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-Information-Services/Learn-About-Our-Complaints-Process**)**

Dr. Frederick Chi Chung Leung (CPSO #64040)
(the Respondent)

INTRODUCTION

The Patient had been the Respondent's patient since 2002. The Patient had a history of chronic back and hip pain due to several work injuries and motor vehicle accidents. Sadly, the Patient passed away from a fentanyl overdose in 2016. The Complainant, the Patient's relative, contacted the College of Physicians and Surgeons of Ontario (the College) to express concerns about the Respondent's scare.

COMPLAINANT'S CONCERNS

The Complainant is concerned that the Respondent failed to provide adequate care to the Patient. For example, the Respondent:

- **overprescribed painkillers, including fentanyl;**
- **failed to monitor medication use and approved refills ahead of schedule;**
- **did not acknowledge the addictive properties of the painkillers;**
- **should have been alerted to the dangers of the medication and increasing dosages;**
- **failed to address the root cause of the Patient's pain and relied on fentanyl instead; and**
- **failed to refer the Patient to a pain specialist.**

COMMITTEE'S DECISION

A Family Practice Panel of the Committee considered this matter at its meeting of February 7, 2019. The Committee required the Respondent to attend at the College to be cautioned in person with respect to his inappropriate prescribing of narcotics and poor medical record keeping. The Committee also accepted the Respondent's undertaking, which includes provisions for supervision and education related to narcotics prescribing and record keeping.

COMMITTEE'S ANALYSIS

Concern that the Respondent overprescribed painkillers, including fentanyl

Based on the Committee's review of the information, and as s discussed below, the Committee concluded that the Respondent overprescribed opioid medication to the Patient.

Concern that the Respondent failed to monitor medication use and approved refills ahead of schedule

The Committee was concerned that the Respondent did not follow the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain appropriately. Specifically, he did not adequately enforce the narcotics contract the Patient signed, by allowing the early release of his medication and repeat prescriptions for lost medication.

Concern that the Respondent did not acknowledge the addictive properties of the painkillers

The Committee was satisfied that the Respondent had knowledge of the addictive properties of opioid; however, he did not recognize that the Patient may well have been abusing his medication (as evidenced by his requests for early refills and "lost" prescriptions).

Concern that the Respondent should have been alerted to the dangers of the medication and increasing dosages

As noted above, the Respondent appeared aware of the risks of opioids. However, in the Committee's view, he did not act appropriately in the circumstances (such as by initiating a frank discussion with the Patient regarding the doses that he was using and his many requests for early releases or repeat prescriptions for lost medication, to determine whether abuse was an issue.)

The Committee took no further action on the Complainant's other concerns that the Respondent failed to address the root cause of the Patient's pain and relied on fentanyl and failed to refer the Patient to a pain specialist.