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)

INTRODUCTION

In December 2018, a physician contacted the College with concerns about Dr. Irvine, specifically that Dr. Irvine left a walk-in clinic without prior notice, deliberately falsified patient charts, prescribed large amounts of narcotics and controlled substances, was working with a pharmacy to hide criminal activity, had patient charts that lacked documentation, and posted a Google Review recruiting students from local universities who may require medications for attention deficit hyperactivity disorder (ADHD), learning difficulties, and psychiatric problems.

Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Irvine's practice.

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

As part of this investigation, the Registrar appointed an independent Assessor to review one of Dr. Irvine's patient charts and submit a written report to the Committee.

- The Assessor concluded that:
    - Dr. Irvine did not meet the standard of practice.
    - Dr. Irvine's records did not meet the standard of practice as the notes did not follow the Subject, Objective, Assessment, Plan (SOAP) format.
    - Dr. Irvine's prescriptions did not meet the standard of practice, as his prescriptions were all handwritten, barely legible at times, with multiple prescriptions written on a single small prescription pad. They were often not dated or did not have a patient identification number, no directions for use, or have a total quantity for narcotic prescriptions.

- Dr. Irvine's narcotics prescribing did not meet the standard of practice, as there was no documentation of any pain clinic referrals, no narcotic treatment agreement, and prescriptions were provided too frequently and in large amounts. There was no evidence that Dr. Irvine calculated the total daily dose for fentanyl and hydromorphone in terms of morphine equivalents.

- Dr. Irvine displayed a moderate lack of knowledge in relation to appropriate doses for nabilone, duloxetine, and prednisone, and a mild lack of knowledge in relation to ordering appropriate tests to diagnose a C. difficile infection.

- Dr. Irvine displayed a moderate lack of judgment in relation to frequent prescriptions of high doses of opioids.

- Dr. Irvine's clinical practice, behaviour, or conduct exposed or was likely to expose his patients to harm or injury. For example, his incomplete medical documentation could have harmed patients by inhibiting continuity of care. His barely legible or incomplete prescriptions could have resulted in harm to patients if these were to result in a medication or dosing error. His inappropriate medication doses could have exposed patients to preventable adverse effects. Lastly, his practice of prescribing high doses of opioids could have harmed patients because of the risk of addiction, overdose, and diversion into the community.

- The Committee agreed with the Assessor's findings. The Respondent's care in this case was certainly not appropriate, exhibited a lack of judgment and knowledge, and may have placed patients at a risk of harm.

- The Committee noted that in regard to the Google Review, the Respondent had a reasonable explanation (he was in London), and this does not match the location of the Google Review. As a result, the Committee took no further action on that aspect of the investigation.

- For the remainder of the Committee's concerns, 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.