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. Ronald Lawrence Hall (CPSO #57078)
(the Respondent)

INTRODUCTION

The Respondent began providing primary care to Patient 1 in 2019. Patient 2 joined his practice as a newborn in 2020. The Complainant contacted the College of Physicians and Surgeons of Ontario to express concerns about the Respondent's care of the Patients.

COMMITTEE'S DECISION

A General Panel of the Committee considered this matter at its meeting of September 1, 2023. The Committee required the Respondent to appear before a Panel of the Committee to be cautioned with respect to intentionally prescribing an overdose of azithromycin to de-escalate a situation. The Committee also decided to accept an undertaking from the Respondent that is now posted on the public register.

COMMITTEE'S ANALYSIS

Concern that the Respondent overprescribed clonazepam to Patient 1, causing her to fall into a state of psychosis, resulting in her being hospitalized for two weeks in September 2021

The Respondent initially stated that he did not prescribe clonazepam 2.0 mg to Patient 1. The College then provided the Respondent with a copy of Patient 1's pharmacy record. Upon review, the Respondent acknowledged that it differed from the pharmacy record in the patient chart and that it demonstrated that he did prescribe clonazepam 2.0 mg to Patient 1 on October 9 and 21, 2019, and May 3, 2021.

It was troubling to the Committee that the Respondent was unable to correctly ascertain from review of the medical record whether he had prescribed a high dose of clonazepam to Patient 1. This indicated to the Committee that the Respondent failed to document the treatment appropriately.

Upon review of the medical record, the Committee was of the view that clonazepam was not the correct medication for Patient 2's clinical issue. The fact that the Respondent prescribed it to her, and at a high dose, was concerning to the Committee as it suggested that he lacked sufficient understanding of clonazepam use and dosing.

Concern that the Respondent prescribed azithromycin to Patient 2 without an assessment and overprescribed azithromycin such that the pharmacist refused to fill the prescription and stated it would have caused serious harm to Patient 2

The Respondent explained the circumstances when he overprescribed azithromycin for Patient 2. He stated that the Complainant was acting in a threatening manner in the office, demanding a prescription for Patient 2, and he was concerned about his and the receptionist's safety. He made the decision to write the prescription for azithromycin at an excessively high dose in the belief that it would be "impossible to fill." His purpose was to deescalate the situation and get the Complainant to leave the office.

The Committee considered this to be a dangerous and bizarre method of deescalating a difficult situation. The Complainant might have become even more agitated at the pharmacy upon being refused the prescription. There was also the possibility the pharmacist might have missed the intentional overdose, which could have put Patient 2 at risk of a complication. The Respondent's actions in this regard were reckless.

On the basis of the above, the Committee had concerns about the Respondent's practice with regard to prescribing (including of benzodiazepines and controlled substances), medical record-keeping and management of conflict and aggressive behaviour in medical practice. The Committee determined that it was appropriate to caution the Respondent as set out above and accept the Respondent's signed undertaking.