

## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Michael Godfrey Sumner, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity and any information that would disclose the identity of Dr. Sumner's patients whose names are disclosed at the hearing 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: Sumner, M. G. (Re)**

**THE DISCIPLINE COMMITTEE OF THE 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**  
being Schedule 2 of the *Regulated Health Professions Act, 1991*,  
S.O. 1991, c. 18, as amended.

**B E T W E E N:**

**THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. MICHAEL GODFREY SUMNER**

**PANEL MEMBERS:**

**DR. P. CHART  
S. BERI  
DR. P. TADROS  
DR. E. ATTIA (Ph.D.)  
DR. P. ZITER**

**Hearing Date:** **2012:** July 30 (Motion), September 27 and 28  
**2013:** March 4  
**Decision Date:** March 4, 2013  
**Release of Written Reasons:** April 22, 2013

**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 July 30, 2012 (Motion), September 27 and 28, 2012, and March 4, 2013. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Michael Godfrey Sumner committed an act of professional misconduct:

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

The Notice of Hearing also alleged that Dr. Sumner is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991* (“the Code”).

### **RESPONSE TO THE ALLEGATIONS**

Dr. Sumner initially denied the allegations against him. Following the admission into evidence of patient records and the report and oral testimony of the College’s expert witness, Dr. Sumner changed his response to the allegations and admitted the allegation of professional misconduct in the Notice of Hearing, that he failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence.

### **FACTS AND EVIDENCE**

The following facts were set out in an Agreed Statement of Facts and Admission which was filed as an exhibit and presented to the Committee:

## **PART I – FACTS**

1. Dr. Michael Godfrey Sumner is a psychiatrist who graduated from the Hahnemann Medical College in Pennsylvania in 1966 and has held a certificate of independent practice with the College of Physicians and Surgeons of Ontario (“College”) since 1985.

### **The Clinical Review**

2. In December 2009, the College received information from a psychiatrist who expressed concerns about a patient she had seen who was being treated by Dr. Sumner. The College commenced an investigation and retained Dr. X to opine on Dr. Sumner’s competence and standard of practice based on a review of 15 patient charts. Dr. X is co-chair of the Division of Adult Psychiatry and Deputy Head of Psychiatry at the teaching hospitals affiliated with Queen’s University in Kingston Ontario. A copy of his resumé is Exhibit 3 on this hearing.

3. Dr. X provided a report to the College dated November 16, 2010. In Dr. X’s opinion, Dr. Sumner failed to maintain the standard of practice in his care and treatment of 4 of the 15 patients under review. A copy of the report of Dr. X is Exhibit 5 on this hearing.

4. In his report, Dr. X found some aspects of Dr. Sumner’s practice to be commendable, and noted that he was an honest and well-intentioned psychiatrist who has a real sense of advocacy on behalf of his patients. However, he had a number of concerns, the full extent and details of which are set out in his reports and the oral testimony provided to date before the Discipline Committee. Among other things, Dr. X expressed the following concerns regarding Dr. Sumner’s care of certain patients:

- (a) The lack of documentation of any cognitive testing in certain patients for whom Dr. Sumner had made a diagnosis of brain injury with cognitive deficits;
- (b) Dr. Sumner made diagnoses of brain injury where there was no clear or compelling evidence to support the diagnosis;

- (c) Dr. Sumner provided treatment to certain patients that did not follow from the diagnosis made;
- (d) Dr. Sumner's charts failed to explore or document certain patients' presenting problem or chief complaint;
- (e) Dr. Sumner failed to recognize that deficits in attention and concentration are not specific to an acquired brain injury but are also a core feature of affective disorders; and
- (f) Dr. Sumner did not provide certain patients with standard pharmacotherapy for their depression, anxiety and psychosis.

5. Dr. X also prepared a supplementary report dated December 16, 2010, which is Exhibit 6 on this hearing. In this second report, Dr. X noted that Dr. Sumner's below standard care in the four charts identified resulted in his patients being exposed to the following risks:

- Patients were exposed unnecessarily to psychotropic medications, specifically anticonvulsants, psychostimulants and cholinesterase inhibitors. The exposure to unnecessary medication posed theoretical risks of harm or injury; however, there is no evidence from the charts reviewed that any significant harm or injury resulted from this unnecessary exposure;
- Dr. Sumner failed to provide standard treatment, or provided inadequate treatment, of certain patients' underlying serious mental illness such as major depression, anxiety and psychosis, thus prolonging patients' suffering and increasing the risk of consequences as a result of the untreated underlying illness. However, there was no evidence that any serious permanent damage, harm or injury occurred; and
- One patient's psychotic symptoms were extremely likely to have been precipitated and perpetuated by Dr. Sumner's clinical care.

6. Prior to the Discipline Committee hearing, Dr. Sumner served an expert report on the College by Dr. Y. Dr. Y is a Professor of Psychiatry and Pharmacology at the University of Toronto and Head of the Mood Disorders Psychopharmacology Unit at the University Health Network. Dr. Y opined on Dr. Sumner's use of topiramate. He did not opine on whether Dr. Sumner's care of the 15 patients reviewed by Dr. X met the standard of care. Dr. Y concluded that although Dr. Sumner employs topiramate earlier in the treatment algorithm than would be considered common practice by most practitioners as well as earlier than recommended in published treatment guidelines, it is not outside of the realm of reasonableness to consider topiramate in the context in which Dr. Sumner was using it.

### **Monitoring and Recent Practice**

7. As a result of an Order issued by the Inquiries, Complaints and Reports Committee, Dr. Sumner's practice has been subject to supervision since June of 2011. The reports of the supervisor, Dr. Z, have noted improvements in Dr. Sumner's practice. The three most recent reports have concluded that Dr. Sumner's patient care and record keeping is now meeting the standard of care. A copy of the monitoring reports of Dr. Z dated October 3, 2011, January 30, 2012, April 27, 2012, June 30, 2012, October 31, 2012 and February 27, 2013 are attached, collectively, at Tab 1 [to the Agreed Statement of Facts and Admission].

### **PART II – ADMISSION**

8. Dr. Sumner admits the facts set out in paragraphs 1 through 7 above, and specifically acknowledges the deficiencies set out in paragraph 4 and in the reports of Dr. X.

9. Dr. Sumner admits that the conduct described above constitutes professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991 in that he failed to maintain the standard of practice of the profession.

**FINDING**

The Committee accepted as true all of the facts set out in Agreed Statement of Facts and Admission. Having regard to these facts and the documentary evidence and oral testimony of Dr. X, the Committee accepted Dr. Sumner's admission and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession.

**PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for Dr. Sumner made a joint submission as to an appropriate penalty and costs order. The Committee appreciates that the law requires the acceptance of a joint submission, unless its acceptance would be contrary to the public interest and bring the administration of justice into disrepute. This is not such a case.

The documentary evidence and oral testimony of Dr. X (the medical expert) was found to be consistent with the agreed statement of facts presented to the Committee.

Aggravating factors were considered and included findings in a prior CPSO hearing in 2007, in which the Committee found that deficiencies in Dr. Sumner's care of patients constituted professional misconduct. In that case, there were similar findings of fundamental errors in diagnosis and treatment of a vulnerable group of patients which exposed them to unnecessary risks.

The Committee also considered mitigating factors which included Dr. Sumner's admission that his care failed to maintain the accepted standard of practice of the professions, even though that admission and acceptance of responsibility only came after the presentation of evidence at the hearing.

It was also noted that Dr. Sumner successfully completed a recordkeeping course, which addressed one of the areas of deficiency identified.

The Committee considered and took into account the monitoring reports of Dr. Z which were very positive and clearly stated that Dr. Sumner is capable of meeting acceptable

standards of care when under close and continuous supervision. The proposed penalty provides for an indefinite period of close supervision which ensures public protection.

The three month suspension is in line with the penalty imposed in similar cases which were presented to the Committee by counsel in a book of authorities. This 3 month suspension also serves as a specific and general deterrent to the member and the profession at large.

In summary, the Committee felt that the components of the proposed penalty were sufficient to protect the public and punish the member while at the same time provide an opportunity for remediation. The order proposed in the joint submission serves to maintain public confidence in the medical profession.

## **ORDER**

Therefore, having stated the findings in paragraph 1 of its written order of March 4, 2013, the Committee ordered and directed, on the matter of penalty and costs, that:

2. the Registrar suspend Dr. Sumner's certificate of registration for a period of three (3) months commencing April 15, 2013.
3. the Registrar impose the following terms, conditions and limitations on Dr. Sumner's certificate of registration:
  - i. Dr. Sumner may practise only under the supervision of a College-approved clinical supervisor ("Clinical Supervisor") who has signed an undertaking in the form attached [to the Order] as Schedule "A". The Clinical Supervisor will meet with Dr. Sumner, review 10 of Dr. Sumner's patient charts and all of Dr. Sumner's charts for new patients once a month, including a review and approval of all clinical treatment plans and of the psychopharmacology proposed by Dr. Sumner, and report to the College a minimum of once every three months;



- ii. If the Clinical Supervisor who has given an undertaking is unable or unwilling to continue to fulfill its terms, Dr. Sumner shall, within 20 days, obtain an undertaking in the same form from a similarly qualified person who is acceptable to the College;
  - iii. If Dr. Sumner is unable to obtain a College-approved supervisor as set out in paragraphs (i) or (ii) above, he must cease practising medicine immediately until such time as he has obtained a Clinical Supervisor acceptable to the College. The fact that he cease practising under this condition will constitute a term, condition or limitation on Dr. Sumner's certificate of registration;
  - iv. If, after a minimum of one year from the date of this Order, the Clinical Supervisor recommends a reduction in the frequency of the meetings between Dr. Sumner and the Clinical Supervisor, and if the College pre-approves of the recommendation, the frequency of the monitoring may be reduced, in accordance with the College's approval;
  - v. Dr. Sumner will abide by all recommendations of his Clinical Supervisor with respect to practice improvements and education;
  - vi. Dr. Sumner may bring a motion to vary the terms of his supervision no earlier than three years after the date of this Order of the Discipline Committee;
  - vii. Dr. Sumner will be responsible for all costs associated with the implementation of this Order.
4. Dr. Sumner pay to the College costs in the amount of \$14,600 within 60 days of the date of this Order.

At the conclusion of the hearing, Dr. Sumner waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.