

**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 Lap Yan Ku (CPSO# 63957)  
(the Respondent)**

**INTRODUCTION**

The Patient was brought to hospital by ambulance after a methadone overdose. The Patient had been unresponsive but the paramedics were able to revive the Patient with Narcan (naloxone) prior to departing the scene.

The Patient was admitted under the care of the Respondent. The Respondent discharged the Patient home the next morning.

A few hours after discharge, the Patient was found at home without vital signs; paramedics attended and were unable to resuscitate him.

The Complainant, the Patient's family member, 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 prematurely discharged the Patient from hospital after a methadone overdose. The Patient was found deceased at his home a few hours after discharge.**

**COMMITTEE'S DECISION**

A General Panel of the Committee considered this matter at its meeting of September 11, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to appropriate emergency room (ER) management of a patient who has had a methadone overdose and thorough documentation in the record.

The Committee also directed staff to negotiate an undertaking with the Respondent.

The undertaking requires the Respondent to engage in professional education. As detailed in the undertaking, the Respondent must be supervised for a minimum of six months; complete education in medical record-keeping and opioid overdose management; and undergo a reassessment approximately six months after the clinical supervision ends.

*The College received the Respondent's signed undertaking, dated October 10, 2019, on October 10, 2019.*

## **COMMITTEE'S ANALYSIS**

As part of this investigation, the Committee retained an independent Assessor who specializes in family and emergency medicine. The Assessor opined:

- The Respondent did not meet the standard of practice of the profession in his care of the Patient.
- The Respondent's care displayed a lack of knowledge and judgement. Management of a methadone overdose in the ER requires a prolonged period of observation. The Respondent incorrectly attributed the low oxygen saturation to a respiratory illness and sleep apnea, which was an error in judgement.
- Based on the review of this single chart, if the same clinical situation presented itself again and similar decisions were made, the Respondent's clinical practice would expose his patients to harm.

The Committee agreed with the Assessor's conclusion that the Respondent did not meet the standard of care in treating the Patient.

As the Assessor indicated, for an acute overdose of methadone in which there is respiratory depression requiring a Narcan drip, the standard is to monitor the patient for at least 24 hours. In addition, a patient should be monitored for at least six hours after the Narcan drip has stopped. As a result, the Committee was of the view that the Respondent's decision to discharge the Patient approximately 8.5 hours after admission was inappropriate. The Respondent should have kept the Patient for observation.

Based on the chart, it was evident that the Patient had significant respiratory depression due to the overdose, and a low oxygen saturation at the time of discharge. In the Committee's view, the Respondent should not have discharged the Patient given the ongoing signs of respiratory depression.

The Respondent also failed to order a toxicology screen and failed to order charcoal upon admission, and should have considered ordering an arterial blood gas rather than a venous one.

Finally, the Committee found the Respondent's documentation to be very poor. His writing was difficult to read and he documented very little for such a complex case.