NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Frederick Edward Aldrick McIntosh, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. McIntosh, 2020 ONCPSD 7

DISCIPLINE COMMITTEE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by
the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
which is Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. FREDERICK EDWARD ALDRICK MCINTOSH

PANEL MEMBERS:

DR. PEETER POLDRE (CHAIR)
MR. MEHDI KANJI
DR. ROBERT SHEPPARD
MR. PIERRE GIROUX
DR. CAROLE CLAPPERTON

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MR. KIRK MAIJALA

COUNSEL FOR DR. MCINTOSH:

MR. ADAM PATENAUDE

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. GIDEON FORREST

Hearing date and Decision Date: **January 10, 2020**
Release of Reasons Date: **February 25, 2020**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on January 10, 2020. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct and setting out its penalty and costs order, with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. McIntosh committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. McIntosh is incompetent as defined in subsection 52(1) of the Code**.**

THE FACTS

The following facts were set out in a Statement of Uncontested Facts and Plea of No Contest which was filed as an exhibit and presented to the Committee:

BACKGROUND

1. Dr. Frederick Edward Aldrick McIntosh (“Dr. McIntosh”) is an 82-year-old otolaryngologist who received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (“the College”) on June 26, 1969. He received his specialist certification in otolaryngology from the College on November 22, 1973.

2. At the relevant time, Dr. McIntosh practised at A+ Medical Clinic in Toronto, Ontario.

I - DIAGNOSTIC IMAGING REFERRALS

a) Failure to Maintain the Standard of Practice of the Profession

3. On January 22, 2016, the College received information from the Ministry of Health and Long-Term Care (the “Ministry”) advising that it had observed a pattern of referrals from Dr. McIntosh to an independent health facility where patients underwent multiple diagnostic studies on a single service date. Information from the Ministry indicated there was no medical necessity for the imaging tests.

4. Based on the information from the Ministry, the College commenced an investigation of Dr. McIntosh’s practice. In the investigation, the College obtained supporting documentation from the Ministry as well as patient records and requisition forms from A+ Medical Clinic.

5. The College retained Dr. Linda Klapwyk as a Medical Inspector to review Dr. McIntosh’s practice, in particular his ordering of diagnostic imaging, and to opine on whether Dr. McIntosh’s care met the standard of practice of the profession. Dr. Klapwyk is an experienced family physician and professor of family medicine at the University of Toronto. Dr. Klapwyk reviewed Dr. McIntosh’s OHIP billings and nineteen (19) of Dr. McIntosh’s patient charts and conducted an interview with Dr. McIntosh. Dr. Klapwyk

provided a report to the College, dated July 23, 2018, attached at Tab 1 to the Statement of Uncontested Facts and Plea of No Contest.

6. Dr. Klapwyk concluded that Dr. McIntosh failed to maintain the standard of practice of the profession. Dr. Klapwyk opined that, in all nineteen (19) patient charts reviewed, almost all of the diagnostic imaging and cardiac tests ordered by Dr. McIntosh lacked documentation supporting an indication for doing the tests.

7. In his interview with Dr. Klapwyk, Dr. McIntosh blamed his office staff for adding tests onto his requisition forms without his knowledge by checking off additional tests on the requisition forms after Dr. McIntosh had signed them. Assuming this was the case, Dr. Klapwyk noted that there was no documented concern by Dr. McIntosh at follow-up visits with patients about the amount of testing that had been done without Dr. McIntosh's authorization.

8. Dr. Klapwyk opined that if Dr. McIntosh ordered the diagnostic imaging tests, he displayed a lack of knowledge and judgment and did not maintain the standard of practice of the profession.

9. Dr. Klapwyk also opined that even if the tests were ordered by Dr. McIntosh's office staff without his knowledge, Dr. McIntosh still failed to maintain the standard of practice of the profession as follows:

a) Dr. McIntosh failed to protect his patients from harm due to unnecessary tests, worry, and radiation exposure;
b) Dr. McIntosh demonstrated a lack of judgment in not documenting any concern about tests being done that he did not order; and
c) Dr. McIntosh demonstrated a lack of judgment in failing to notify the appropriate authorities when he became aware of tests being ordered in his name.

10. In Dr. Klapwyk's opinion, Dr. McIntosh exposed his patients to a risk of harm or injury.

11. Dr. Klapwyk's opinion is that Dr. McIntosh failed to maintain the standard of practice of the profession in other aspects of his care, including:

a) brief, illegible, and incomplete documentation;
b) poor or lacking documentation of examination findings, documentation of pain histories, and standard tools for narcotic documentation, such as patient contracts, brief pain inventories, narcotic flow sheets, opioid risk tools, or urine drug screening;
c) inadequate knowledge of guidelines for bone density screening or breast tests;
d) lack of knowledge of allergy scratch testing techniques; and
e) incorrect[ly] documented billing codes and diagnostic codes at the bottom of each note, in that assessments were billed despite the absence of examination and brief histories in almost all encounters.

b) Disgraceful, Dishonourable or Unprofessional Conduct

12. Dr. McIntosh's failure to ensure that his patients received only necessary diagnostic testing demonstrated a lack of judgment and professionalism. Dr. McIntosh ought to have been aware that diagnostic testing was being ordered without his authorization, documented his concerns once he became aware, and contacted the appropriate authorities about patients receiving testing that he did not order.

II - ORTHOTIC DEVICE PRESCRIBING

a) Failure to Maintain the Standard of Practice of the Profession

13. On January 18, 2017, the College received information from Health Canada's Non-Insured Health Benefits ("NIHB") program advising that it had concerns about Dr. McIntosh's prescribing of soft orthoses over a two-day period in August 2016. Specifically, the NIHB program advised that Dr. McIntosh had prescribed to thirty-eight (38) NIHB clients over the two-day period and that over half of the patients seen were prescribed more than ten (10) orthoses, while nine (9) patients were prescribed fourteen (14) devices.

14. Based on the information received from the NIHB program, the College commenced an investigation into Dr. McIntosh's orthotic device prescribing.

15. During a College interview, Dr. McIntosh advised the College that he had been recruited by two men, Mr. AA and Mr. BB, to prescribe orthotic devices to First Nations patients. Mr. AA is a chiropractor and Mr. BB has a suspended certificate of registration with the College of Chiropractors of Ontario.

16. Dr. McIntosh went to Sudbury with Mr. AA and Mr. BB in August, October, and November 2016. They drove together to a community centre in a nearby First Nations community. Patients would see a family member of one of the men in a van, who would take impressions for devices, and then Dr. McIntosh would assess the patient in a different van. Dr. McIntosh documented the patient encounters on a typed form that was provided to him by Mr. AA and Mr. BB and retained by them. Dr. McIntosh tested the blood or urine sugar of some diabetic patients and advised them to go to the hospital if their sugar was high. Dr. McIntosh billed OHIP for assessing the patients. Mr. AA and Mr. BB paid for Dr. McIntosh's hotel, food, and transportation to Sudbury. On two occasions, Mr. AA and Mr. BB also paid Dr. McIntosh a fee for his services.

17. The College retained Dr. Nancy Merrow as a Medical Inspector to opine on whether the care provided by Dr. McIntosh met the standard of practice of the profession. Dr. Merrow is an experienced family physician and Chief of Staff at Orillia Soldiers

Memorial Hospital. Dr. Merrow reviewed patient records provided by Mr. AA and Mr. BB and conducted an interview with Dr. McIntosh. Dr. McIntosh told Dr. Merrow that Mr. AA and Mr. BB had altered his prescriptions for orthotic devices after the fact, by adding additional devices to the prescription, and that the medical records provided by Mr. AA and Mr. BB to the College were not created by Dr. McIntosh in their entirety. Dr. Merrow's report to the College, received August 30, 2018, is attached at Tab 2 to the Statement of Uncontested Facts and Plea of No Contest. Dr. Merrow's addendum report to the College, dated November 2, 2018, is attached at Tab 3 to the Statement of Uncontested Facts and Plea of No Contest.

18. Dr. Merrow concluded that Dr. McIntosh failed to maintain the standard of practice of the profession in his prescribing of orthoses to patients. In particular, Dr. Merrow opined that Dr. McIntosh failed to maintain the standard of practice in that Dr. McIntosh:

a) prescribed devices to patients that he knew required proper care and follow-up without a plan to follow-up and reassess patients;
b) used a template created by someone else which was poorly designed and inadequate for proper record keeping; and
c) failed to safeguard any adequate records to represent the care provided and the follow-up required.

19. Dr. Merrow opined that Dr. McIntosh displayed a lack of judgment in his failure to maintain records, misjudgment of the intentions of Mr. AA and Mr. BB, and testing patients for diabetes and prescribing orthoses with no plan for follow-up.

20. Dr. Merrow also provided an addendum report, dated November 2, 2018, in which she opined that Dr. McIntosh failed to maintain the standard of practice of the profession, displayed a lack of knowledge, skill, and judgment, and exposed patients to a risk of harm in all the patient charts that she reviewed, in that:

a) the side of the body to which the assessment pertained was not specified in the charts;
b) there was no indication that any advice or treatment plan other than a prescription for devices was considered, such as exercise, physiotherapy, or analgesics;
c) there was incomplete or inadequate history of complaints and examinations; and
d) there was no evidence that patients received an appropriate assessment or treatment of their musculoskeletal conditions.

b) Disgraceful, Dishonourable, or Unprofessional Conduct

21. In allowing himself to be used in the orthotics scheme devised by Mr. AA and Mr. BB, Dr. McIntosh displayed a lack of judgment and professionalism. Dr. McIntosh ought to have known that the scheme was fraudulent.

PLEA OF NO CONTEST

22. Dr. McIntosh does not contest the facts specified above, and does not contest that, based on these facts, he engaged in professional misconduct, in that:

(a) He failed to maintain the standard of practice of the profession, under paragraph 1(1)(2) of O. Reg. 856/93, made under the *Medicine Act, 1991* ("O. Reg. 856/93")
(b) He engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, under paragraph 1(1)33 of O. Reg 856/93.

WITHDRAWAL

Counsel for the College withdrew the allegation of incompetence.

PLEA OF NO CONTEST – RULE 3.02

Rule 3.02 of the Rules of Procedure of the Discipline Committee regarding a plea of no contest states as follows:

> 3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:
>
> a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
> b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
> c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

FINDING

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts and Plea of No Contest.

On reading the Notice of Hearing dated January 23, 2019, the Statement of Uncontested Facts And Plea of No Contest, and on hearing the submissions of counsel for the College and counsel for Dr. McIntosh, the Committee found that Dr. McIntosh committed an act of professional misconduct under paragraph 1(1)2 of O. Reg 856/93, in that he has failed to maintain the standard of practice of the profession, and under

paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

PENALTY AND REASONS FOR PENALTY

Agreed Statement of Facts

The following fact was set out in an Agreed Statement of Facts Relevant to Penalty which was filed as an exhibit and presented to the Committee:

UNDERTAKING TO RESIGN AND NEVER REAPPLY

1. On December 18, 2019, Dr. McIntosh entered into an undertaking with the College of Physicians and Surgeons of Ontario (the "College"), whereby he agreed to resign his certificate of registration with the College and never apply or reapply for registration as a physician in Ontario or any other jurisdiction as of the date of this hearing. Dr. McIntosh's Undertaking to the College, dated December 18, 2019, is attached at Tab 1 to the Agreed Statement of Facts Relevant to Penalty.

Joint Submission

Counsel for the College and counsel for Dr. McIntosh made a joint submission as to an appropriate penalty and costs order. The parties jointly proposed that Dr. McIntosh attend before the panel to be reprimanded, and pay costs to the College of $6,000.00 within 30 days of the date of the order.

Although the Committee has discretion to accept or reject a joint submission on penalty, the law provides that the Committee should not depart from a joint submission

unless the proposed penalty would bring the administration of justice into disrepute, or is otherwise not in the public interest (*R. v. Anthony-Cook,* 2016 SCC 43).

In considering the penalty proposed, the Committee looked at the principles underlying penalty orders. Public protection is of paramount concern in any penalty. The penalty must preserve the reputation and integrity of the profession and maintain public confidence in the College's ability to regulate the profession in the public interest. The penalty must denounce the wrongful conduct and deter the member from further misconduct, and act as a general deterrence to the members as a whole. If appropriate, the penalty should facilitate rehabilitation of the member.

The Committee must apply these principles to the unique facts and circumstances of the case and determine a penalty that is fair, just and appropriate. Aggravating and mitigating factors must be considered. Similar cases are also considered and although the Committee is not bound by them, they can provide helpful guidance, given the general principle that similar kinds of professional misconduct should usually attract similar penalties.

Aggravating Factors

Diagnostic Imaging Referrals

Dr. McIntosh showed a remarkable lack of judgment in his involvement in the improper ordering of numerous tests. Although he claimed he did not know about the numerous tests being ordered and completed, and blamed his staff, even if that were true, he subsequently was complicit in not reporting the inappropriate tests to anyone. He completed no documentation in the patients' charts either before the tests were done to explain why they were necessary, or after the results were reported to him. The testing was an expense that wasted already-stretched public health dollars in this province. The

x-ray tests in particular exposed young patients to unnecessary radiation, were unprofessional and failed to protect the patients.

Orthotic Device Prescribing

Dr. McIntosh failed to maintain the standard of practice of the profession by maintaining no records for the patients he saw. There was no documentation or follow-up. Dr. McIntosh relied on inadequate forms of the chiropractor and the suspended chiropractor that he was working with. Dr. McIntosh was complicit in a scheme in which he was compensated by OHIP and also by those for whom he was working.

Multifaceted Nature of the Professional Misconduct

Dr. McIntosh failed to maintain the standard of practice in other areas of his practice. He showed deficient knowledge about guidelines for ordering bone density screening and breast studies. His knowledge was deficient in the area of allergy scratch testing. His documentation was sparse and inadequate in general. Documentation, including documentation of history taking, examinations, and urine testing with regard to opioid prescribing was lacking. OHIP codes and diagnostic codes were entered improperly on the charts. Assessments were billed even though in most of the charts Dr. McIntosh did not document any history or examination.

It is an aggravating factor that Dr. McIntosh's deficiencies encompass many areas of his practice.

Mitigating Factors

Dr. McIntosh has no previous history with the College. It is also to his credit that he has pled no contest thus saving the College the time, resources and expense of a potentially lengthy hearing, and eliminating the need for witnesses to testify.

In December 2019, Dr. McIntosh signed an undertaking to resign from the College and agreed not to apply or reapply to practise medicine in Ontario or any other jurisdiction.

Prior Cases

Counsel provided the Committee a Joint Book of Authorities that contained three prior cases of the Committee: *Kumra* 2019, *Virani* 2016, and *Abdurahman* 2018. The Committee recognizes that prior cases are not binding as precedent, and accepts as a principle of fairness that like cases should be treated alike.

The *Kumra* case is most analogous to the current one. Dr. Kumra voluntarily resigned his certificate of registration and he was reprimanded and ordered to pay costs to the College of $6,000.00 within 30 days of the date of the Order. Dr. Kumra's case is more severe than that of Dr. McIntosh, in that Dr. Kumra failed to co-operate with the College and had a prior history with the College relating to dishonesty. In the *Kumra* case, Dr. Kumra billed OHIP for services he did not provide. Specifically, he instructed his staff to bill the patient's family or household members for treatment at the time of the appointment of one member of the family. He also improperly accepted cash from patients in exchange for executing a Special Diet Allowance forms while at the same time billing OHIP. In addition, he did not sufficiently assess patients and satisfy himself that patients had any of the specified conditions upon which the special diet allowance is based. When Ontario Works began rejecting the Special Diet Allowance forms he was completing, Dr. Kumra engaged a physician friend to attend his clinic and fill out the forms and they would share the cash paid by the patients.

Dr. Kumra failed to produce and maintain medical records with various excuses of being hacked or having his computers stolen.

The *Virani* case involved the doctor borrowing large sums of money from his patients and not paying them back. He did not disclose to them his own losses prior to asking the patients for money. When civil judgments were made against Dr. Virani, he subsequently declared bankruptcy. Patients sustained severe economic losses. No clinical care issues were involved in the *Virani* case, in contrast to Dr. McIntosh's case. The *Virani* case was not sufficiently analogous to Dr. McIntosh's to provide assistance to the Committee.

In the *Abdurahman* case, the physician had an agreement under an alternative payment plan; that is, he was paid an annual lump sum for his services. The physician billed OHIP when the agreement specifically prohibited him from doing so. Dr. Abdurahman was dishonest in other ways with regard to his billing and practise. However, in contrast to Dr. McIntosh's case, there was no professional misconduct with regard to failing to maintain the standard of practice with knowledge and documentation deficiencies. The Committee did not consider the *Abdurahman* case sufficiently analogous to the current one to be helpful.

CONCLUSION

The Committee finds that, given the aggravating factors in this case, the need to send a strong message of deterrence to the membership of the profession, and the need for public protection, a stringent penalty is required. Public confidence in the effective regulation of the medical profession by the College in the public interest will be enhanced.

The Committee accepts the terms of the proposed draft order on penalty and costs, which the parties have jointly agreed are appropriate. Dr. McIntosh's voluntary resignation and his undertaking never to practise medicine in Ontario or any other jurisdiction will protect the public. If Dr. McIntosh had not resigned his certificate of registration and entered into the undertaking, based on the facts as set out in the Agreed Statement of Facts and Plea of No Contest, the Committee would undoubtedly have revoked his certificate. However, Dr, McIntosh would have been eligible to reapply in one year. In contrast, the undertaking signed by Dr. McIntosh does not allow for him to practise in the future.

The public reprimand serves as a general deterrent to the membership, showing that this type of misconduct will not be tolerated. The Committee expresses its abhorrence at Dr. McIntosh's actions and condemns the deficiencies in his standard of practice. The reprimand and the undertaking serve to maintain the College's reputation and integrity in regulating the profession in the public interest.

ORDER

The Committee stated its findings in paragraph 1 of its written order of January 10, 2020. In that order, the Committee ordered and directed on the matter of penalty and costs:

2. Dr. McIntosh to attend before the panel to be reprimanded.

3. Dr. McIntosh pay costs to the College in the amount of $6,000 within 30 days of the date of this Order.

At the conclusion of the hearing, Dr. McIntosh (via counsel) waived his right to an appeal under subsection 70(1) of the Code. As noted, Dr. McIntosh was not in attendance at the hearing. Upon learning he has health issues, and is living in another

country with no intent to return to Canada, the Committee administered the reprimand in his absence.

TEXT of PUBLIC REPRIMAND
Delivered January 10, 2020
in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

DR. FREDERICK EDWARD ALDRICK MCINTOSH

Dr. McIntosh:

The Discipline Committee is deeply disappointed at the poor judgement you have displayed in regard to the ordering, under your authority, of medical imaging examinations that were clinically unnecessary.

As indicated by expert opinion, you exposed patients to harm with radiation.
In addition, the excessive testing placed a financial burden on the health care resources that are provided to all Ontarians.

In a similar fashion, your poorly documented prescriptions for orthoses to your First Nations patients demonstrates a callous disregard for the integrity of the special programs that are intended to provide for their health care needs.

This Committee fully expects all physicians, including you, to accept responsibility for the quality of your documentation. Surely, the typographical errors in the supposed orthotic assessment forms you completed should have been a clear warning that something was amiss.

Likewise, the large number of excessive imaging results returned to your office should have warranted further scrutiny by you.

As the authorizing physician, the proverbial buck must stop with you.

Your patients, and indeed all citizens of Ontario, expect that all investigations and prescriptions must be done only for the best interests of patients.