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. Donald Chow (CPSO #50405)
(the Respondent)

INTRODUCTION

In early 2017, the Complainant had a fall and developed sharp pain in her thoracic spine, radiating to below her right breast. In the summer of 2017, the Respondent saw the Complainant for an orthopedic consultation. 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

1. **The Complainant is concerned that the Respondent failed to provide adequate care to her. For example, the Respondent:**
    a. **sent the magnetic resonance imaging (MRI) requisition to the Complainant's family physician but failed to submit it to the central booking department at one of the hospitals where he has privileges; and**
    b. **gave the Complainant a referral for physiotherapy but failed to advise her the reason for the referral.**
2. **The Complainant is concerned that the Respondent behaved in an unprofessional manner. For example, the Respondent:**
    a. **failed to advise the referring physician that he is no longer performing surgeries and as such is "abusing OHIP [the Ontario Health Insurance Plan]" as he is seeing patients and not able to offer surgery, and then he is referring patients to another surgeon;**
    b. **failed to advise the Complainant in advance that he needs to have her x-ray and MRI images on a DVD for his records, for which she will need to obtain a physician's written request for the diagnostic imaging facility;**
    c. **failed to advise the Complainant in advance that she is responsible for paying the fee of $55.00 for the diagnostic images;**
    d. **"lectured" the Complainant about not knowing her weight and talked about another patient who was "the fattest patient who broke the MRI machine"; and**
    e. **failed to answer the Complainant's questions in a professional and objective manner, but instead would laugh, respond with a question, or go off topic and tell her various stories.**

COMMITTEE'S DECISION

An Internal Medicine Panel of the Committee considered this matter at its meeting of February 11, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to cooperation with the College and his failure to follow through on ordering tests.

COMMITTEE'S ANALYSIS

Concerns regarding inadequate care (concerns 1a -b)

The record indicated that the Respondent did not fax the MRI requisition to the hospital; instead, the Complainant's family doctor later sent in the MRI requisition. The Respondent's failure to send the MRI requisition to the hospital was concerning and delayed investigation of the Complainant's pain.

Concerns regarding unprofessional behaviour (concerns 2a - e)

The Committee took no further action on the concerns respecting unprofessional behaviour.

Cooperation with the College

The Respondent failed to respond to multiple requests from the College's investigator to provide a response to this complaint. The Committee was disappointed in his decision not to participate in the process. The Committee also noted that the College's investigator had to visit the Respondent's office twice to obtain the medical records, as the Respondent did not provide them. This failure to cooperate with the College's investigation raised concerns regarding the Respondent's professionalism.