

## **NOTICE OF PUBLICATION BAN**

In the College of Physicians and Surgeons of Ontario and Dr. Ian Leroy Metcalfe, this is notice that the Discipline Committee ordered that there shall be a ban on publication or disclosure of the identity, and any information that would disclose the identity, of the patients who are referred to during the hearing or in any document filed 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 to a fine of not more than \$10,000 for a first offence and not more than \$20,000 for a subsequent offence.

**Indexed as: Metcalfe (Re)**

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

**IN THE MATTER OF** a Hearing directed  
by the Executive Committee of  
the College of Physicians and Surgeons of Ontario  
pursuant to Section 36(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. IAN LEROY METCALFE**

**PANEL MEMBERS:**

**DR. M. DAVIE (CHAIR)**  
**M. POWER**  
**DR. L. THURLING**  
**B. TAA (Ph.D.)**  
**DR. D. WALKER**

**Hearing Dates:** June 18, 2007  
**Decision Date:** June 18, 2007  
**Release of Written Reasons Date:** August 30, 2007

**PUBLICATION BAN**

## **DECISION AND REASONS FOR DECISION**

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the “Committee”) heard this matter at Toronto on June 18, 2007. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its order as to penalty and costs, with written reasons to follow.

### **PUBLICATION BAN**

On June 18, 2007 the Committee made an order in writing, with reasons, that there shall be a ban on publication or disclosure of the identity, and any information that could disclose the identity, of the patients who are referred to during the hearing or in any document filed at the hearing pursuant to subsection 45(3) of the Health Professions Procedural Code (the “Code”), being Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

### **THE ALLEGATION**

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

1. 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 acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

### **RESPONSE TO THE ALLEGATION**

Dr. Metcalfe admitted to the allegation of professional misconduct, as set out in the Notice of Hearing.

**FACTS AND EVIDENCE**

The following Statement of Agreed Facts was filed as an exhibit and presented to the Committee:

1. Dr. Metcalfe is a family physician. He has held a certificate of registration in Ontario authorizing independent practice since 1985 and has been a member of the College of Family Physicians since 1989.
2. From 1986 until November 2004, Dr. Metcalfe worked at a medical centre in Ontario. He was the Assistant Medical Director of that Centre from 1988 to 1991.
3. In about November, 2003, the medical centre went through a re-organization and also introduced a new booking system for patient appointments, a rostering and electronic record system, and a new electronic billing system.
4. From July to November, 2004, Dr. Metcalfe fictitiously filled in timeslots in the rostering and the electronic records system. Some of these fictitious entries related to advice that may have been given over the telephone or at other appointments, or indirectly through a relative who attended Dr. Metcalfe in person or which never occurred in any form, but all were made to look as though an appointment had taken place in person on the date and in the time slot filled in the patient's chart and elsewhere on the system. That is, Dr. Metcalfe would put a patient's name in an available "slot" so that it appeared that the slot was filled by a patient encounter, when it was not.
5. The conduct in question related to at least 28 patient encounters in the period from July to November 2004 as follows:

(i) *Patient Z*

One afternoon in the fall of 2004 at 3:18 p.m. Dr. Metcalfe sent a message asking that the patient be referred to a sleep clinic as the patient wanted a sleep study. The sleep study was booked by the Clinic's clerk at 3:20 p.m. At 3:57 p.m. Dr. Metcalfe booked the patient for an appointment at 4:15 p.m. and at 3:59 p.m.

created the patient encounter. However, the referral for the sleep study was sent at 3:18 p.m. on that day. The patient was not seen by Dr. Metcalfe. The record states that the patient was seen by Dr. Roy Metcalfe for a snoring referral, diagnosis sleep disorder. The relevant documentation is attached at **Tab 1** [to the Statement of Agreed Facts].

(ii) *Patient Y*

In the fall of, 2004, a patient encounter history was created by Dr. Metcalfe. The visit was said to be for ear draining in respect of a diagnosis of suppurative otitis media and is said that a prescription was given. This patient encounter did not occur. The relevant documentation is attached at **Tab 2** [to the Statement of Agreed Facts].

(iii) *Patient X*

In summer 2004 Dr. Metcalfe entered a visit with the patient X. for anemia, indicating a diagnosis of iron deficiency anemia. The record he created states that the patient needed a re-check on iron stores and Hgb after anemia workup on iron supplement. In fact, the patient had had a blood transfusion several months before and had had some previous lab requisitions. In April, 2004 the patient note states that a requisition was given for a re-check. In fact, that patient encounter did not occur and no laboratory work was done as a result of the alleged requisition given on that date. Although the patient's husband was seen on the summer date, the patient was not. The relevant documentation is attached at **Tab 3** [to the Statement of Agreed Facts].

(iv) *Patient W*

The record states that the patient was seen in the fall of 2004 for sinuses by Dr. Metcalfe. The patient encounter did not occur. The relevant documentation is attached at **Tab 4** [to the Statement of Agreed Facts].

(v) *Patient V*

An encounter with a visit date in the fall of 2004 was created by Dr. Metcalfe for this patient. The note includes subjective and objective analyses, an assessment of a URI, and a plan of symptomatic treatment. This patient encounter did not occur. The relevant documentation is attached at **Tab 5** [to the Statement of Agreed Facts].

(vi) *Patient U*

An encounter with a visit date in the fall of, 2004 was created by Dr. Metcalfe. The visit was said to be for "ears" and a diagnosis said to made of a viral URI. In fact, the patient had been referred by Dr. Metcalfe to a specialist in respect of repeated ear infections in February, 2004 and did not see Dr. Metcalfe again for that condition. The patient encounter entered, which included the subjective and

objective analyses, an assessment and a plan, did not occur. The relevant documentation is attached at **Tab 6** [to the Statement of Agreed Facts].

*(vii) Patient T*

In the fall of 2004, the patient's mother was seen by Dr. Metcalfe. Dr. Metcalfe then created a patient encounter for patient T with a visit for nausea and a diagnosis of behaviour disorder of childhood and adolescence. The patient encounter did not occur. The relevant documentation is attached at **Tab 7** [to the Statement of Agreed Facts].

*(viii) Patient S*

In the fall of 2004, the patient's wife and daughter were in to see Dr. Metcalfe and at that time asked for a lab requisition for the patient. A patient encounter was created by Dr. Metcalfe for the patient for that date. The patient encounter did not occur. The relevant documentation is attached at **Tab 8** [to the Statement of Agreed Facts].

*(ix) Patient R*

In the fall of 2004 Dr. Metcalfe created a patient encounter for patient R for that date for the reason of "Ritalin/weight check." The patient encounter did not occur. The relevant documentation is attached at **Tab 9** [to the Statement of Agreed Facts].

*(x) Patient Q*

Two patient encounters in the fall of 2004 were created by Dr. Metcalfe. The first encounter states that the plan was to refer to Dr. B. In fact, a letter dated earlier than this visit to Dr. B had already been sent. This visit did not occur. Similarly, the visit said to have taken place later in the fall of 2004 with respect to the knee and a requested x-ray did not occur. The relevant documentation is attached at **Tab 10** [to the Statement of Agreed Facts].

*(xi) Patient P*

The patient's daughter, O saw Dr. Metcalfe in the fall of 2004. At that appointment, she obtained a prescription for her mother, P. O. did attend this appointment but P did not. The appointment entry created for P by Dr. Metcalfe states that she saw Dr. Metcalfe for travel, with a diagnosis of anxiety and depression, that she is going to the Caribbean for holiday and wants something in case she gets ill. A prescription was given. The relevant documentation is attached at **Tab 11** [to the Statement of Agreed Facts].

*(xii) Patient N.*

Dr. Metcalfe created a patient encounter for the fall of 2004 at 2:00 p.m. for a mole changing on the patient's left forearm. In fact, the patient did not have a mole on her left forearm and did not see Dr. Metcalfe about this then or at any other time. She had previously had a mole removed on her right calf by Dr. Metcalfe. The relevant documentation is attached at **Tab 12** [to the Statement of Agreed Facts].

*(xiii) Patient M*

Dr. Metcalfe created an encounter for the patient for the fall of 2004. The assessment was said to be a URI and the plan, symptomatic treatment. This patient encounter did not occur. The relevant documentation is attached at **Tab 13** [to the Statement of Agreed Facts].

*(xiv) Patient L*

Dr. Metcalfe created a patient encounter with this patient for the fall of 2004. The visit was said to be for the throat and a diagnosis was a viral URI. In fact, the patient had seen another physician at the Clinic earlier that same month in 2004 and had not returned to the clinic since. The relevant documentation is attached at **Tab 14** [to the Statement of Agreed Facts].

*(xv) Patient K*

Dr. Metcalfe created a patient visit for a genital wart. The encounter was said to have occurred in the fall of 2004. In fact, this visit did not occur. The relevant documentation is attached at **Tab 15** [to the Statement of Agreed Facts].

*(xvi) Patient J*

Dr. Metcalfe created an encounter for the fall of 2004 for a visit of anxiety and a diagnosis of anxiety and depression. That patient encounter did not occur. The relevant documentation is attached at **Tab 16** [to the Statement of Agreed Facts].

*(xvii) Patient I*

Dr. Metcalfe created a patient encounter for this patient for the fall of 2004, with a visit for "throat" and a diagnosis of a viral URI. This patient encounter did not occur. The relevant documentation is attached at **Tab 17** [to the Statement of Agreed Facts].

*(xviii) Patient H*

Dr. Metcalfe made an electronic entry for the fall of 2004 at 3:00 p.m. for this patient. That patient encounter did not occur. The patient had been seen at another health centre with respect to the fall recorded by Dr. Metcalfe in the Patient Encounter History. The relevant documentation is attached at **Tab 18** [to the Statement of Agreed Facts].

*(xix) Patient G*

Dr. Metcalfe created a patient encounter for the fall of 2004 at 3:45 p.m. which did not occur. Dr. Metcalfe did send a letter dated that date to a specialist. The relevant documentation is attached at **Tab 19** [to the Statement of Agreed Facts].

*(xx) Patient F*

F attended with her grandfather for an appointment for him in the fall of 2004. Dr. Metcalfe created a patient encounter for F. on that date, which did not occur. The plan was said to be to refer F to Dr. A. In fact, the referral of the patient to Dr. A had been made two days earlier. The relevant documentation is attached at **Tab 20** [to the Statement of Agreed Facts].

*(xxi) Patient E*

Dr. Metcalfe created a visit in the fall of 2004 which did not occur. The visit was to be for re-checking a burn; the plan was to “continue same.” The patient encounter did not occur. The relevant documentation is attached at **Tab 21** [to the Statement of Agreed Facts].

*(xxii) Patient D*

Dr. Metcalfe created an encounter for the fall of, 2004 which did not occur. This was to be for a renewal of Ritalin. In fact, the patient was not seen in the office but there was a prescription renewal only. The relevant documentation is attached at **Tab 22** [to the Statement of Agreed Facts].

*(xxiii) Patient C.*

Dr. Metcalfe created a patient encounter for late October 2004 for a leg ulcer; diagnosis diabetes mellitus. Some medications were prescribed. In fact, the patient encounter did not occur. Some prescriptions had been given earlier in the fall of 2004 for this patient. It appears that the patient was seen on the same day in late October 2004 by a different physician at the Clinic for an abrasion in the ear canal. The patient’s husband had been seen in the fall of 2005 by Dr. Metcalfe. The relevant documentation is attached at **Tab 23** [to the Statement of Agreed Facts].

*(xxiv) Patient ZZ*

Dr. Metcalfe created a patient encounter for this patient for the fall of 2004, for a “non painful red eye.” The plan was to reassure and no treatment was required. In fact, this patient encounter did not occur. The relevant documentation is attached at **Tab 24** [to the Statement of Agreed Facts].

*(xxv) Patient YY*

Dr. Metcalfe created a patient encounter for the fall of 2004 for “insurance form completion.” In fact, this encounter did not occur. The relevant documentation is attached at **Tab 25** [to the Statement of Agreed Facts].

*(xxvi) Patient XX*

Dr. Metcalfe created a patient encounter for the fall of 2004. The visit did not occur. Dr. Metcalfe did, on the previous day in 2004, provide a prescription renewal for birth control pills for the patient. The relevant documentation is attached at **Tab 26** [to the Statement of Agreed Facts].

*(xxvii) Patient WW*

Dr. Metcalfe created a patient encounter for the fall of 2004 for depression. The plan was to continue same, which included medications. In fact, Dr. Metcalfe provided a prescription only on that date and there was no patient encounter. There was a prescription renewal telephoned in to the pharmacy. The relevant documentation is attached at **Tab 27** [to the Statement of Agreed Facts].

*(xxviii) Patient VV*

Dr. Metcalfe created a patient encounter for the fall of 2004 for a “post CVA check.” In fact, the patient did not see Dr. Metcalfe although clinical notes from the summer were sent to the insurer around that time. The relevant documentation is attached at **Tab 28** [to the Statement of Agreed Facts].

6. In addition to these, there were 22 other appointments for which the clinic attempted, but could not ascertain, whether the patient encounter had occurred.
7. Dr. Metcalfe did not make any financial gain from this. However, his actions did deceive and have an adverse impact on his colleagues, by making him appear to be more busier and productive than he actually was. Other treating physicians could have relied on these records to the detriment of the patient, but there is no evidence that any patient care was compromised.
8. Dr. Metcalfe admitted to this conduct when confronted by Dr. UU, the Director of the centre.

## **FINDING**

The Committee accepted as true all of the facts set out in the Statement of Agreed Facts. Having regard to these facts, the Committee accepted Dr. Metcalfe's admission and found that he committed an act of professional misconduct under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or acts 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**

Counsel for the College and counsel for the member submitted their proposals for penalty and costs. The panel considered carefully the facts and submissions on both sides in coming to its decision, as well as the precedents filed by counsel for the parties.

Counsel for the College was seeking a suspension of three months, one month of which was to be suspended if Dr. Metcalfe completed the Ethics Course provided by the College. In addition, costs of \$2,500.00 would be imposed and the matter would be recorded in the Register. Three precedent cases were presented as supportive of this penalty (*Fiorillo, Holder, Garry*). The College submitted that the moral issue of breaking trust by making false statements on medical records required suspension in each of these cases.

Counsel for Dr. Metcalfe argued that no suspension should be ordered and submitted that a reprimand only in addition to costs would suffice as an appropriate penalty. Dr. Metcalfe testified on his own behalf and a letter from a treating therapist whom he had attended six times in the spring of 2005 was submitted as an Exhibit (#3). Precedent cases involving falsification of records were cited in support of this lesser penalty. (*Bradford, Zhuk, McGowan, Garry and Fiorillo*)

Significantly, the panel noted that the case of Dr. Metcalfe was somewhat unique in that no precedent case was presented by either side that involved such repeated, premeditated

and protracted (over several months) fabrications of medical records. In all but one of the cases both suspension and reprimand had been ordered.

After careful deliberation, the Committee decided on a more severe penalty than that submitted by the College. Concurring with College counsel, the panel agreed that a suspension of three months, one month of which would be suspended if Dr. Metcalfe completed the College's Ethics Course, would be appropriate. Costs of \$2,500.00 were also imposed as submitted by the College. In addition the Committee felt strongly that a public reprimand was required to express their abhorrence of Dr. Metcalfe's behaviour.

There were aggravating factors which were of grave concern to the panel. Dr. Metcalfe had not only broken trust with his colleagues, who counted on him to bear equal responsibility for the clinical care of several thousand patients, but, most importantly he had deceived the patients who trusted him with their medical care. The public has a right to expect that their physicians will protect the integrity of their medical records which ought to reflect accurately the facts related to their healthcare. Although apparently no harm befell any patient as a consequence of Dr. Metcalfe's fabricated clinical findings and non-existent patient visits, this repeated falsification of records exposed many patients to potential harm. Safe and appropriate treatment depends on an accurate account of past clinical history. The penalty will serve to assure the public that such wilful tampering with medical records will be dealt with severely.

Although there was no "direct" financial benefit to himself, Dr. Metcalfe was reimbursed on the assumption that his clinic hours were in fact dedicated to real clinical work. Thus his behaviour was dishonest and self-serving and without concern for the welfare of his patients or the obligation owed to his colleagues.

The panel was also alarmed by the fact that Dr. Metcalfe, although clearly troubled for many months, did not admit his misdeeds or seek assistance of any kind until confronted by his clinic colleague with the fact of his many false chart entries. The panel did not

accept that stress caused by the reorganization of the clinic provided either explanation or justification for his blatantly unethical behaviour.

The panel noted that he is a teacher and role model for medical trainees. As such he has additional responsibility to uphold the standards of the profession. The penalty must serve not only as a specific deterrent to any future such actions by Dr. Metcalfe but also as a general deterrent to all members of the profession, providing a strong admonition that such transgressions will not be tolerated.

Counsel for the member pointed out that Dr. Metcalfe had taken these matters with “extreme seriousness” and the panel noted his apparent remorse before them as a witness. The Committee acknowledges his previous professional contribution in the same community for many years. We also acknowledge that his admission to the allegation of professional misconduct eliminated the necessity for a long, expensive, and arduous hearing. Patients were thus spared the stress of appearing as witnesses in such a process. These facts were taken to be mitigating factors in determining a penalty.

### **ORDER**

Therefore, the Discipline Committee ordered and directed that:

1. The Registrar suspend Dr. Metcalfe’s certificate of registration for a period of three (3) months, one (1) month of which shall be suspended if Dr. Metcalfe successfully completes, at his own expense, the College’s Ethics Course and provides proof thereof to the College, to be completed by December 31, 2007.
2. Dr. Metcalfe pay to the College costs in the amount of \$2,500.00.
3. Dr. Metcalfe appear before the panel to be reprimanded.
4. The results of this proceeding be included in the register.

Dr. Metcalfe waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.