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 Nahas (CPSO #72330)
(Family Medicine)
(the Respondent)

INTRODUCTION

The Complainant was in a car accident and assessed in the Emergency Room (ER). The ER physician referred him to the Respondent's Clinic for treatment of a whiplash and soft tissue injury and associated pain. About a week later, the Complainant attended the Clinic where he initially completed questionnaires and was seen by Clinic staff. The Respondent later saw the Complainant once for an intake assessment, after which the Complainant received treatment from Clinic staff.

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 is concerned that the Respondent conducted himself and his clinic in an unprofessional and self-serving manner in that he:

- **did not perform a physical assessment of the Complainant's injuries;**
- **gave false information about what treatments the Clinic could provide, specifically, regarding laser light acupuncture and massage;**
- **had the Complainant return for multiple appointments before advising him that the Clinic could not provide the care he required; and**
- **referred the Complainant to a different clinic when it was found that his insurance would not provide for additional benefits over and above minor injury guidelines (MIG).**

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of January 12, 2022. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to failing to complete a history and physical examination of a patient and formulate a diagnosis, before completing patient forms involving financial compensation.

In addition, the Committee decided that it was prepared to accept an undertaking from the Respondent. The undertaking includes, among other things: six-month clinical supervision; professional education in medical record-keeping,

complementary/alternative medicine (CAM), ending the physician-patient relationship, consent to treatment, and medical ethics/professionalism; and a reassessment.

The College received the Respondent's signed undertaking, dated June 7, 2022, on June 8, 2022.

COMMITTEE'S ANALYSIS

As part of this investigation, the Committee retained an independent Assessor who specializes in family medicine. The Assessor concluded that the Respondent did not meet the standard of care in treating the Complainant. In particular, the Assessor noted concerns with the Respondent's record-keeping, his diagnosis of a mental health disorder on the disability form, his treatment plan for insurance billing, his adherence to the College policy on CAM, and his professional responsibility.

The Assessor also opined that the Respondent displayed a lack of judgement by not conducting a thorough history and physical examination of the Complainant, and that his clinical practice, behaviour and conduct was likely to expose his patients to a moderate risk of harm or injury.

The Respondent reviewed the Assessor's report and agreed that he should have conducted a physical examination at the intake stage, and that he should have documented the care he provided in the medical record. However, he disagreed with the Assessor's view of his diagnosis of a mental health disorder, which he believes was supported by his observations of the Complainant. He also disagreed with the Assessor that the Complainant should have been classified in the minor injury category for insurance. The Respondent said there was no CAM diagnosis in this case, only conventional ones. The Respondent retained an opinion provider to review the care he provided to the Complainant. That opinion provider also concluded that the Respondent's record-keeping was deficient, and that the Respondent should have completed a physical examination of the Complainant; otherwise, he generally disagreed with the Assessor's other concerns.

The Assessor's opinion remained unchanged after reviewing the Respondent's response and opinion provider's report.

The Committee agreed with the Assessor's conclusions that the Respondent did not meet the standard of care in treating the Complainant, displayed a lack of judgement by not conducting a thorough history and physical examination of the Complainant, and

the Respondent's clinical practice, behaviour and conduct was likely to expose his patients to a moderate risk of harm or injury.

In particular, the Committee was concerned about the following:

Record-keeping: The Respondent did not complete and document an assessment of the Complainant and develop a diagnosis before completing insurance forms. In particular, on the forms submitted to the insurer the Respondent indicated the Complainant had a mental health disorder, yet there is no history, rationale, explanation or differential in the medical record to support this psychiatric diagnosis.

Adherence to CAM policy: The Respondent did not complete and document an assessment before providing CAM to the Complainant and did not document a conventional diagnosis or consent to CAM treatment in the medical record. This was not in accordance with the College's CAM policy. The Committee agreed with the Assessor that the treatments the Respondent recommended have little or no evidence to support their use, especially for the Complainant's condition, and this is also contrary to the CAM policy.

Professionalism: In general, the Committee had concerns about the Respondent's ethics and professionalism. This included his decision to stop providing care when the Complainant only qualified under MIG, which was not in the Complainant's best interests, as well as his failure to complete a physical examination and document a full assessment and diagnosis before submitting a form for insurance coverage.

Undertaking and caution

The Respondent has a concerning College history, including two prior investigations in which similar concerns were identified regarding his documentation, consent, examination and failure to follow the College's CAM policy. In both cases the Committee cautioned the Respondent, and in 2018 the Committee also required the Respondent to complete a specified education and remediation program, including six-month clinical supervision and professional education in medical record-keeping. This prior similar history elevated the Committee's concerns in this matter.

The Committee's concluded its concerns could be addressed by the undertaking and caution described above.

With respect to the specific concerns raised in the complaint, the Committee noted as follows:

Re: did not perform a physical assessment of the Complainant's injuries

The Respondent failed to conduct a physical examination of the Complainant or document any assessment in the medical record, and thus failed to maintain the standard of the profession. The Respondent has undertaken to pursue professional education and be under clinical supervision to address these concerns.

Re: gave false information about what treatments the Clinic could provide, specifically, regarding laser light acupuncture and massage
-AND-
Re: had the Complainant return for multiple appointments before advising him that Clinic could not provide the care he required
-AND-
Re: referred the Complainant to a different clinic when it was found that his insurance would not provide for additional benefits over and above minor injury guidelines

The Committee is limited to a documentary review of information and it is unclear if the Respondent provided "false" information about the treatments available at the Clinic; however, the Complainant did attend multiple appointments at the Clinic, began treatment and was expecting to continue to receive treatment there. It was only after the Complainant's insurer advised that the Complainant did not qualify for benefits above and beyond the MIG, that the Complainant was discharged and referred to another clinic. In the Committee's view, the Respondent's decision to end the physician-patient relationship was unethical and not in the patient's best interest, and thus did not meet expectations of the College policy *Ending the Physician-Patient Relationship*. This subject is one of the areas in which the Respondent has undertaken to pursue professional education.