Indexed as: Adams (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Sections 36 of the Health Professions Procedural Code of the Regulated Health Professions Act 1991, S.O. 1991, c. 18, as amended.

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. FRANK STEPHEN ADAMS

PANEL MEMBERS: DR. O. KOFMAN (CHAIRPERSON)
DR. M. RAPP
DR. J. McGILLEN
H. MAEOTS

HEARING DATE(S): August 9-11, 1999 and September 8-10, 1999

DECISION RELEASED: April 14, 2000

DECISION AND REASON FOR DECISION

This matter was heard by the Discipline Committee of the College of Physicians and Surgeons of Ontario at Toronto on August 9 - 11, 1999, and September 8 - 10, 1999. The Committee heard oral argument at the conclusion of the hearing, and had the benefit of subsequent written submissions filed by the parties which addressed questions in writing from the Committee.

ALLEGATIONS

In the Notice of Hearing the allegations were that Dr. Frank Stephen Adams was guilty of professional misconduct in respect of the period after January 1, 1994 for failure to maintain the standard of practice of the profession, and of incompetence in that he displayed in his professional care of a patient a lack of knowledge, skill or judgment of a nature or to the extent that demonstrates that he is unfit to continue in practice or that his practice should be restricted. The hearing was initiated by the College, following an investigation pursuant to section 75 of the *Health Professions Procedural Code*. The allegations arose out of the detailed review by Dr. D. Moulin, neurologist and pain expert, of the medical practice of Dr. Adams with regard to his management of 25 patients with chronic non-malignant pain. Dr. Moulin reviewed the charts and files of these patients who had been seen by Dr. Adams between 1995 and 1998, and concluded that the care provided by Dr. Adams fell below the accepted standard of practice for eight of the 25 patients as determined by his review of the charts and clinical files.

PLEA

Dr. Adams pleaded not guilty to the allegations of professional misconduct and incompetence as set out in the Notice of Hearing.

FACTS

All of the 25 patients' charts that Dr. Moulin had reviewed were available to the Committee. However the hearing proceeded on the basis of the evidence with regard to the eight specific cases that Dr. Moulin had determined to be below the acceptable standard of practice.

Dr. Moulin was the only witness called by the College. Counsel for the respondent produced two expert witnesses on behalf of Dr. Adams. Dr. H. Merskey, a psychiatrist, is regarded as an expert in the field of pain management, as is Dr. R. Jovey, who although self-taught, has a

special interest in addiction medicine and chronic non-cancerous pain problems. In addition, Dr. Adams, testified as a witness.

The evidence presented with regard to the care of each of the eight patients was related to the period after January 1, 1994, when Dr. Adams treated these patients who had a variety of non-cancerous chronic pain problems. Non-cancerous chronic pain was defined as pain arising from previous underlying conditions lasting for a sustained period of time and considered to be an irreversible chronic condition.

Dr. Adams is qualified as a psychiatrist. His practice, however, primarily relates to the management of chronic pain problems. He refers to himself as a neuro-psychiatrist and clinical pharmacologist.

In Dr. Moulin's written report that was filed as an Exhibit, it was stated that it is now generally accepted by most regulatory bodies in Canada and the United States that opioid analgesics can provide significant improvement and quality of life in selected patients with chronic non-cancer pain. Complete pain relief is not a realistic outcome. There is no accepted ceiling dose beyond which further dose escalation is contraindicated. The goal is to achieve a state of opioid responsiveness which is defined as a favourable balance between pain relief and side effects.

Dr. Moulin further referred to the consensus statement and guidelines from the Canadian Pain Society on the use of opioid analgesics for the treatment of chronic non-cancer pain, 1998, which were developed by a task force chaired by Dr. R Jovey and in which Dr. Moulin and Dr. Merskey participated. These guidelines were entered as an Exhibit during the hearing and stated that evaluation of the patient should include at least the following information:

1. a detailed pain history and the results of previous treatments;
2. a directed physical examination, including musculo-skeletal examination, to look for clues to specific pain syndromes;
3. a review of previous diagnostic studies and assessments. Additional investigation or consultation if required, to fill in gaps in the previous diagnostic work-up;
4. the assessment of significant psychological, social or behavioural factors that may affect the current pain problem or future treatment plans. This includes the assessment of risk factors for addiction.

The document does not refer to the parenteral use and treatment of opioids in the management of chronic non-cancerous pain problems.

Similarly, the "Guidelines for Management of Chronic Non-malignant Pain" from the College of Physicians and Surgeons of Alberta issued in February 1993 were entered as an Exhibit. These guidelines include standard advice as follows:

1. take a complete pain history and physical examination. Assessment of physical function and evaluation of disability are important;
2. this document also states that parenteral dose of opioids to treat chronic non-malignant pain should be strongly discouraged and abhorred.

The Committee considered the evidence in respect to the eight cases, including the comments of the expert witnesses. The evidence of Dr. Moulin, in writing and oral testimony, was accepted as reliable by the Committee.

Patient 1 was a 41 year old woman seen in September of 1995 for headache. She had previous oral morphine treatment. Her chart and Dr. Moulin's evidence both indicated that Dr. Adams recommended intramuscular Dilaudid without a trial of oral Dilaudid first, and without ruling out medication-induced headache. Dr. Jovey indicated in his report that it was possible that patient 1 was suffering from medication-induced headache. Dr. Moulin testified that the long-term parenteral administration of opioids is inappropriate in most cases. Dr. Jovey testified that he had knowledge of colleagues who had a small number of patients on parenteral opioid treatment and he had a very small number of patients in whom vigorous attempts to treat them with oral medications failed who had done very well on parenteral opioids over a long period of time. In his written report he referred to only one such patient who had a particularly unusual medical problem. Dr. Merskey stated that to his knowledge there are reputable colleagues who occasionally have used regular injection treatments on a moderate, more than short-term basis.

Patient 2 was seen from April 1997 to March 1998 for headaches. She had been given progressive dose escalations of intramuscular Demerol with a continuing lack of efficacy according to Dr. Moulin and without ruling out medication-induced headaches which Dr. Jovey also considered as a possibility. She was given 200 mg. of Demerol intramuscularly, five times daily, with an extra 200 mg. intramuscularly daily as required. Dr. Adams testified that he was using the principle of dosing to effect.

Patient 3 was a 42 year old woman who was seen in the period of July 1996 through March 1997. She had experienced chronic headaches over a period of 13 years. She had a previous brief trial of oral Tylenol and Demerol. Dr. Adams treated her with injectable Demerol without further trial on oral analgesics. The amount was increased and on one occasion she used a 30 day supply within 12 days. Dr. Jovey agreed in his testimony that she showed a worrisome trend in her escalating use of injected Demerol.

Patient 4 was a 33 year old woman when first seen in May of 1996 for what was characterized as fibromyalgia and painful diabetic neuropathy. She had been on a sustained release morphine. Dr. Adams treated her with a combination of Dilaudid by injection and oral Dilaudid. She started at 4 mg. of injectable Dilaudid 3 times a day. Within a year and a half she progressed to 100 mg. 5 times a day, plus an increase in her oral Dilaudid. Dr. Moulin noted that the charts indicated no sustained benefit. She was also prescribed Ritalin, a central nervous system stimulant. Dr. Adams did not conduct a physical examination. Dr. Adams defended his treatment on the basis that he was exercising clinical judgment. Dr. Adams also claimed that he relied on the physical findings made by the referring doctor.

Patient 5 was a 26 year old woman seen in April of 1997 for generalized pain attributed to fibromyalgia. Dr. Adams did not conduct a physical examination. Patient 5 had a strong psychiatric history. There was no evidence that Dr. Adams inquired about the patient's previous drug abuse, and there was no evidence that he had asked her anything to elucidate whether she had previously abused drugs. When asked, the patient disclosed her previous history of drug abuse to another physician. The evidence was that Dr. Adams discounted previous psychiatric assessments. He referred to patient 5's encounters at a Psychiatric Hospital as leaning to the "usual meaningless potpourri of psychiatric diagnoses, including bi-polar and obsessive-compulsive behaviour". Patient 5 was provided with increasing doses of parenteral Dilaudid with inadequate monitoring that led to multiple abscesses.

Patient 6 was a 44 year old man seen in June of 1996 for headaches, presumably secondary to a closed head injury from two motor vehicle accidents. Dr. Adams did not conduct a physical examination. Dr. Adams indicated in his chart that he had an excellent response to opioid analgesics. In spite of that Dr. Adams increased the Dilaudid on the same visit by 66% which he explained as follows: "I increased his Dilaudid somewhat because I do not want him to get behind in his pain".

Dr. Moulin was concerned that even though the patient had achieved an excellent response, the dose that was given to him was increased and it was his belief that Dr. Adams was trying to achieve complete 100% relief, which in Dr. Moulin's view was inappropriate. Dr. Adams' evidence stated that he was trying to achieve pain relief equivalent to 60 - 65% and he was exercising his reasonable clinical judgment.

There were two patients to whom large quantities of Acetaminophen were prescribed. Patient 7 was a 33 year old man who experienced chronic headaches following a motor vehicle accident. He was ultimately treated with Acetaminophen in quantities of more than 7 grams per day.
Patient 8 was a 31 year old man who saw Dr. Adams in November, 1996 with chronic shoulder pain following a motor vehicle accident that had occurred eight years previously. After a trial of Morphine and Dilaudid he was given Percocet which contains Acetaminophen and Oxycodone. He ultimately took 30 Percocet tablets daily for a total daily Acetaminophen dose of 9.75 grams daily. This was considered excessive by Dr. Moulin and placed the patient at substantial risk of liver and renal damage. The usual acknowledged upper limit or normal for Acetaminophen according to the Alberta Guidelines, 1993 was 4 grams. In Dr. Moulin's opinion in these two cases, Dr. Adams showed a lack of knowledge, skill or judgment and failed to maintain the accepted standard of practice for a specialist managing chronic pain. There was no evidence of monitoring for possible liver damage, although it was stated but without record that in one case liver function tests were being monitored by the patient's general practitioner.

ISSUES

There were several important questions that arose from the evidence that was considered by the Committee with regard to Dr. Adams' treatment and management of these specific eight patients, all of whom had chronic non-malignant pain problems. Several questions were posed by the Committee to be answered by counsel in written argument.

Question 1

What was the standard of practice of the profession for the use of long-term high dosage injectable opioids in the treatment of chronic non-malignant pain, during the period January 1, 1994 through 1997?

Question 2

How did these standards relate to the current published Canadian (Ontario plus other provinces) guidelines?

Counsel for the College submitted that during the period January 1, 1994, through 1997, the standard of practice of the profession was that long-term, high dosage injectable opioids were not acceptable in the treatment of chronic non-malignant pain except, perhaps, under the most unusual circumstances. Dr. Moulin testified that, on the use of injectable narcotics in the patients he reviewed, that there were several reasons why he considered it to be unacceptable, on the basis that it carries risks without out-weighing the benefits.

Dr. Merskey testified that, in his practice, he has never prescribed parenteral narcotics for patients with chronic non-cancer pain on a repetitive basis. He could not be sure whether any other physician, in a teaching setting in Ontario, had ever prescribed parenteral narcotics for chronic non-cancer pain on a repetitive schedule basis. Dr. Jovey, in answer to the question as to whether Dr. Adams met the accepted standard of care in the specific time period, qualified his response stating that the treatment would meet the acceptable standard of care for the use of opioids in non-cancer pain if the period January 1, 1994 through 1997 was not specified. Dr. Jovey also testified that the handful of patients that he had on injections were actually weaned off injectable narcotics, at least in part. He never prescribed 200 milligrams of Demerol intramuscularly 5 times a day on a repetitive, indefinite basis, which is how Dr. Adams treated patient 2. Dr. Jovey testified that several colleagues in Canada specializing in the area of pain medicine use parenteral administration of opioids in certain limited cases. In general there was agreement that parenteral administration of opioids is not a first-line therapy.

The only guidelines in evidence are from the College of Physicians and Surgeons of Alberta (the Alberta Guidelines of 1993), and from the Canadian Pain Society, 1998. The Alberta Guidelines state that parenteral dosing of opioids to treat chronic non-malignant should be strongly discouraged and daily intramuscular injections abhorred. The Canadian Pain Society Guidelines are silent on the question of parenteral administration of opioids on an ongoing repetitive basis. In any event the Canadian Pain Society Guidelines were not in existence during the time at issue, and do not reflect a consensus achieved by discussion and were not published by a medical body. Counsel for Dr. Adams submitted that the Alberta Guidelines although reviewed by the Ontario College have never been accepted formally or adopted by this province and that the Ontario College is currently in the process of attempting to formulate guidelines in this area. The

Committee concluded that the standard of practice of the profession for the relevant time period is reflected in the testimony of Dr. Moulin.

Question 3

Indicate the positive and negative evidence that has been presented to justify Dr. Adams' long-term use of Acetaminophen in very high dosage for the management of chronic non-malignant pain.

Dr. Moulin testified that a dose of 7.15 grams per day which was the dose prescribed for patient 7 has a risk of liver and renal toxicity. In Dr Moulin's literature search there are multiple examples of serious renal and liver damage in doses between 4 and 10 grams per day. Similarly the 9.75 grams of Acetaminophen per day prescribed for patient 8 was well above the acceptable maximum dosage. In Dr. Moulin's view these patients were being placed at an unacceptable risk with little chance of benefit.

Dr. Merskey testified that he does not condone prescriptions of Acetaminophen that total more than six grams daily, on a repetitive basis. He testified that it is not the standard of doctors to give these doses on a repetitive basis.

Question 4

What is the evidence that his use of Acetaminophen has or has not met the standard with respect to the period after January 1, 1994 through 1997, and in terms of displaying adequate or lack of knowledge, skill or judgment?

Dr. Adams' own evidence was that he was familiar with the Alberta Guidelines published in 1993 and was aware of the warning contained therein and that no greater than 12 tablets (4 grams) of Acetaminophen may be taken per day because of risk of the Acetaminophen toxicity. Dr. Adams testified that "based on my experience and other factors, I decided that that was a guideline, it was not a regulation. Certainly it was not a regulation that applied to me, based on my medical experience and other medical evidence and I did not agree to that."

Dr. Jovey's evidence was that the 10 gram figure was applicable in the context of acute overdoses. Dr. Jovey shared Dr. Moulin's concern about chronic Acetaminophen intake above 4 grams daily.

DECISION

The Committee was unanimous in its decision that Dr. Adams was guilty of professional misconduct in the care of his patients for failure to maintain appropriate standards of practice, and of incompetence in that he displayed a lack of knowledge, skill or judgment of the patient, of a nature, or to the extent that demonstrates that he is unfit to continue in practice or that his practice should be restricted. The following reasons are the basis for this decision:

1. Dr. Adams is a psychiatrist who practices primarily as a pain specialist and refers to himself as a neuro-psychiatrist and clinical pharmacologist. He failed to take a complete history and carry out a physical examination in all of the eight patients who were assessed for a variety of chronic pain problems. He did describe neuro-cognitive tests which he substituted for standard types of assessment and investigation that would have routinely be done by most physicians. There is no evidence that the tests that were done were valid or had reproducible results, although they may have been of benefit to Dr. Adams specifically. The need to take a complete history and physical examination is stated in the Alberta Guidelines that were issued in February of 1993 and are also included in the Canadian Pain Society Guidelines (1998), in which Drs. Jovey, Merskey and Moulin participated.

2. Dr. Adams did not consider a differential diagnosis, nor did he order appropriate laboratory and clinical investigations to establish a specific diagnosis in the majority of his patients.

3. His use of parenteral opioids on a long-term basis was excessive and did not meet any recognized standard. It was strongly discouraged and abhorred as stated in the 1993 Alberta Guidelines which were the only significant published Canadian guidelines at that time. Dr. Adams did not monitor his patients adequately as determined by the multiple abscesses that developed in one patient.

4. The Committee accepts the submission of counsel for the College that the standard of practice of the profession is determined by answers to questions such as:
   (a) What is taught to medical students and residents?
   (b) What is actually done in practice?
   (c) What is known to be effective and safe in publications (peer reviewed)?

(d) What is accepted by competent and ethical physicians?

In response to the evidence accepted by the Committee that Dr. Adams failed to maintain the standard of practice of the profession, no witness testified that Dr. Adams' treatment of the patients at issue was taught in medical programs, and no publications were tendered showing that Dr. Adams' treatment was safe or effective.

5. Similarly, in the matter of Acetaminophen toxicity, all three medical experts were in agreement that chronic Acetaminophen intake above 4 to 6 grams daily was at risk and hence contraindicated. There was no evidence presented that Dr. Adams monitored the liver or kidney function in the two patients to whom he prescribed large quantities of Acetaminophen, and the Committee concluded that he had not. Hence in this regard he failed to maintain the standard of the profession, and displayed a serious lack of knowledge, skill or judgement. Dr. Adams' treatment of these patients was considered to be more than an error in judgment.

Accordingly, the Committee concluded, on what it found to be clear, convincing and cogent evidence that Dr. Adams was guilty of professional misconduct in that he failed to maintain the standard of practice of the profession, and that he was incompetent in that he displayed in his professional care of a patient a lack of knowledge, skill or judgment of a nature, or to an extent that demonstrates that he is unfit to continue in practice, or that his practice should be restricted.

The Hearing Office is directed to schedule a further hearing to hear evidence and submissions as to the appropriate penalty in this matter.

Indexed as: Adams (Re)

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Executive Committee of the College of Physicians and Surgeons of Ontario, pursuant to Section 36(1) of the ***Health Professions Procedural Code***, being Schedule 2 to the ***Regulated Health Professions Act***, 1991, S.O. 1991, c.18, as amended

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. FRANK STEVEN ADAMS

PANEL MEMBERS: DR. O. KOFMAN (CHAIR)
DR. M. RAPP
DR. J. McGILLEN
H. MAEOTS

PENALTY HEARING DATE: July 20-21, 2000

ORIGINAL DECISION RELEASE DATE: October 6, 2000

AMENDED DECISION RELEASE DATE: December 14, 2000

PENALTY DECISION AND REASONS FOR DECISION

The Discipline Committee held a hearing at the College of Physicians and Surgeons of Ontario on July 20, 2000 at Toronto to determine the appropriate penalty to be imposed on Dr. Frank Steven Adams in this matter.

Dr. Adams had been found guilty by the Discipline Committee of professional misconduct in that he failed to maintain the standard of practice of the profession, and of incompetence, in that he displayed in his professional care of patients, a lack of knowledge, skill or judgment of a nature, or to an extent that demonstrates that he is unfit to continue in practise, or that his practice should be restricted.

The Committee recognizes that the management of chronic pain with the use of narcotics in non-malignant pain problem is accepted. The penalty in this case is not based on opposition to this, but is rendered because basic medical practice principles were essentially ignored by Dr. Adams, creating significant risks to his patients.

The Committee was concerned that Dr. Adams, who is a psychiatrist, has been using substantial quantities of narcotics on a long-term basis in non-malignant pain problems without adequate history-taking or physical examination. For many years he has essentially limited his history-taking and physical examination to an assessment of cognitive function, which he had devised and which has not been validated in the scientific literature. This limitation has existed despite the fact that many of the patients have complex chronic pain problems that necessitate evaluation of multiple areas of the body and hence require comprehensive and appropriate history-taking and physical examination. For these reasons retraining in this area is required by Dr. Adams.

The Committee considered that the primary purposes of the Penalty appropriate to this case were:

1. To protect the public from substandard care.

2. To send a message as a general deterrent to all physicians with regard to the necessity of performing adequate history and physical examinations and taking particular care in the management of chronic pain problems.

The penalty of revocation of Dr. Adams' certificate of registration was considered. However the Committee decided that it is not the appropriate penalty in the circumstances of this case, provided that the following penalty order is implemented. The panel agreed with Dr. Dwight Moulin, expert witness for the College, who in evidence stated that, "I do not believe that he (Dr. Adams) is unfit to practice based on the failure to maintain standards in these eight patients. My own opinion is that the practice has to be restricted or remediated in a very significant way, otherwise I'm fearful of what might happen in the future with these patients, or other patients."

The Committee was of the opinion that the deficiencies that existed could be satisfactorily corrected by further education, remediation and monitoring. The Committee also concluded that the public would be adequately protected by restrictions on Dr. Adams' certificate of registration.

The Committee had considerable concern that Dr. Adams has not acknowledged or admitted to the problems for which he has been found guilty. His attitude and apparent lack of insight is such that long-term monitoring was considered essential.

PENALTY

The Discipline Committee makes the following order as to penalty:

1. Dr. Adams is to be reprimanded and such reprimand is to be recorded on the register.

2. The Registrar is directed to suspend Dr. Adams' certificate of registration, except as is hereinafter provided, in the amended order until he has successfully completed, at his own expense, with a practice supervisor, a program that is designed or approved by the College, that establishes that he has the appropriate knowledge, skill and judgment to

perform and interpret conventional history taking and physical examination, which includes mental status assessment.

a) Dr. Adams shall be permitted to retain a restricted form of certificate of registration which will limit his practice to the examination of patients under the direct supervision of a preceptor in an academic setting, for as long as he is taking the program designed or approved by the College.

b) The preceptor shall be the practice supervisor for the purpose of the program specified in this order, and the program shall involve assessment, remediation, and reassessment in the areas of concern identified under paragraph 2.

c) The College shall require as a measure of the successful completion of the program the delivery by the preceptor of a written report satisfactory to the Registrar that states that Dr. Adams has the appropriate knowledge, skill and judgment to perform and interpret conventional history-taking and physical examination, including mental status assessment.

3. Upon his return to practice, following the filing of proof with the Registrar of Dr. Adams' successful completion of the program required in paragraph 2, the Registrar shall be directed to impose the following terms, conditions and limitations upon Dr. Adams' certificate of registration;

a) Dr. Adams shall immediately implement, in his practice, the Consensus Statement and Guidelines from the Canadian Pain Society, or such other guidelines as may be approved subsequently by the College regarding the use of opioid analgesics for the treatment of chronic non-cancer pain, including:

i) the addiction screening questions regarding opioid therapy in patient histories;

ii) the points of discussion regarding opioid therapy in patient histories, and;

iii) utilization of a patient agreement for those patients at high risk for non-compliance with opioid therapy.

b) Dr. Adams shall provide no more than a two-week supply of narcotic medication to any patient, whether by way of repeat, refill, partial fill, or new prescription, without seeing and assessing the patient to determine whether further narcotic medication is required and, if so, the appropriate dosage of any further narcotic medication.

c) Dr. Adams shall see and assess those patients who are currently being treated by him by way of parenteral administration of opioids every two weeks or less, with the intent of either discontinuing the parenteral administration of opioids or transferring of the care of such patients to a physician who is capable of managing these problems.

d) Dr. Adams shall not use parenteral administration of opioids in his practice.

e) Dr. Adams shall see and assess those patients whom he is treating by stabilized oral doses of opioids every 60 days or less.

f) Dr. Adams shall monitor monthly the hepatic and renal functions of any patients who are being treated with 4 grams or more of acetaminophen daily.

g) Dr. Adams shall assist the College in monitoring his compliance with the terms, conditions and limitations in paragraphs (a) to (f) above, by participating in a review by the College of pharmacy records as described in paragraph

h) Dr. Adams will consent to a review of his clinical practise. This review together with review of the pharmacy records, will be performed by an assessor satisfactory to the Registrar who will report the findings to the Registrar, initially at six months and subsequently every year thereafter for three years from the date of commencement of the penalty. Dr. Adams will be responsible for all costs associated with these assessments and reports. If the reports are not satisfactory to the Registrar during the period of monitoring, the Registrar will take such action as deemed appropriate.

4. The Registrar shall be directed to further suspend indefinitely the certificate of registration of Dr. Adams if he breaches the terms, conditions and limitations on his certificate of registration, that are set out in paragraphs 3(a) to (h) of this Order.