

**SUMMARY of the Decision of the Inquiries, Complaints and Reports Committee  
(the Committee)**

Information about the complaints process and the Committee is available at:  
<https://www.cpso.on.ca/Public/Services/Complaints>

**Dr. John Chi Cheong Chan (CPSO# 73893)**

**INTRODUCTION**

The College received information raising concerns about psychiatrist Dr. Chan's billing around his attendances at a group home, which the reporting individual indicated were very brief in nature. Subsequently, the Committee approved the Registrar's appointment of investigators to conduct a broad review of Dr. Chan's practice.

**COMMITTEE'S DECISION**

A General Panel of the Committee considered this matter at its meeting of February 12, 2019. The Committee required Dr. Chan to attend at the College to be cautioned in person with respect to his care in a group home setting (including duration and frequency of counseling sessions), medical record-keeping and billing. The Committee also accepted an undertaking from Dr. Chan related to these issues, which provided that he would engage in professional education and then a reassessment of his practice by an assessor selected by the College.

**COMMITTEE'S ANALYSIS**

As part of this investigation, the Registrar appointed an assessor ("the Assessor") to review a number of Dr. Chan's patient charts and other documents, interview Dr. Chan, and submit a written report to the Committee.

The Assessor concluded that most of the charts reviewed did not meet the standard of care; the Assessor identified deficiencies in Dr. Chan's medical record-keeping and noted that the number of patient contacts seemed remarkably disproportionate to the amount of active care offered and many treatment contacts did not meet the criteria for the billing code used. The Assessor was of the view that charts (in different numbers) showed a lack of knowledge, skill, and judgement. The Assessor did not think there was a risk of harm in any of the charts.

Dr. Chan responded to the Assessor's report, including that he acknowledged the deficiencies in his record-keeping; in this regard, he reported that he completed a record-keeping course. Dr. Chan said it was never his intention to bill inappropriately and in hindsight he likely should have taken further steps to confirm the billing code. He also said on reflection he could have ensured better communication at the outset with group home staff. He explained the basis for the frequency of patient visits.

The Committee had concerns about Dr. Chan's medical record-keeping and clinical contact and billing patterns. The Committee noted that its concerns would be satisfied, in part, if an

undertaking could be obtained from Dr. Chan to address the issues in question, and such an undertaking was successfully obtained.

In addition to the undertaking, the Committee was concerned that Dr. Chan made very frequent visits to the group homes, beyond what would be normally expected, and he documented little active treatment using an inappropriate billing code in terms of the duration of sessions and the personnel available for most of the visits. Therefore, the Committee was required Dr. Chan to attend at the College to be cautioned.