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. Richard Alexander Irvine (CPSO #25701)
(the Respondent)

INTRODUCTION

The Complainant saw the Respondent regarding medications for her attention deficit hyperactivity disorder (ADHD).

The Complainant contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's care and conduct.

COMPLAINANT'S CONCERNS

The Complainant was concerned that the Respondent failed to provide adequate care at his clinic. Specifically, the Respondent:

- **Prescribed medication to the Complainant under the wrong patient name;**
- **Increased the Complainant's dose of Vyvanse from 60 mg to 100 mg without following up on medication side effects and the way the prescription was affecting her; and,**
- **Failed to follow up with the Complainant's care following his departure from the clinic she attended.**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of October 16, 2019. Upon receipt of the Respondent's signed undertaking to resign his certificate of registration and never reapply in any jurisdiction, the Committee required the Respondent to attend at the College to be cautioned in person regarding his inadequate documentation, treatments, and assessments.

COMMITTEE'S ANALYSIS

Re: Mislabeling

- The Respondent explained that it was likely his administrative staff that mislabelled the Complainant's prescription. However, the Committee noted that it was the physician's responsibility to ensure the correct name was on every prescription he signed.

Re: Increased dosage and follow-up of dosage change

- The Respondent did not have adequate documentation regarding the Complainant's dosage change and follow-up. The Respondent started the Complainant on Vyvanse based on a diagnosis by a psychologist and the fact that the Complainant took a friend's Vyvanse and was "able to get everything done". This was not acceptable care. There was no functional inquiry, physical examination, or a discussion about treatment options documented. Subsequent changes to the Complainant's Concerta and Vyvanse medications were increased without any documentation of the rationale for these changes. This caused the Committee to find that neither the Respondent's clinical care nor documentation were adequate.

Re: Follow-up care after the Respondent's departure from the clinic

- The Respondent simply gave two weeks' notice to the clinic and appeared to have assumed that other physicians in the walk-in clinic would see the patients he left behind. There was no systematic notification sent to his patients and no formal transfer of care to another physician. Many of those patients relied on the Respondent for regular prescription renewals over a long period of time, including the Complainant. This was not an adequate approach for leaving a medical practice and jeopardized the continuity of care for not only the Complainant, but other patients in the practice.

Undertaking to Resign

- The Committee noted that the Respondent expressed his willingness to sign an undertaking never to re-apply for a medical licence in Ontario or any other jurisdiction. This, along with a caution regarding his inadequate documentation, treatments, and assessments, satisfied the Committee's concerns in this case.