

**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. James Anthony Ross (CPSO #90304)  
(the Respondent)**

## **INTRODUCTION**

The Patient attended the Emergency Department (ED) with severe pain after sustaining a fall at home. The Respondent was the attending emergency physician. The Patient was concerned that he refused to listen, displayed unprofessional behaviour and accused her of faking her pain and “looking for a fix”.

## **COMMITTEE’S DECISION**

The Committee considered this matter at its meeting of October 15, 2025.

The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to his lack of cooperation with the College in this investigation, his approach to pain management in the ED, including opioid prescribing, and the use of judgemental, non-compassionate and stigmatizing language in the medical record.

## **COMMITTEE’S ANALYSIS**

As set out in *Ontario Regulation 856/93 (Professional Misconduct)* under the *Medicine Act, 1991*, failing to respond appropriately or within a reasonable time to a written inquiry from the College may be considered an act of professional misconduct. Over a period of five months, College staff made multiple attempts (by email, telephone and mail including courier with confirmation of delivery) to communicate with the Respondent. While a written response to a complaint is not a requirement, the disregard to respond at all, in the Committee’s view represents a lack of respect for the regulatory process. Additionally, by ignoring the College’s attempts to engage him, the Respondent has precluded the Committee from considering his perspective, including an explanation as to the reason he approached the Patient in this manner.

The ED record shows that the Patient had a complex medical history and was on Percocet and many other medications not noted by the Respondent. Despite making notes suggesting that the Patient would engage in opioid diversion/abuse, the Respondent then proceeded to add more Percocet over a period of multiple weeks, which is not appropriate pain management. Providing a large quantity of Percocet over time is also not prudent practice for an emergency physician.

The language the Respondent used in his documentation suggests a lack of empathy, negative bias towards the Patient and is not in keeping with the College's expectations of compassionate care. The notes suggest that there was some doubt as to whether the Patient was indeed experiencing pain. Pain is subjective and physicians must start by hearing and believing patients' concerns unless there is compelling information not to do so. Further, discussing the issues around the Respondent not renewing Percocet if the Patient lost them ("by narcotics on the street or evidence of double doctoring") is not professional, especially if there is no context to explain why he might have said this. Even if the Patient had a history of substance misuse (and there is nothing to suggest she did), the same compassionate care is expected for all patients.

## **CONCLUSION**

Therefore, the Committee required the Respondent to appear before a Panel of the Committee to be cautioned as outlined above.

This is a summary of the Committee's decision as it relates to the caution disposition.