NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Garry Yehudah Shomair, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Shomair, G. Y. (Re)

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

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the **Health Professions Procedural Code** being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. GARRY YEHUDAH SHOMAIR

PANEL MEMBERS:

DR. P. CHART (Chair)
D. DOHERTY
DR. J. WATTS
DR. E. ATTIA (Ph.D.)
DR. C. LEVITT

Hearing Date: December 18, 2012
Decision Date: December 18, 2012
Release of Written Reasons: February 27, 2013

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on December 18, 2012. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Garry Yehudah Shomair committed an act of professional misconduct:

1) under paragraph 1(1)2 of O. Reg. 856/93, in that he has failed to maintain the standard of practice of the profession.

The Notice of Hearing also alleged that Dr. Shomair is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Shomair admitted the allegation of professional misconduct in the Notice of Hearing that he failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence.

FACTS AND EVIDENCE

The following facts were set out in an Agreed Statement of Facts and Admissions which was filed as an exhibit and presented to the Committee:

FACTS

Background

1. Dr. Garry Yehudah Shomair ("Dr. Shomair") is a psychiatrist practising in Toronto. He received his Certificate of Independent Practice in 1975. Dr. Shomair works primarily with children and teenagers who suffer from serious mental illness.

Complaint and Investigation under Section 75(1)(a) of the Health Professions Procedural Code (the "Code") Regarding Patient A

2. In September 2009, the College received a letter of complaint from a physician regarding Dr. Shomair's treatment of a 14-year-old patient, Patient A. In particular, the physician expressed concern over the large amount of medication and the polypharmacy being prescribed for Patient A by Dr. Shomair.

3. The complaint led to the initiation of a s. 75(1)(a) investigation by the College.

4. As part of the College's investigation, Dr. X was retained as a Medical Inspector. On or about June 17, 2010, Dr. X notified the College of her immediate concern that Dr. Shomair's treatment of Patient A exposed the patient to significant potential harm. Similar to the physician complainant, Dr. X expressed concern regarding the prescribing of multiple psychotropic medications simultaneously and in high doses.

5. Dr. X's final report was received on July 26, 2010. In her report, Dr. X opined that the care provided by Dr. Shomair to Patient A did not meet the standard of practice of the profession, in that there was no comprehensive consultation/assessment note in the files; that the progress notes were difficult to follow and did not provide a coherent account of changes in the treatment plan; and that Dr. Shomair appears to have been reluctant to reconsider his initial diagnosis of Bipolar Disorder.

6. Dr. X further opined that Dr. Shomair's care of Patient A displayed a lack of clinical judgment and an unintentional disregard for the patient's welfare with respect to: the prescription of multiple psychopharmaceutical agents over several years duration; the addition of medications and escalation of the dosages to the point of drug toxicity; and

the fact that shortly after Patient A was tapered off of multiple medications and discharged on two specific medications, within a few weeks Patient A was again on multiple medications beyond recommended therapeutically safe dosages.

7. Dr. X opined that while Dr. Shomair's care for Patient A may have been well intentioned, he put Patient A at risk for physical and neurological harm, in that Patient A had been on multiple psychotropic medications simultaneously and in doses beyond those recommended even for adults for several years, without documented improvement in her clinical symptoms or ability to function.

Broader Investigation under Section 75(1)(a) of the Code

8. Based on the concerns raised by Dr. X, the College commenced a broader investigation into Dr. Shomair's practice under s.75(1)(a) of the Code.

9. In this investigation, Dr. X was asked to review 25 patient charts and provide an opinion on Dr. Shomair's care and treatment of these patients. In her report, dated April 5, 2011, Dr. X opined that Dr. Shomair's record-keeping fell below the standard of practice of the profession for 17 out of 25 patient charts. In particular, she noted the following charting deficiencies:

a. Charts were sparse, with poor legibility;

b. Initial assessments of patients did not include documentation of a provisional diagnosis, differential diagnosis and/or an explicit plan of action; they also lacked reference to why the patient was referred or when a referral source did not want to receive reports;

c. Ongoing assessment notes did not contain a clear-cut diagnosis, a coherent treatment plan for care, or sufficient detail on the content of appointments, including mental status examinations, elaboration on the thought process behind treatment decisions, and the outcome of treatment decisions; and

d. Reports and emails were copied or printed on recycled paper.

10. Dr. X also concluded that Dr. Shomair's care and treatment of multiple patients fell below the standard of practice of psychiatry in his psychopharmacological practice and/or his diagnostic practices. Her conclusions include:

a. Dr. Shomair uses multiple psychopharmaceutical agents simultaneously without clear indication in his charting and without regard for drug interactions with polypharmaceutical practice;

b. Dr. Shomair … failed to recognize the toxic effects of medications that he was prescribing at megadoses (far in excess of the upper limit of dosing for these agents) and concurrently with multiple other psychotropic medications. He demonstrated a lack of knowledge, skill and judgment in increasing the dose of topiramate (Topamax) and quetiapine (Seroquel) when the young adolescent to whom these drugs were being administered clearly described significant side effects and toxic effects; and

c. Dr. Shomair lacks skill and judgment in his diagnostic practice. Of significant concern is his ready diagnosis of Bipolar Disorder without assessment and application of diagnostic criteria.

11. Dr. X further opined that Dr. Shomair fell below the standard of practice in his medical monitoring of pharmacological treatments in virtually all of the patients reviewed in that he did not consistently monitor important physical parameters which may be affected by medications that he prescribes including pulse, blood pressure and growth/body weight.

Clinical Supervision

12. On October 4, 2010, Dr. Shomair's Certificate of Registration was restricted pursuant to s.37 of the Code. By order of the Inquiries, Complaints and Reports Committee, he was required to practise under the guidance of a clinical supervisor and meet with this individual weekly to review patient records and to discuss any issues or concerns arising therefrom. The review was to include all patients seen during the week who have a diagnosis of Bipolar Disorder or Developmental Mood Modulation Disorder.

13. With the support of his clinical supervisors, Dr. Shomair's supervision was reduced from weekly to bi-weekly in the fall of 2011.

14. Dr. Shomair's clinical supervision began in November 2010 and since that time he has been supervised by 4 physicians. His first Clinical Supervisor was Dr. Z. In Dr. Z's first report, dated November 19, 2010, he noted similar concerns to those raised by Dr. X. For example, he stated:

a. There is a pattern of polypharmacy with excessive dosages and atypical dosing regimens.

b. We reviewed in particular the importance of monitoring blood pressure and weight changes on a regular basis. I had some concern during this appointment regarding Dr. Shomair's insight about the risks involved in the case that led to his report.

c. Although the diagnostic rigour with which they had been diagnosed with Bipolar Disorder was suboptimal, there were no major concerns noted with regard to treatment. We revisited again the importance of adherence with DSM-IV diagnostic guidelines.

d. The patient regarding which this complaint was initially made remains exposed to risk by virtue of the medications with which she is being treated; however, Dr. Shomair is undertaking a tapering plan that to date has gone uneventfully.

15. In addition, Dr. Z reported that he and Dr. Shomair discussed the following topics:

a. We reviewed options that could be undertaken, including more assertive tapering, re-hospitalization for medication reconciliation, and referral to a different practitioner.

b. We reviewed the contraindications to Wellbutrin and also its dosing parameters. We reviewed the dosing titration for Lamotrigine, as well as the risk of Steven Johnson Syndrome.

16. Dr. Z reported that Dr. Shomair was generally cooperative and actively engaged in the process of quality improvement.

17. In his next report, dated December 20, 2010, Dr. Z noted the following concerns:

a. In reviewing a second chart, I found that the assessment note did not include a clear-cut diagnosis or plan. I advised Dr. Shomair that even in a situation where no formal consult was requested, that in a first time assessment of a patient it is optimal to include a provisional diagnosis, a differential diagnosis and an explicit plan of action…. however, there were no major concerns in the pharmacotherapeutic regimen of that patient and in fact, he was being referred on for pharmacotherapy.

b. We reviewed the chart of a patient who Dr. Shomair diagnosed as having Bipolar Disorder at the age of 5 years. Indeed, some of the symptoms were suggestive of a possible bipolar disorder however the criteria with which the diagnosis was being rendered was based on the views of a specific researcher in the United States which are not consistent with the DSM-IV.

c. The patient was on a higher than recommended dose of Topiramate and we reviewed the fact that there is limited evidence for Topiramate as a mood stabilizer.

d. My central concern relates to the above-noted patient regarding whom the complaint was made. My sense is that Dr. Shomair is stuck between the competing pressures of tapering that patient off of her complicated therapeutic regimen, and the pressure of being concerned that such a tapering will precipitate a symptomatic exacerbation or even aggression towards herself or others.

18. As an overall comment, Dr. Z indicated that Dr. Shomair is actively participating and engaged in the process and notes that Dr. Shomair is largely accepting of guidance and suggestions and in most cases there is evidence of change in his practices.

19. In his final report to the College, dated February 18, 2011, Dr. Z stated:

    a. One theme that has emerged is a tendency towards characterizing oppositional symptoms as those of bipolar disorder.

    b. Several of Dr. Shomair's patients are on high doses of tryptophan. He challenged my assertion that high dose tryptophan is not evidence based. We reviewed warnings regarding interactions with serotonin reuptake inhibitors and the fact that a recent consult from Dr. W had also suggested in one of his patients to eliminate tryptophan.

    c. In several cases patients are being managed with the diagnosis of Bipolar Disorder without documentation of clear cut mood episodes over a decade or more of follow-up. Although this does occur in classical Bipolar Disorder, many of the diagnoses in these cases were given at the age of 4 and 5 years old, which raises questions about the nature of their underlying illness. A consistent message that I have attempted to convey to Dr. Shomair is the importance of becoming familiar with diagnostic criteria and treatment guidelines from professional organizations such as the American or Canadian Psychiatric Associations or the International Society for Bipolar Disorders.

    d. A theme that emerged with several patients is significant parental pressure to increase medications to control negative behaviours. In several circumstances, it appeared that parents are doing this without consulting Dr. Shomair. Although this is a common clinical challenge, I encouraged Dr. Shomair to be more direct with regard to his expectations of managing doses and medication regimens.

    e. … an ongoing area of concern is the pattern of layering medications. Many of Dr. Shomair's patients are severely impaired and chronically symptomatic and this leads to dose titration, as well as addition of other medications. There were several circumstances in which patients diagnosed with bipolar disorder were experiencing mood instability in the context of anti-depressant and/or stimulant

> medications and I encouraged Dr. Shomair to attempt to eliminate medications with propensity for mood destabilization prior to combining mood stabilizing medication.

20. At the conclusion of this report Dr. Z recommended that Dr. Shomair make the following improvements:

> 1) Stick with DSM-IV criteria with regard to diagnosing patients and with regard to characterizing [sic] the longitudinal course of illness.
>
> 2) As much as possible, consult treatment guidelines and practice parameters regarding pharmacotherapy decisions, and minimize the use of medications that do not have approvals or evidence in the illnesses that they are being applied.
>
> 3) Try to document in greater detail the content of appointments with patients, including a mental status examination and including elaboration of the thought process behind treatment decisions (which is most often coherent and logical).
>
> 4) Develop a clear strategy for managing parents of patients who pressure him toward polypharmacy, dose escalation, and specific diagnoses, or who repeatedly refuse suggestions regarding pharmacological or behaviour treatments.

21. In the same report, Dr. Z also noted that Dr. Shomair:

a. sees patients that are highly impaired and do not comprise a standard of clinical caseload;

b. is working with complex patients and complex families whom in many cases have difficulty finding another provider; and

c. was able to provide descriptions of mental status, the justification for his decisions, and the logic behind his approach, which in the vast majority of cases is coherent.

22. Dr. Z indicated that a significant amount of time was spent discussing how Dr. Shomair's notes could better reflect both the content of sessions and the thought process that goes behind his decision making. Dr. Z also indicated that he found Dr. Shomair open to the vast majority of suggestions, inquisitive and also extremely caring about his patients. He noted that Dr. Shomair attended consistently, abided by the guidelines in terms of bringing charts and was open to discussing them.

23. Attached as Schedule 1 [to the Agreed Statement of Facts and Admissions] are copies of Dr. Z's clinical supervision reports from November 2010 to February 2011, which form part of this Agreed Statement of Facts and Admissions.

24. By letter dated August 29, 2011, Dr. Z wrote to the College to confirm his agreement that it was appropriate for Dr. Shomair's supervision to proceed on a twice monthly basis.

25. Since November 2011, Dr. Shomair's Clinical Supervisor, Dr. Y, has been of the view that Dr. Shomair's care meets the standard of practice of the profession and that his care displays appropriate levels of knowledge, skill and judgment.

26. Attached as Schedule 2 [to the Agreed Statement of Facts and Admissions] are copies of Dr. Y's clinical supervision reports from November 2011 to November 2012, which form part of this Agreed Statement of Facts and Admissions.

ADMISSIONS

27. Dr. Shomair admits the facts set out above.

28. Dr. Shomair admits that his record-keeping in 18 of the 26 charts reviewed by Dr. X fell below the standard of practice of the profession. In particular, he accepts the following:

a. His notes were often sparse and should have been documented in accordance with the SOAP method.

b. He should not have been photocopying reports and emails on recycled paper.

c. He should have documented when a referral source did not want to receive reports.

d. His initial assessments of patients should include documentation of a provisional diagnosis, differential diagnosis and an explicit plan of action.

e. His documentation should contain greater detail on the content of appointments with patients, including a mental status examination and an elaboration on the thought process behind treatment decisions.

f. He should consistently and appropriately document the reasoning behind the psychopharmacological interventions being used.

g. His assessment notes should include a clear-cut diagnosis (to the extent possible), a coherent plan of care and indication of treatment outcomes.

29. Dr. Shomair admits that he failed to maintain the standard of practice of the profession of psychiatry in his care and treatment of multiple patients. In particular, he accepts the following:

a. In his treatment of Patient A, he simultaneously prescribed Adderall, Seroquel, Strattera, Topamax, Wellbutrin, Trileptal, Remron and Invega and some of these prescriptions were in doses that exceeded the recommended daily doses. The prescription of multiple psychopharmaceutical agents occurred over several years' duration and without appropriate tapering.

b. In treating Patient A, he did not accept the views of other specialists regarding diagnosis and medication regime. He also reintroduced multiple medications beyond recommended therapeutically safe doses after these medications were tapered and all but two discontinued during in-patient treatment.

c. With respect to multiple patients, his prescription of Seroquel and Topomax was, at times, higher than recommended doses despite possible side effects and, in one case, despite described significant side effects and toxic effects.

d. His psychopharmacological management of multiple patients, including Patient A, did not include appropriate regard to drug interactions and/or responses to adverse side effects. In addition, his psychopharmacological interventions were not properly documented, making it difficult to follow patients' current medications, identify adverse effects and/or recognize possible drug interactions.

e. His diagnoses of Bipolar Disorder and/or ADHD in multiple patients, including Patient A, were made without appropriately documented assessments and without sufficient attention to diagnostic criteria.

f. His medical monitoring of pharmacological treatments of multiple patients, including Patient A, did not include consistent monitoring and/or documentation of important physical parameters including pulse, blood pressure and growth/body weight.

g. His prescriptions of medications targeting ADHD were in some cases written in the absence of a diagnosis of ADHD.

30. Dr. Shomair further admits that his failure to maintain the standard of practice of the profession, as outlined above, constitutes professional misconduct under clause 51(1)(c) of the Code.

FINDING

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admissions. Having regard to these facts, the Committee accepted Dr. Shomair's admission and found that he committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The Committee was mindful of the legal standard that a joint submission of this nature should be accepted unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

In making the determination of a penalty, the Committee is guided by the principles that a penalty should provide protection to the public, be proportional to the finding and maintain public confidence in the profession and in its ability to regulate itself. A penalty order should also reflect denunciation of the misconduct, address both general and specific deterrence and, where appropriate, provide for rehabilitation of the member.

Dr. Shomair's misconduct was serious, in that it involved multiple deficiencies of record-keeping, pharmacotherapy and monitoring. The charts that were reviewed were selected specifically to include adolescents or young adults with bipolar disorder, patients who appear to have done well, despite being a group of patients who can be difficult to treat and who would have difficulty in finding other therapists. Dr. Shomair showed no unwillingness to consult with other physicians, and in mitigation, he admitted the misconduct and was willing to undergo supervision, educational programs and an assessment after a suitable period in which to demonstrate changes in his practice. Furthermore, he has no prior findings of misconduct.

The Committee is aware that parental pressure to increase dosage to control negative behaviour, or to do so without consultation, can be challenging. With very sick patients and powerful drugs, it is important to be clear and assure compliance. The Committee notes this as important in supervision.

The attention of the Committee was drawn to precedents of College Discipline Committee penalties in *Graham* [2009], *Gleeson*[2008], *Hoffer*[2008] and *Sumner*[2007] and the Committee agreed that the penalty was consistent with previous decisions, all of which involved similar periods of supervision, educational programs and subsequent re-assessment.

The Committee admitted into evidence letters of support for Dr. Shomair from the parents of an adolescent patient whom he treated, and from three psychiatrists with similar practices and knowledge of his practice. Although such letters may often be given relatively little weight in determining penalty, the Committee did note that one of the psychiatrists specifically commented favourably on his management of one patient whose records were part of the experts review for this hearing. The Committee also noted that Dr. Shomair's supervisor to date has reported that Dr. Shomair is responsive to his suggestions, has changed his approaches to therapy in an appropriate manner and shows appropriate levels of understanding, skill and judgement.

The administration of a reprimand provides an appropriate denunciation of the misconduct, while the requirement for supervision and the subsequent re-assessment meet the need for public protection and the maintenance of public confidence. The requirement to participate in specific psychopharmacology courses and a medical record-keeping course will allow Dr. Shomair to avail himself of rehabilitation opportunities.

The Committee accepted as appropriate that Dr. Shomair should pay costs to the College at the tariff rate of $3,650.00 for a one day hearing.

ORDER

Therefore, having stated its findings in paragraph 1 of its written order of December 18, 2012, the Committee ordered and directed on the matter of penalty and costs that:

2) Dr. Shomair attend before the panel to be reprimanded.

3) the Registrar impose the following terms, conditions and limitations on Dr. Shomair’s certificate of registration for the specified periods of time set out herein:

(a) Dr. Shomair shall, within thirty (30) days from the date of this Order, retain a College-approved clinical supervisor, who will sign an undertaking in the form attached [to the Order] as Schedule “A” (the “Clinical Supervisor”). For a period of twelve (12) months commencing on the day the Clinical Supervisor is retained, Dr. Shomair may practise only under the supervision of

the Clinical Supervisor, who will meet with Dr. Shomair on a bi-weekly basis for the duration of the supervision;

(b) Dr. Shomair shall abide by all recommendations of his Clinical Supervisor with respect to his standard of practice in respect of, but not limited to, the treatment of patients with Bipolar Disorder, medication dosages, pharmacotherapy and record-keeping and documentation;

(c) Dr. Shomair shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the parties deem necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and to monitor Dr. Shomair's compliance with the Order. This shall include, without limitation, providing the Clinical Supervisor with the reports of any assessments of Dr. Shomair's practice in the College's possession;

(d) Approximately six (6) months after the completion of the period of supervision required by paragraph 3(a), Dr. Shomair shall undergo a re-assessment of his clinical practice by a College-appointed assessor (the "Assessor(s)"). This re-assessment will include determining whether Dr. Shomair meets the standard of practice of the profession and whether Dr. Shomair is in compliance with this Order. The Assessor(s) shall make recommendations regarding Dr. Shomair's practice and shall report the results of the re-assessment to the College. The College shall determine, in its sole discretion, what recommendations, if any, Dr. Shomair must abide by and whether any of the recommendations will constitute terms, conditions or limitations on his certificate or registration;

(e) Dr. Shomair shall consent to the disclosure to the Assessor(s) of the reports of the Clinical Supervisor arising from the supervision, and shall consent to the sharing of all information between the Clinical Supervisor, the Assessor(s) and the College, as any of the parties deem necessary or desirable in order to fulfill their respective obligations;

(f) Dr. Shomair shall, at his own expense, participate in and successfully complete an educational program in medical record-keeping approved by the College, no later than one (1) year from the date of this Order.

(g) Dr. Shomair shall, at his own expense, participate in and successfully complete at minimum two courses in pharmacology, approved by the College, no later than one (1) year from the date of this Order. The content of these courses shall include the topic of child and adolescent psychopharmacology.

(h) Dr. Shomair shall be responsible for any and all costs associated with implementing the terms of this Order.

4) Dr. Shomair shall pay to the College costs in the amount of $3,650 within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Shomair waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.