these patients required narcotic analgesics was a matter of judgment, and in such a situation, the Committee must give the benefit of the doubt to the doctor.

He reviewed what he considered to be some principles of the management of chronic intractable pain. It is the highest ethical responsibility of a physician to relieve pain. Pain may be due to indefinable organic causes. In such a situation a physician must exercise judgment in making a diagnosis and in deciding on treatment. In so doing, the physician may presume that the patient is telling the truth unless there is very clear evidence to the contrary. This management may require long-term narcotic analgesics and the defence expert testified that such prescribing does not breach the standards. Furthermore, the law [Re: Brett v. Board of Directors of Physiotherapy (1991), 77 Q.L.R. (4th) 144 (Ont. Div.Ct.) aff'd (1993) 104 D.L.R. (4th) 421 (C.A.)]. indicates that where there is a substantial minority of respected opinion a finding of misconduct cannot properly be made. Defence counsel also maintained that the CPSBC document endorsed this approach. He went on to say that there is great difficulty in distinguishing between genuine pain and the pain claimed by drug seekers. There is also blurring of a distinction between addiction and therapeutic dependency. Specialists have a specific but limited role in chronic pain management. Psychiatric patients may also have organic pain. Finally, long-term benzodiazepine treatment is warranted in some patients.

Defence counsel submitted that Dr. Arnold exercised her judgment regarding management of these patients based on her knowledge of the patients, not as demonstrated by the charts, but by her testimony. She maintained that she did proper examinations and this was confirmed by the testimony of the patients and the letters to lawyers. She believed the patients had real pain. The specialists largely supported her management. However, they were not of great assistance in helping her to distinguish true physical pain from psychosomatic pain.

Further support for Dr. Arnold with regard to the standards allegation can be seen in the fact that the BDD accepted her explanations for most of the patients and it did not restrict her narcotic prescribing privileges.

Defence counsel acknowledged deficiencies in her charting of these eleven patients and he said she has now amended her practices. He said these charts are not reflective of her practice as evidenced by the fact that 51 charts were passed as adequate by the prosecution experts.

She was criticized by the prosecution experts for not using other modalities of therapy. However, she is a large user of NSAID's, there was a physiotherapy facility at her office, and she said she used a "ladder approach" to prescription of narcotic analgesics. A specialists' opinion was often sought.

In response to the criticism that excessive amounts of narcotic analgesics were prescribed, counsel for Dr. Arnold asserted that the College experts were vague in their testimony but that Dr. Martin set the limit at 12 opioid containing pills per day which is the same standard set out in the CPSBC document.

Defence counsel submitted that Dr. Arnold's monitoring of the use of these drugs was adequate. She questioned the patients regarding their responses and side effects. There is no evidence that any of the patients became addicted. She did warn her patients regarding the dangers of these drugs and was reluctant to prescribe them.

She saw the patients regularly and knew them well. She often counselled her patients regarding abusive drugs. The patients and the pharmacist supported her testimony. Defence counsel maintained that all the hallmarks of careful monitoring are present.

Defence counsel addressed the prosecution allegation that Dr. Arnold lied. The controversy regarding different stories given regarding IPA he said were simply due to the faultiness of her memory. Prosecution counsel had raised suspicion that the black books did not exist but the secretary's evidence and the existence of the lawyers letters composed on the basis of information in the black books support Dr. Arnold's statement regarding these books.

Defence counsel submitted that the allegation regarding the blank box on the WCB form was a reckless allegation of fraud. It is much more likely she overlooked this box or considered it not relevant than that she purposely left it blank. Furthermore there was no motive. Finally, the term "falsified" implies a positive false statement with intention.

Defence counsel cited the following examples where he said the prosecution experts and witness were not fair:

1) They were far more certain regarding drug abuse than Dr. Martin or the clinicians who dealt with the patients;
2) These experts assumed that the patients were drug seekers and interpreted ambiguous behaviour from this perspective;
3) Although there was at least a plausible organic basis for the pain in each case the prosecution experts chose to believe that there was no organic basis. They relied entirely on the admittedly deficient charts. They assumed that if a record for a physical examination was not in the chart that the examination was not done. These experts back-tracked on cross-examination when confronted with the possibility that Dr. Arnold might have performed appropriate assessments but did not record them;

4) Drug seeking behaviour, which in fact represents only a suspicion of drug abuse, was assumed by these experts to represent de facto evidence of abuse;

5) Street drug use and drug overdoses do not in themselves preclude the presence of organic pain and the need for narcotic analgesics;

6) Dr. FDR should be discredited because of his exceedingly low threshold for suspicion of drug abuse. He developed only a cursory knowledge of these patients and quickly concluded that they were abusers;

7) These experts failed to give Dr. Arnold the benefit of the doubt. For example, they assumed that Dr. Arnold was dishonest regarding the blank box in the WCB form or that she fabricated her findings based on the information in the black book for the lawyer's letters.

Dr. Martin, he said, gave cogent evidence in support of Dr. Arnold's approaches. He said that Dr. Martin represents a "responsible and competent body of professional opinion", (re Brett) and the Committee ought not to make a finding that she fell below the standard of practice of the profession. Furthermore a guilty finding would have a chilling effect on the use of narcotic analgesics in the province.

Defence counsel submitted that should the Discipline Committee find Dr. Arnold guilty of falling below the standard, it cannot find her guilty of improper prescribing or disgraceful, dishonourable or unprofessional conduct on the same facts.

He submitted, as well, that even if the Committee finds Dr. Arnold guilty of falling below the standard, it should not make a finding of incompetence. The only areas of debate relate to the narcotic prescribing practices and the records. The inadequate charting should not cause the Committee to find her to be incompetent, nor should improper prescribing of narcotic analgesics be extrapolated to her entire practice. The prosecution experts were not asked regarding her general level of competence. There is no evidence of missed pathology. Defence witnesses indicated, in fact, an exemplary practice.

ADVICE FROM COUNSEL OF THE DISCIPLINE COMMITTEE

Independent legal counsel to the Discipline Committee rendered advice regarding matters of law. He clarified the defence counsel's statement that to make a finding of guilt the Committee must find that there was no basis whatsoever for Dr. Arnold to exercise her judgment and prescribe narcotic analgesics. The counsel for the Discipline Committee advised that the Committee should consider all the evidence, weight the credibility of the witnesses and then determine whether the evidence regarding the standards supports Dr. Arnold's prescribing practices.

Second, he commented regarding the defence counsel's statement that the prosecution experts did not establish the standard for the maximum dose of narcotic analgesics. He advised that the Committee must first determine from the evidence whether the College did establish objective standards. If the Committee decides that the standard was established, it then must decide if her practise fell below the standard. If the Committee decides that the standard was not established it is still open to the Committee to decide whether there was over-prescribing based on the evidence of the experts.

Third, with regard to allegations #2 and #3, the important issue that the Committee must determine is whether there was a mindful attempt to deceive.

Fourth, with regard to the allegation of incompetence, the **Act** states that the finding must relate to a patient, not that the doctor must be found to be generally incompetent in her practice.

DECISION

The Committee carefully considered the evidence presented at the hearing. The law as it applies in this case was considered as was the credibility of the various witnesses.

First Matter (Records Failure)

There was little doubt that Dr. Arnold failed to maintain records as required under Section 29 (1) of Ontario Regulation 448/80 as amended. Dr. Arnold did not adequately record the history, the physical findings, the investigations, the diagnosis and treatment. This failure was more than marginal, and, in fact, glaringly obvious. All the experts, both prosecution and defence, and Dr. Arnold herself admitted to this deficiency. The Committee therefore found these allegations proven.

Second Matter (Falsifying Record)

The Committee accepted Dr. Arnold's explanation for neglecting to fill in the box on the W.C.B. form for QAE (chart 3.3). The form appears to have been completed in haste as is so often the case with forms. There could have been little hope for significant benefit to the patient and the claim was subsequently rejected. The Committee believes there was no intention to deceive. There was neither evidence to suggest collusion or any prespect of personal gain for Dr. Arnold.

Third Matter (Contravening Law)

The Committee accepted Dr. Arnold's explanation for neglecting to fill in the box on the WCB form. The form appears to have been completed in haste as is often the case with forms. There was no evidence of an intention to deceive. There could have been little or no hope of significant benefit for the patient. There was no evidence to suggest collusion or any prospect of personal gain for Dr. Arnold.

Similarly, the Committee found that Dr. Arnold did not intentionally submit a false report, and consequently did not contravene the law.

Fourth Matter (Standards Failure)

The Committee found the Dr. Arnold failed to maintain the standard of practice of the profession. In some, but not all, of these patients she prescribed narcotic analgesics and other habit forming drugs, apparently as first line drugs, sometimes more than one narcotic analgesic concomitantly, often in large doses and with little sustained effort to reduce the dosage. Commonly, diagnoses were vague or unsubstantiated.

Generally, she did monitor the patient's drug dosage by frequent visits and she almost always recorded the number of pills prescribed. The allegation of failure to monitor her patients appropriately was found not proven.

She appeared both in her practice and in the hearing to have little understanding of drug seeking behaviour. Examples are set out below.

She did become aware of drug dependency with some patients. However, she either attempted to reduce or taper their drug use without consistent resolve, or if their drug seeking behaviour involved deceit she dismissed them from her practice.

Chart 3.1 - IPA

This woman, who had overwhelming psychosocial problems was already taking regular and significant quantities of narcotic analgesics when Dr. Arnold took over her care. There was probably no organic basis for her back pain. Dr. Arnold was well aware of her excessive use of narcotics. She was aware of her therapeutic dependency. She was elated at the prospect of an admission to a Treatment Centre. Poor documentation precludes assessment of Dr. Arnold's thoughts at the time she was caring for the patient. Dr. Arnold did seek the advice of specialists who focussed on the psychogenic aspects of her problems and could find little to substantiate an organic diagnosis. Dr. Arnold had great difficulty in communicating with the attending psychiatrist.

The Committee believes that IPA's care was not up to the standard, but that Dr. Arnold's obligations were made difficult to fulfil by the lack of communication with the psychiatrist and by the magnitude of the patient's problems. However, there was little or no recognition on Dr. Arnold's part of the patient's problems with drugs. She seemed impelled to prescribe narcotics for virtually any reason. She made no attempt to grapple with the problem. She did appear to monitor the drug use but failed to take any action.

The Committee concluded that Dr. Arnold failed to meet the standards of practice of the profession with respect to the care of this patient. The Committee therefore found Dr. Arnold guilty of the standards failures set out in paragraphs 13(a), (c) and (d) for this patient.

Chart 3.2 - LWP

LWP was also taking narcotic analgesics when she entered Dr. Arnold's practice and there were significant psychosocial problems. The patient was seen by at least three consultants who believed her pain was primarily psychogenic. Dr. Arnold failed to pay heed to the Pain Clinic consultant regarding tapering the narcotic analgesics. Dr. Arnold repeatedly gave the patient large quantities of narcotic analgesics over at least three years without a specific diagnosis for various complaints, and with little attempt to grapple with her exceedingly complicated problems.

Monitoring of her condition and drug treatment was frequent but, again, nothing came of the monitoring. Drug seeking was clearly evident but no attempt was made to deal with such behaviour or with the patient's dependency.

The Committee therefore concluded that in her apparently thoughtless management of LWP the doctor's care was clearly below the standard. Specifically, particulars in paragraphs 13(a),(c) and (d) were proven.

Chart 3.3 - QAE

This man was not addicted to drugs on entry into Dr. Arnold's practice, but by the time she discharged him from her practice he was using street drugs, clearly demonstrating drug seeking behaviour, and he was using large quantities of narcotic analgesics and narcotic anti-tussive drugs, prescribed by Dr. Arnold, without control.

Dr. Arnold did refuse to prescribe narcotic analgesics and ultimately dismissed the patient from her practice after he refused to comply with the recommendation that he have a CT scan. However, it appears that this dismissal occurred only after inquiries of the BDD regarding her narcotic prescribing practices. The Committee found that with regard to this man, Dr. Arnold also fell below the standard of practice of the profession. Particulars in paragraphs 13(a),(c) and (d) were proven.

Chart 3.4 - NZV

This man, as well, was on narcotic analgesics at the time that Dr. Arnold accepted his care. Dr Arnold appears to have recognized drug addiction in this man and she counselled him. Efforts to have him attend a pain clinic were desultory. Despite consultants' opinions regarding the nature of his pain, Dr. Arnold continued to prescribe large quantities of narcotic analgesics. From the records, there is scant evidence of physical examinations although both Dr. Arnold and the patient claimed these were done frequently. Dr. Arnold failed to deal definitively with this man's problems and was complicit in continuing his narcotic use without adequate indication. There was clear evidence of drug seeking behaviour and drug dependency, which Dr. Arnold appears to have recognized, at least at one time, but she managed the problem in only the most casual of ways. In view of the consultants' advice and the evidence at the hearing, the Committee did not accept Dr. Arnold's view that this man had undeniable organic pain. The Committee found that Dr. Arnold fell below the standard with regard to management of this patient. It therefore found that the particulars in paragraph 13(a),(c) and (d) were proven.

Chart 3.5 - WLK

Dr. Arnold appeared to become aware of this man's drug abuse in 1989, especially after he saw Dr. FDR, but while occasionally refusing to prescribe she generally continued to prescribe drugs for various reasons. Finally, when it became clear that he was not cooperating with her plan, she dismissed him from her practice in August 1990, again after she knew of the BDD inquiries.

The Committee found that Dr. Arnold fell below the standard in her care of this man as, once again, she failed to deal with his problem with drugs even though at times she appeared to recognize it. It therefore found that the particulars in paragraph 13(a),(c) and (d) were proven.

Chart 3.6 - CGR

This woman was also taking narcotic analgesics before becoming Dr. Arnold's patient. Dr. Arnold continued to prescribe these medications even after a pain specialist made a diagnosis of fibromyalgia and advised a treatment plan which included stopping Talwin. This woman did not definitely demonstrate drug seeking behaviour but used excessive quantities of narcotics. Dr. FDR left another plan to reduce the narcotic use in the office record in 1989, but this plan was ignored. No clear indication for continued narcotic prescribing was given. The Committee believes that this patient, as well, represented a pattern of mindless prescription of narcotic analgesic drugs for a patient with drug dependency. Doses were excessive with no valid reason. Dr. Arnold failed to deal with the patient's drug use and dependency. The particular in paragraph 13(a) was proven. Dr. Arnold fell below the standard of the practice of the profession.

Chart 3.7 - OCD

The evidence was clear that this man was given large amounts of narcotics for inadequate reasons. Dr. Arnold ignored the advice of several specialists and Dr. FDR. She appeared to choose the diagnosis of specialists that could support the use of narcotic drugs. She continued to treat this man with narcotic analgesics without attempts to deal with the underlying problem. This man abused street drugs and demonstrated numerous examples of drug seeking behaviour. Again, Dr. Arnold was found to have clearly fallen below the standard. Particulars in paragraph 13(a),(b) and (d) were proven.

Chart 3.8 - VAN

Dr. Arnold admitted being duped by this patient who was the only one of eleven patients who she believed, in retrospect, demonstrated drug seeking behaviour. The Committee believes that Dr. Arnold's major fault with regard to this patient lay in her accepting the patient into her practice for the sole purpose of prescribing Fiorinal C 1/2 for migraine headache when the family doctor had refused to prescribe this medication. In addition, she agreed not to inform the family doctor. This behaviour was not included in the allegations but the Committee was shocked by the breach of ethics.

The quantities of Fiorinal C 1/2 prescribed were not considered excessive. However, Dr. Arnold clearly failed to recognize drug seeking behaviour when it should have been obvious, thereby reflecting her complete lack of understanding and/or concern regarding narcotic drug use and her seemingly wilful urge to prescribe these drugs. The Committee found that the particular in paragraph 13(c) was proven.

Chart 3.9 - XCB

Dr. Arnold willingly complied with this man's request for potent narcotic analgesics. The patient abused street drugs and alcohol. Dr. Arnold counselled him regarding drug abuse, but continued to prescribe narcotics. Dr. Arnold prescribed potent narcotics without adequate determination of the nature and the cause of this man's complaints. There was some monitoring. He was recognized by others as a drug seeker but Dr. Arnold appeared to be blind to the possibility that he was seeking drugs for non-medical reasons. The Committee found that the particulars in paragraphs 13(a),(c) and (d) were proven.

Chart 3.10 -QIP

Again, Dr. Arnold appears to have become aware of a problem with drug abuse and counselled the patient, but she continued to prescribe the medications. The man was known to have been addicted to cocaine previously. In addition to Valium, two narcotic analgesics were prescribed concomitantly. Dr. Arnold acknowledged that the patient became a drug seeker by the time she terminated the relationship. The care of this man was found to be sub-standard. Dr. Arnold lacked steadfastness and failed to carry out a treatment plan. She prescribed narcotics usually willingly and without proper foundation. She monitored the patient's drug use by frequent visits. She may have been aware of his problem at times but failed to deal properly with his dependency. The Committee therefore found that the particulars in paragraph 13(a),(c) and (d) were proven.

Chart 3.11 - PPE

This patient appeared to require narcotic analgesics for the over-use syndrome and she had to continue to work. Narcotic analgesics in limited quantities were prescribed for a limited period of time (15 months). There was no evidence of drug seeking behaviour. Although this patient ultimately had an organic diagnosis and is now not taking narcotic analgesics, she was handled in a similar fashion to other patients. Although this woman was given narcotic analgesic drugs for a limited time and

eventually stopped the drugs, Dr. Arnold's pattern of prescribing potent analgesic drugs without adequate justification was repeated. The patient did not demonstrate drug seeking behaviour or dependency.

The Committee found that Dr. Arnold fell below the standard in regard to the particular in paragraph 13(a).

Fifth Matter (Improper Prescribing)

3.1 IPA

For the reasons indicated above the Committee found that Dr. Arnold abused her authority to prescribe narcotics and other habit forming drugs (Particular 14). Second, she should have known that this woman was a drug seeker and willingly prescribed all kinds of drugs on request or demand without adequate reasons. Dr. Arnold was advised by several physicians that IPA was dependent on drugs and she failed to involve herself with the problem (Particular 15).

3.2 LWP

Similarly, the Committee, found Particulars 14 and 15 proven with regard to LWP

3.3 QAE

Particulars 14 and 15 were proven. Dr. Arnold improperly prescribed narcotic analgesic drugs for this patient. He was getting drugs from other sources and she ought to have been aware of this. She did terminate the relationship but only after she became aware of his drug problem after six years and after the letter from the BDD concerning other patients.

3.4 NZV

The Committee found Particulars 14 and 15 were proven for the reasons stated above.

3.5 WLK

Dr. Arnold abused her authority to prescribe narcotics; she became aware of drug seeking and she did not respond appropriately on several occasions. Thus, Particulars 14 and 15 were proven.

3.6 CGQ

No adequate reason was found for the continued use of narcotics for this woman and the Committee found that Dr. Arnold abused her authority. Dr. Arnold was advised to reduce the patient's medication but she did not. There was no definite evidence of drug seeking and thus only particular 14 was proven.

3.7 OCD

Particulars 14 and 15 were proven.

3.8 VAN

Dr. Arnold's improper prescription of narcotics in this patient was of a different nature than that of the other cases. She prescribed relatively small doses of narcotics for headache for a patient of another doctor who had expressly refused to prescribe the medications. Particular 14 was proven.

She should have recognized that this woman was seeking drugs improperly and at the hearing acknowledged her gullibility. The Committee was not inclined to find Particular 15 proven, Dr. Arnold's problem in this case representing an error of judgment.

3.9 XCB

Particulars 14 and 15 were proven.

3.10 QIP

Particulars 14 and 15 were proven.

3.11 PPE

Particular 14 was proven but there was no convincing evidence of drug seeking in this patient.

Summary

Thus, with all eleven patients the Committee found Dr. Arnold to have failed to maintain the accepted standard of care of the profession. The Committee recognizes the difficulties inherent in accessing pain, that the physician expects a patient to be truthful and that the physician's obligation to the patient is to relieve suffering. Judgment is required, but judgment must be based on some information derived from a careful history and physical examination, the prudent use of investigative procedures and consideration of specialists' opinions when indicated. The Committee was not impressed that Dr. Arnold approached these patients in such a fashion as to be able to render appropriate judgment in most cases.

Dr. Arnold prescribed narcotics without adequate reason often without having tried less potent drugs first and without serious attempts to wean them. She seemed oblivious to drug seeking behaviour and failed to deal with drug dependency even when she appeared to recognize it.

Her records were of such poor quality that the Committee could not determine what

were the historical findings or the physical findings, and had great difficulty in assessing her thinking and her approach to these patients. In her testimony, she demonstrated a knowledge of their histories, but the Committee had difficulty accepting that she could remember the physical findings several years later. Even if she did recall these facts, Dr. Arnold did not convince the Committee that she had any organized and careful approach to these patients who were on chronic narcotic analgesics including those who may have had an organic basis for their pain. Similarly, narcotic anti-tussive agents were used in many patients for prolonged periods without any convincing description of an indication.

The Committee accepts that the maximum dose for acetaminophen is approximately 4,000 mg. per day, but the maximum dose of narcotics cannot be so explicitly stated since there is great individual variation in requirements and tolerance. The Committee found that Dr. Arnold prescribed narcotics in excessive quantities, often two different narcotics at the same time for different indications, that she failed to appreciate the possible adverse effects and usually she made no attempt to wean the patients from these drugs.

Dr. Arnold's credibility was strained. For example, she carried on a busy practice of 6,000 patients and was seeing at least 75 patients per day. She stated she did repeated physical examinations on these patients and two of the eleven patients confirmed this in their testimony. The Committee had difficulty imagining the logistics of such examinations and, in fact, believed it would not be necessary in many cases. Secondly, the Committee had trouble believing that Dr. Arnold would have such an encyclopedic memory of these patients' findings especially when no adequate documentation was made. Similarly, she recalled conversations about counselling or confrontations regarding drug abuse with several patients, several years after the fact and yet there was no documentation to remind her. Thirdly, Dr. Arnold was often convinced that there was an organic basis for her patient's pain when, in fact, no such organic basis was suspected by specialists who had seen the patient nor was any suggested by the investigative procedures. Dr. Arnold appeared to tailor her evidence

according to the circumstances, and the Committee therefore did not find her to be credible.

Dr. Martin appeared to be an advocate for Dr. Arnold. He was unwilling to be critical of virtually any aspect of her care, save for her records. The Committee was particularly struck by his unequivocal support for Dr. Arnold's behaviour in relation to her acceptance of the role requested of her by VAN, The Committee, therefore, did not find Dr. Martin to be objective and his value as an expert was thereby considerably diminished. Further, while the Committee recognizes the principles enunciated in *Re: Brett* to the effect that a member cannot be found guilty of professional misconduct, or falling below the standard, if there exists a responsible and competent body of professional opinion that supports the conduct of the doctor, there was no evidence that Dr. Arnold's prescribing practices represented any respected group of the profession in their approach to the use of narcotic analgesic agents.

The Committee gave little weight to the testimony of Dr. Arnold's colleague and the pharmacist because they have an on-going business relationship. The secretary merely confirmed that the black books were missing without any known reason. The patients largely confirmed Dr. Arnold's testimony and gave the Committee the impression of having been coached. Their testimony had little bearing on the standard of practice issues.

Dr. FDR's testimony, which was supported by his contemporaneous records, was accepted. He had no apparent interest in impugning Dr. Arnold when he was working as a locum tenens. He impressed the Committee as being strongly imbued with the concepts of proper medical practice especially with regard to narcotic analgesics and the assessment of pain. He did considerably more than fall in step with Dr. Arnold's practice patterns until she returned.

Incompetence

In addition to the allegation of professional misconduct, the College also alleged that

Dr. Arnold is incompetent in that she displayed in her professional care of these patients a lack of knowledge, skill or judgement or disregard for the welfare of the patients of a nature or to an extent that demonstrates she is unfit to continue in practice. The Committee considered this allegation separately from the allegation of professional misconduct. It did so to determine whether Dr. Arnold's knowledge, skill and judgement was sufficient to permit her to continue in practice today.

The Committee was unanimously of the view that Dr. Arnold's care of these patients demonstrates a profound lack of knowledge, skill and judgement and a disregard for the welfare of her patients. The Committee reached this conclusion because of her consistent failure to deal with these patients appropriately and because of her inability at the hearing to appreciate the serious consequences of her prescribing practices. Amongst other things, and leaving aside the matter of her records, she failed to adequately diagnose her patients; she prescribed narcotic analgesics for questionable reasons; she failed to appreciate the importance of an overall treatment plan; she continued to prescribe drugs for prolonged periods (and in some instances continued to prescribe drugs even though she recognised drug abuse); she failed to appreciate the hazards of prolonged and excessive use of narcotics; she failed to appreciate or understand drug-seeking behaviour; and she attempted to care for patients who required a level of care beyond her expertise. The Committee therefore finds Dr. Arnold unfit to continue in practice and finds her to be incompetent.

Indexed as: Arnold (Re)

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 60(6) of the **Health Disciplines Act**, R.S.O. 1990, C.H. 4

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ROSEMARY JOAN ARNOLD

PANEL MEMBERS: DR. J. CURTIS (Chair)
DR. J. THOMPSON
DR. M. GOODMAN
F. HOSHIZAKI

HEARING DATE: SEPTEMBER 19-23, 1994
FEBRUARY 1-2, 1995
FEBRUARY 9, 1995
APRIL 3-6, 1995

DECISION/RELEASED DATE:

DECEMBER 19, 1995

PENALTY HEARING DATE:

APRIL 1-2, 1996

PENALTY DECISION/RELEASED DATE:

JULY 3, 1996

PENALTY DECISION AND REASONS FOR PENALTY

The hearing regarding penalty was held April 1-2, 1996

SUBMISSIONS BY PROSECUTION COUNSEL

Prosecution counsel advised that he was seeking a revocation of Dr. Arnold s Certificate of Registration. He submitted that Dr. Arnold was found guilty of professional misconduct and incompetence involving 11 patients over a period of several years. In his opinion Dr. Arnold s cynical disregard for the usual caveats regarding narcotic use is tantamount to drug trafficking. Dr. Arnold, he submitted, has demonstrated no evidence of remorse, remediation, or understanding of her failure to meet the standards of the profession. He cited four cases which have been before the Discipline Committee of the College of Physicians and Surgeons of Ontario over the past several years in which, he submitted, the findings were similar to the present case and the penalty was revocation.

SUBMISSIONS BY DEFENCE COUNSEL

Defence counsel presented 14 physicians as witnesses and testimonials in writing from five more physicians. Thirteen of the fourteen physicians who gave viva voce evidence have dealt with Dr. Arnold professionally usually as consultants. Some acknowledged social contact. One physician had worked as a locum tenens for Dr. Arnold in 1987 for five weeks. Two doctors, one with extensive experience with the use of narcotics, chronic pain syndromes, and medical records, and the other with extensive general experience, volunteered to assist in monitoring her practice by chart review or mentoring and indicated they would provide regular reports to the College.

The doctors who testified attested to her caring manner, her compassion, her knowledge of her patients and her competence. Most were aware of the close relationship she has with her patients. Most were aware of the difficulties in dealing with the type of patients in Dr. Arnold s practice. The consultants testified that her referrals were timely and appropriate and that follow-up was according to the recommendations made by the consultants. None recalled any instance of Dr. Arnold missing serious pathology. These physicians were unaware of any negative sentiment toward Dr. Arnold among their colleagues and they were all aware of difficulties patients have in finding family physicians in the Kitchener area.

Dr. ZTC presented information regarding a workshop he jointly developed for primary care physicians entitled Chronic Opioid Therapy in Non-Malignant Pain which is offered several times yearly. This course provides a methodology for dealing with people with chronic pain syndromes who require narcotics. In the course, guidelines for the proper use of narcotics, risk profiles for addiction as well as regulatory body and legal issues are discussed. He maintained that the safe use of narcotics can often ameliorate chronic pain and allow functional improvement.

An Associate Registrar of the College of Physicians and Surgeons of Ontario testified regarding the available help in assessment and remediation through Physician Review and Enhancement Program (PREP).

In addition to the physician witnesses, defence counsel presented Dr. Arnold s minister who described her as good , a close friend who described her as honest and open to learning, and four patients all of whom attested to her competence, kindness, thoroughness and their faith in her. There was an additional letter from a patient that was admitted on consent.

In his submissions, defence counsel emphasized that Dr. Arnold has been deeply remorseful regarding the findings and her failure to meet the standards of the profession. He urged the Committee to be cognizant of the kind of person she is and the kind of practice that she has. Dr. Arnold has been disadvantaged by the fact that a systematic approach to the management of these patients was, at the time she was treating them, undeveloped. Her personal qualities and the dedication to her patients was exemplified by the witnesses described above. He submitted that there is no evidence of incompetence, save her management of the 11 patients with respect to narcotic use.

Defence counsel submitted that Dr. Arnold is prepared to agree to the following:

1) a restriction to her Certificate of Registration prohibiting her from prescribing narcotics until she can satisfy the Registrar that these privileges ought to be restored;
2) She will limit the number of patients she sees to 50 per day;
3) She will undergo PREP achieving Level 3 or better and complete any remedial measures recommended;
4) She will engage in continuing medical education in accordance with the annual requirements of the College of Family Physicians of Canada;
5) She will enroll in the CPSO course in the proper maintenance of health records;
6) She will attend the workshop on Chronic Opioid Therapy in Non-Malignant Pain;
7) She will consent to and will co-operate with College inspectors and investigations which may be ordered;
8) She will agree to co-operate with the monitoring offered by the two local physicians as described above.

Defence counsel submitted that the cases referred to by prosecution counsel, where revocation was the penalty, were examples of physicians who were incorrigible, incapable of rehabilitation, contemptible, and totally lacking in insight, control or intelligence. In turn, he presented nine CPSO Discipline Committee cases and two Alternate Dispute Resolution cases where the offences were similar, or more serious, and the penalty was usually a reprimand, a suspension, part of which was often suspended if the doctor met certain conditions.

REPLY EVIDENCE BY PROSECUTION COUNSEL

Prosecution counsel refuted defence counsel s proposition that the Committee must find general incompetence in order to justify revocation. Incompetence with one patient is sufficient grounds for such a finding.

ADVICE BY SUBMISSION LEGAL COUNSEL

Counsel to the Discipline Committee reviewed the law and advised the Committee that it must make an order with respect to each of the two findings, professional misconduct and incompetence.

DECISION REGARDING PENALTY

In making its decision regarding penalty the Committee, aware of the stress Dr. Arnold has already undergone, was not inclined to be punitive. The key aims of penalty in this circumstance are protection of the public and rehabilitation. The Committee believes that Dr. Arnold must demonstrate her general competence before being allowed to practise again and she must upgrade her recognized deficiencies (records and narcotic prescribing). Further she must expend effort to maintain her competence. In addition to the above principles the Committee believes that the public and the profession must be reminded that care such as was provided in this case is not tolerated by the profession.

The Committee was guided in its decision by the Kular decision (*Members Dialogue*, November 1993), the facts of which were closest to those in this case. The penalty involved the necessity of Dr. Kular achieving Level 3 in PREP, restriction of his licence to prescribe certain medications until he demonstrated competence in this regard, and inspection of his practice.

In brief, the Committee decided upon a recorded reprimand and a suspension to be followed by an imposition of restrictions on Dr. Arnold s certificate of registration. The suspension may be suspended provided Dr. Arnold satisfies certain conditions.

More specifically, the Committee ordered the following penalty be imposed in relation to both the finding of professional misconduct and the finding of incompetence:

1. Dr. Arnold shall be reprimanded and the reprimand shall be recorded on the Register.

2. Dr. Arnold s certification of registration shall be suspended for a period of twelve (12) months. The period of suspension shall commence on a date which shall be fixed by the Registrar who shall take this action within thirty (30) days of this the date upon which Order becomes final. In any event, the term of this suspension shall commence not more than one hundred and eighty (180) days after the date upon which this Order becomes final.

3. The suspension shall itself be suspended on the following terms and conditions:

(a) Dr. Arnold shall be referred by the Director of the Education Department of The College of Physicians and Surgeons of Ontario (the College) to the McMaster Physician Review Program (PREP) at the first available opportunity;

(b) within fifteen (15) days of the date upon which this Order becomes final Dr. Arnold shall provide her written consent to the release by the College to PREP of any information considered appropriate by the Director of Education of the College prior to the assessment taking place;

(c) Dr. Arnold shall attend PREP at the first available opportunity as directed by the Director of Education of the College and shall co-operate in every respect with the assessment provided by PREP;

(d) within fifteen (15) days of the date upon which this Order becomes final Dr. Arnold shall provide her written consent to the release by PREP to the College of the result of the assessment and of any information with respect to the assessment as may be considered necessary by the Director of the Education Department of the College;

(e) Dr. Arnold shall complete any period of supervision and any program of upgrading, which may be recommended by PREP, successfully and to the satisfaction of the Registrar and shall submit herself to such further re-assessment or re-assessments as may, from time to time, be recommended by PREP and shall complete any training, upgrading or period of supervision recommended by PREP from time to time on the occasion of any re-assessment or re-assessments which may be recommended, sufficient to achieve PREP Level 3 at a minimum;

(f) Dr. Arnold shall within thirty (30) days of the submission to her of an invoice therefor pay the costs of her assessment and re-assessment or re-assessments at PREP in an amount prescribed by the Registrar;

(g) within fifteen (15) days of the date upon which this Order becomes final, Dr. Arnold shall provide her written consent to unannounced inspections of her

practice by College inspectors, at her expense, twice yearly during the three years following the date on which this Order becomes final with particular attention to her records and narcotic prescribing (if any), and shall co-operate in such inspections;

(h) within fifteen (15) days of the date upon which this Order becomes final, Dr. Arnold shall request that her privileges to prescribe narcotics be terminated by the Bureau of Drug Surveillance. Such termination of her privileges shall be in effect for a minimum of one year or until such later time as she provides evidence satisfactory to the Registrar that this restriction can be safely removed. Such evidence shall include but will not be restricted to successful completion of the Chronic Opioid Therapy in Non-Malignant Pain Workshop;

(i) Dr. Arnold shall meet the annual requirements of the College of Family Physicians of Canada (CFPC) for continuing medical education and will provide written evidence satisfactory to the Registrar that she has done so within 13 months of registering as a member of CFPC;

(j) Dr. Arnold shall attend a course of record keeping administered by the College at her expense within one year of the date upon which this Order becomes final and will provide written evidence satisfactory to the Registrar that she has done so within 30 days of completion of the course.

4. In the event that the suspension imposed under 2 above is suspended under 3 above, it shall resume and Dr. Arnold s certificate of registration shall be suspended in the following events:

(a) in the event that Dr. Arnold fails to attend PREP and co-operate with the assessment provided by PREP pursuant to 3(c) above, the suspension of her certificate of registration shall resume forthwith upon such default and shall continue for the remainder of the period of twelve (12) months;

(b) in the event that Dr. Arnold fails to achieve PREP Level 3 when first assessed the suspension of her certificate of registration shall resume forthwith and shall continue for the remainder of the period of twelve (12) months or until she

achieves PREP Level 3, whichever shall first occur;

(c) in the event that Dr. Arnold:

(i) fails to provide her written consent pursuant to 3(b), (d) and (g) above; or

(ii) fails to request her privileges to prescribe narcotics be terminated pursuant to 3(h) above;

(iii) fails to pay the costs pursuant to 3(f) above;

(iv) fails to provide the written evidence to the Registrar required pursuant to 3(i) and (j) above;

the suspension of her certificate of registration shall resume forthwith upon such event of default and shall continue for the remainder of the period of twelve (12) months or until such default is cured, whichever shall first occur.

5. In the event that the suspension of Dr. Arnold s certificate of registration is not suspended pursuant to 3 above, following completion of suspension for a total period of twelve (12) months, Dr. Arnold s certificate of registration shall thereafter be subject to the following restrictions:

(a) Dr. Arnold s privileges to prescribe narcotics shall be terminated by the Bureau of Drug Surveillance for a minimum of one year or until such later time as she provides evidence satisfactory to the Registrar that this restriction can be safely removed. Such evidence shall include, but will not be restricted to, successful completion of the Chronic Opioid Therapy in Non-Malignant Pain Workshop;

(b) Dr. Arnold may engage in clinical practice only in the same office as and under the direct supervision of a physician acceptable to the Registrar, unless and until all of the following conditions are met:

(i) Dr. Arnold shall be referred by the Director of the Education Department of the College to PREP;

(ii) Dr. Arnold shall provide her written consent to the release by the College to PREP of any information considered appropriate by the Director of Education of the College prior to the assessment taking place;

(iii) Dr. Arnold shall attend PREP at the first available opportunity as directed by the Director of Education of the College and shall co-operate in every respect with the assessment provided by PREP;

(iv) Dr. Arnold shall provide her written consent to the release by PREP to The College of Physicians and Surgeons of Ontario of any information with respect to the assessment and the result of the assessment as may be considered necessary by the Director of the Education Department of the College;

(v) Dr. Arnold shall complete any period of supervision and any program of upgrading which may be recommended by PREP successfully and to the satisfaction of the Registrar and shall submit herself to such further re-assessment or re-assessments as may, from time to time, be recommended by PREP and shall complete any training, upgrading or period of supervision recommended by PREP from time to time on the occasion of any re-assessment or re-assessments which may be recommended, sufficient to achieve PREP Level 3 at a minimum;

(vi) Dr. Arnold shall within thirty (30) days of the submission to her of an invoice therefor pay the costs of her assessment and any re-assessment or re-assessments at PREP in an amount prescribed by the Registrar;

(vii) Dr. Arnold shall provide her written consent to unannounced inspections of her practice by College inspectors, at her expense, twice yearly during the three years following the date on which the suspension of her certificate of registration ends with particular attention to her records and narcotic prescribing (if any), and shall co-operate in such inspections;

(c) Dr. Arnold shall meet the annual requirements of the College of Family

Physicians of Canada for continuing medical education and will provide written evidence satisfactory to the Registrar that she has done so within 13 months of registering as a member of the CFPC.

(d) Dr. Arnold shall attend a course of record keeping administered by the College at her expense within one year of the date upon which this Order becomes final and will provide written evidence satisfactory to the Registrar that she has done so within 30 days of completion of the course.

For purposes of paragraph 5(b) of this order, direct supervision means that Dr. Arnold shall practise in the same facility as the supervisor who shall conduct weekly random reviews of Dr. Arnold s charts and shall advise and intervene in Dr. Arnold s practice when appropriate. The supervisor shall submit monthly written reports to the Registrar confirming that he/she is discharging these responsibilities.

Indexed as: Arnold (Re)

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 60(6) of the **Health Disciplines Act**, R.S.O. 1990, C.H. 4

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ROSEMARY JOAN ARNOLD

PANEL MEMBERS: DR. J. CURTIS (Chair)
DR. J. THOMPSON
DR. M. GOODMAN
F. HOSHIZAKI

HEARING DATE: SEPTEMBER 19-23, 1994
FEBRUARY 1-2, 1995
FEBRUARY 9, 1995
APRIL 3-6, 1995

DECISION/RELEASED DATE:

DECEMBER 19, 1995

PENALTY HEARING DATE:

APRIL 1-2, 1996

PENALTY DECISION/RELEASED DATE:

JULY 3, 1996

SUPPLIMENTARY PENALTY DECISION DATE:

JANUARY 7, 1997

SUPPLEMENTARY DECISION AND REASONS

The Committee received the submissions of counsel for the College and counsel for Dr. Arnold concerning its Decision Regarding Penalty in this matter. The Committee s clear intention as stated on page 5 of that Decision was that Dr. Arnold must demonstrate her general competence before being allowed to practise again . Accordingly, it was the intention of the Committee in its penalty order that Dr. Arnold should be suspended from practice until she achieves Level 3 in PREP at a minimum. To the extent that this is unclear in the way that the Committee expressed it in the penalty order, that was a slip and we wish by these Reasons and Decision to make it clear. The Committee has therefore revised the Decision Regarding Penalty to reflect its true intention as follows:

1. Dr. Arnold shall be reprimanded and the reprimand is to be recorded on the Register.

2. Dr. Arnold s Certificate of Registration shall be suspended for a period of twelve (12) months. The suspension shall commence on a date which shall be fixed by the Registrar who shall take this action within thirty (30) days of today s date and the term of the suspension shall commence within no more than one hundred and eighty (180) days of today s date.

3. The suspension shall continue for the full twelve (12) month period unless and until during that period Dr. Arnold attends the McMaster Physician Review Program (PREP) and successfully achieve PREP Level 3, at a minimum, and further, provided that Dr. Arnold complies with the following terms and conditions:

   (a) Dr. Arnold shall be referred by the Director of the Professional Enhancement Department of the College of Physicians and Surgeons of Ontario (the College) to PREP at the first available opportunity;

   (b) Within fifteen (15) days Dr. Arnold shall provide written consent to the release by the College to PREP of any information considered appropriate by the Director of the Professional Enhancement Department of the College

prior to the assessment taking place;

(c) Dr. Arnold shall attend PREP at the first available opportunity as directed by the Director of Professional Enhancement of the College and shall co-operate in every respect with the assessment provided by PREP;

(d) Within fifteen (15) days Dr. Arnold shall provide her written consent to the release by PREP to the College of the result of the assessment and of any information with respect to the assessment as may be considered necessary by the Director of the Professional Enhancement Department of the College;

(e) Dr. Arnold shall complete any program of upgrading which may be recommended by PREP successfully and to the satisfaction of the Registrar and shall submit herself to such further re-assessments as may, from time to time, be recommended by PREP and shall complete any training or upgrading recommended by PREP from time to time on the occasion of any re-assessment or re-assessments which may be recommended;

(f) Dr. Arnold shall within thirty (30) days of the submission of an invoice thereforE pay costs of her assessment and re-assessment or re-assessments at PREP in an amount prescribed by the Registrar.

(g) Within fifteen (15) days Dr. Arnold shall provided her written consent to unannounced inspections of her practice by the College inspectors, at her expense, twice yearly during the three years following this date with particular attention to her records and narcotic prescribing (if any), and shall co-operate in such inspections;

(h) Within fifteen (15) days Dr. Arnold shall request that her privileges to prescribe narcotics be terminated by the Bureau of Drug Surveillance. Such termination of her privileges shall be in effect for a minimum of one year or until such later time as she provides evidence satisfactory to the Registrar that this restriction can be safely removed. Such evidence shall include but

will not be restricted to successful completion of the Chronic Opioid Therapy in Non-Malignant Pain Workshop;

(i) Dr. Arnold shall meet the annual requirements of the College of Family Physicians of Canada (CFPC) for continuing medical education and shall provide written evidence satisfactory to the Registrar that she has done so within thirteen (13) months of registering as a member of CFPC;

(j) Dr. Arnold shall attend a course of record keeping administered by the College at her expense within one year and shall provide written evidence satisfactory to the Registrar that she has done so within thirty (30) days of completion of the course.

4. In the event that the suspension or part of the suspension of Dr. Arnold s certificate of registration under paragraph 2 above is suspended and Dr. Arnold :

(a) fails to provide her written consent pursuant to 3(b), (d) and (g) above; or

(b) fails to request her privileges to prescribe narcotics be terminated pursuant to 3(h) above;

(c) fails to pay the costs pursuant to 3(f) above;

(d) fails to provide written evidence to the Registrar required pursuant to 3(i) and (j) above;

the suspension of her certificate of registration shall resume forthwith upon such event of default and shall continue for the remainder of the period of twelve (12) months or until such default is cured, whichever shall occur first.

5. In the event that the suspension of Dr. Arnold s certificate of registration is not suspended pursuant to paragraph 3 above, following completion of the suspension for a total of twelve (12) months Dr. Arnold s certificate of registration shall

thereafter be subject to the following restrictions:

(a) Dr. Arnold s privileges to prescribe narcotics shall be terminated by the Bureau of Drug Surveillance for a minimum of one year or until such later time as she provides evidence satisfactory to the Registrar that this restriction can be safely removed. Such evidence shall include, but shall not be restricted to, successful completion of the Chronic Opioid Therapy in Non-Malignant Pain Workshop;

(b) Dr. Arnold may engage in clinical practice only in the same office as and under the direct supervision of a physician acceptable to the Registrar, unless and until all of the following conditions are met:

(i) Dr. Arnold shall be referred by the Director of the Education Department of the College to PREP;

(ii) Dr. Arnold shall provide her written consent to the release by the College to PREP of any information considered appropriate by the Director of the Professional Enhancement Department of the College prior to the assessment taking place;

(iii) Dr. Arnold shall attend PREP at the first available opportunity as directed by the Director of the Professional Enhancement Department of the College and shall co-operate in every respect with the assessment provided by PREP;

(iv) Dr. Arnold shall provide her written consent to the release by PREP to the College of any information with respect to the assessment and the result of the assessment as may be considered necessary by the Director of the Education Department of the College;

(v) Dr. Arnold shall complete any period of supervision and any program

of upgrading which may be recommended by PREP successfully and to the satisfaction of the Registrar and shall submit herself to such further re-assessment or re-assessments as may, from time to time, be recommended by PREP and shall complete any training, upgrading or period of supervision recommended by PREP from time to time on the occasion of any re-assessment or re-assessments which may be recommended, sufficient to achieve PREP Level 3 at a minimum;

(vi) Dr. Arnold shall within thirty (30) days of the submission to her of an invoice therefor pay the costs of her assessment and any re-assessment or re-assessments at PREP in an amount prescribed by the Registrar;

(c) Dr. Arnold shall provide her written consent to unannounced inspections of her practice by College inspectors, at her expense, twice yearly during the three years following the date on which the suspension of her certificate of registration ends with particular attention to her records and narcotic prescribing (if any), and shall co-operate in such inspections;

(d) Dr. Arnold shall meet the annual requirements of the College of Family Physicians of Canada for continuing medical education and shall provide written evidence satisfactory to the Registrar that she has done so within thirteen (13) months of registering as a member of the CFPC.

(e) Dr. Arnold shall attend a course of record keeping administered by the College at her expense within one year of the date upon which this Order becomes final and will providing written evidence satisfactory to the Registrar that she has done so within (30) days of completion of the course.

For purposes of paragraph 5(b) of this order, direct supervision means that Dr. Arnold shall practise in the same facility as the supervisor who shall conduct weekly random reviews of Dr. Arnold s charts and shall advise and intervene in Dr. Arnold s practice when appropriate. The supervisor shall submit monthly written reports to the Registrar confirming that he/she is discharging these responsibilities.