SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee (the Committee)
(Information is available about the complaints process here and about the Committee here)

Dr. Raymond Howard Rupert (CPSO #25597)

INTRODUCTION

The College received information raising concerns about Dr. Rupert's clinical care. Specifically, his clinical care of patients in an addiction treatment centre where he worked (the institution) that he then referred to other centers or facilities. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Rupert's practice.

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of June 13, 2019. In addition to accepting Dr. Rupert's signed undertaking, the Committee required Dr. Rupert to attend at the College to be cautioned in person with respect to failing to comply with the College's *Medical Records*, *Delegation of Controlled Acts, Telemedicine,* and *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice* policies, and on failing to meet the standard of practice, demonstrating a lack of knowledge and judgment, and potentially exposing patients to harm.

COMMITTEE'S ANALYSIS

As part of this investigation, the Registrar appointed an Assessor to review a number of Dr. Rupert's patient charts, interview Dr. Rupert, and submit a written report to the Committee. A second Assessor also reviewed a single patient file for which the first and primary Assessor had a conflict.

The first and primary Assessor concluded that:

- Dr. Rupert did not meet the standard of care in more than half of charts reviewed, with the most pressing concern in the majority of cases being poor documentation.

- There was a disconnect between Dr. Rupert's account that he was restricted from seeing patients from a financial perspective by the institution he worked for, and the institution's claim that this was not true. There was also a disconnect between Dr. Rupert's understanding that he was the Most Responsible Physician (MRP) for all patients in the institution, and institution staff that said he was only responsible for the patients he saw. Dr. Rupert also relied too heavily on non-medical staff at the institution to communicate medical information.

- Dr. Rupert showed a lack of knowledge, skill, and judgment in some areas of his practice. This included prescribing Dilantin, which is not recommended for patients in alcohol withdrawal, prescribing benzodiazepines frequently without rationale or a clear treatment plan in a high-risk patient population, not following up adequately with a Suboxone maintenance patient that he initiated, and not offering thiamine to higher-risk patients in some cases. He appeared to be knowledgeable regarding treating withdrawal syndromes in the interview and in some cases, but the lack of documentation in other cases made it difficult to ascertain his level of expertise and understanding of addiction medicine.

- Dr. Rupert's practice did put patients at a potential risk of harm in some cases. There was a disconnect between his understanding of how patients would be seen and treated by the institution, and it was concerning that he was relying on non-medical staff at the institution to refer patients to him.

The Committee considered the following points in reaching its decision:

- The Committee agreed with the primary Assessor that Dr. Rupert did not meet the standard of care, that he exhibited a lack of knowledge, skill, and judgment, and that his care placed patients at a potential risk of harm. As a result, the Committee had concerns about Dr. Rupert's prescribing practices, telemedicine use, delegation, and medical records.

- The Committee determined that an appropriate resolution would be accepting an undertaking signed by Dr. Rupert, and requiring Dr. Rupert to attend the College to be cautioned on this matter.