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


BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ANTHONY RICHARD ELDON LAWS

PANEL MEMBERS: DR. O KOFMAN (CHAIR) DR. A. KENSHOLE DR. E. THOMPSON R. SANDERS H. MAEOTS

HEARING DATE: November 2, 1998 December 16-17, 1998

DECISION/RELEASED: June 29, 1999 DATE
DECISION AND REASONS FOR DECISION

This matter was heard by the Discipline Committee of the College of Physicians and Surgeons of Ontario at Toronto on November 2, 1998, and on December 16 and 17, 1998.

The Complaints Committee of the College of Physicians and Surgeons of Ontario referred the following allegations regarding the conduct or actions of Dr. Anthony Richard Eldon Laws (“Dr. Laws”) to the Discipline Committee of the College.

ALLEGATIONS

It is alleged in paragraph 4 in the Notice of Hearing that Dr. Laws is guilty of professional misconduct under clause 1(1)33 of Ontario Regulations 856/93 in that he signed or issued, in his professional capacity a document that he knew or ought to have known was false and misleading.

Particulars of this allegation are set out in the Appendix to the Notice of Hearing, as follows:

Dr. Laws provided the College with two false or misleading letters addressed to the patient’s family physician, Dr. F., purportedly created on February 27, 1992, and April 7, 1992.

The initial Notice of Hearing included other allegations of professional misconduct related to standards issues. However, these allegations were withdrawn by the College at the outset of the hearing.

PLEA

Dr. Laws pleaded guilty to the allegation of professional misconduct as set out in paragraph 4 in the Notice of Hearing.

FACTS

A Statement of Agreed Facts was entered as an exhibit and was presented to the Committee. This statement reads as follows:

1. Dr. Laws is a general practitioner who has practised medicine since 1982. Dr. Laws’ practice is located in Oakville, Ontario, which focuses on the treatment of patients with attention deficit disorder (“ADD”) and attention deficit hyperactivity disorder (“ADHD”).
2. In October of 1989, the patient – J.B., underwent a psycho-educational assessment by a psychologist at a Board of Education. At the time J.B. was 10 years of age and attending grade 5 at public school. The assessment concluded he had attentional deficits, along with significant weaknesses in phonetics and spelling, as well as relative weakness in reading comprehension. The attentional deficits had created a negative impact on J.B.’s learning ability. A remedial withdrawal program was established for J.B. which he continued through to the end of grade 6. He was otherwise a very healthy boy who rarely missed school due to sickness.

3. In the fall of 1991, J.B. began grade 7 at a tutorial assistance program. By January of 1992, both the school and J.B.’s parents were experiencing great difficulty in gaining his co-operation. After an unsuccessful attempt with the psychologist at the Child and Family Services Facility at their local hospital, J.B. was recommended to Dr. Laws for treatment of ADHD.

4. J.B. was treated by Dr. Laws from January 31, 1992, through to the date of his death of August 17, 1993. Dr. Laws’ medical records for the treatment of J.B. are contained in the Joint Book of Documents.

5. J.B. was also under the general care of a group of physicians known as the “______ Medical Group”. Originally, Dr. F. was J.B.’s family physician, but after his retirement, other physicians practising with the Medical Group took over his care and treatment.

6. Dr. Laws originally treated J.B.’s ADHD by prescribing Cylert (pemoline). The dosages of Cylert varied over the course of J.B.’s treatment. In May of 1993, Dr. Laws also prescribed Ritalin to J.B.

7. From May 1993, until August 1993, J.B. was ingesting both Cylert and Ritalin.

8. In July of 1993, J.B. was admitted to the hospital where he was diagnosed as having severe necrosis of the liver. He was immediately referred to a children's hospital. There is debate as to whether the necrosis of the liver was caused by a viral hepatitis or hepatotoxicity but, for the purpose of this hearing, it has been agreed that the cause of J.B.’s liver function failure will not be an issue.


10. J.B.’s parents complained to the College by letter dated March 16, 1994. The parent’s alleged that Dr. Laws failed to alert them to the possible side effects of Cylert and Ritalin
and that he failed to take proper steps to monitor J.B.’s liver function for possible hepatoxicity. They further alleged that he prescribed Cylert and Ritalin at the same time to J.B.

11. By letter dated June 20, 1994, Dr. Laws replied to the complaint stating the following:
   a) It is my practice to inform all patients about the benefits, side effects and risks of the medications I prescribe and I believe I did this on these occasions.
   b) My office note to February 24, 1992, indicates blood work was ordered and a requisition was given on that date. I noted on the requisition form that a copy of the report was to be sent to the family doctor, Dr. F. In my letter of February 27, 1992, to Dr. F., I made specific reference to this.

12. Dr. Laws provided the College a copy of a letter purportedly written and sent on February 27, 1992, along with a further letter purportedly sent to Dr. F. on April 7, 1992. The letters are addressed to Dr. F. By February of 1992, Dr. F. had ceased practising for approximately six months (since August 1991). Additionally, the Medical Group, who were at the time caring for J.B., practised at a different location. The Medical Group did not move their practice until late June of 1993, some two months after the letters were purported written.

13. The Medical Group searched their medical records which do not contain either of the February 27 or April 7, 1992, letters written by Dr. Laws in 1992.

14. Dr. Laws admits that he falsified the letters dated February 27, 1992, and April 7, 1992. Dr. Laws admits that he falsified entries in J.B.’s chart on February 24, 1992, and April 2, 1992. Dr. Laws also admits that he did not discuss the risks of liver failure with J.B. or his parents.

15. The College’s expert, Dr. Keene, is of the opinion that the failure to monitor liver function would not, in and of itself, have been below the standard of practice of the profession. However, he also opined that if the treating physician determined that blood work was necessary, then a failure to take proper steps to ensure that the test was performed, would fall below the standard of practice of the profession.

A Joint Book of Documents was entered as an exhibit and was presented to the Committee.
Joint Submissions of the College and Dr. Law were filed with the Committee. This document read as follows:

“The College of Physicians and Surgeons and Dr. Anthony R.E. Laws, the parties to this hearing, have agreed upon the following matters for the purposes of this hearing:

(1) There is scientific evidence of a possible casual link between pemoline (Cylert) and liver toxicity. The determination of whether there is a causal link between pemoline (Cylert) and liver necrosis in any particular individual taking pemoline (Cylert) who suffers liver necrosis requires an examination of all of the circumstances of the particular case since there are other possible cause of liver necrosis.

(2) In this case there has been a debate since J.B.’s admission to the children's hospital as to whether the most likely cause of the liver necrosis was drug-induced toxicity or viral hepatitis.

(3) For the purposes of this hearing only, the parties accept and agree that the evidence in this hearing shall not, and cannot, be used to establish:
   a) that there is a causal link between any medication, including pemoline (Cylert), prescribed by Dr. A.R.E. Laws to J.B. and the liver necrosis which led to J.B.’s death; and
   b) that any failure by Dr. Laws to provide the family with information or instructions on the need for blood work or the monitoring of clinical signs and symptoms caused the death of J.B.

(4) This submission has been reached after careful consideration of all the circumstances of the case. This position obviates the need to call lengthy and complex expert evidence, which would have been called by both parties to this hearing but for their agreement to this submission. It is intended that the submissions should apply to all stages of this hearing, including any penalty proceedings.”

The Committee was not asked to make a finding at the conclusion of the first day of the hearing. Counsel for the College and counsel for the doctor requested that the hearing reconvene at a subsequent date in order to allow for the assessment of Dr. Laws with regard to the various factors that lead to this hearing. It was anticipated that the assessment would be completed some time after the scheduled week for the hearing. As a consequence, a request was made for an
adjournment. The Committee accepted this request and agreed dates were set for continuation of the hearing, on December 16 and 17, 1998.

DECISION

The hearing reconvened on December 16, 1998. At that time the Committee accepted the plea and found Dr. Laws guilty of professional misconduct under clause 1(1)33 of the Ontario Regulation 856/93, in that he signed or issued, in his professional capacity, a document that he knew or ought to have known was false and misleading, as alleged in paragraph 4 in the Notice of Hearing.

EVIDENCE AND SUBMISSIONS RELATING TO PENALTY

The Committee received in evidence and considered an impact statement from the patient's family, heard oral testimony from Dr. Laws and other witnesses, and as well received written letters from various persons that it took into account in regard to penalty.

An impact statement dated December 14, 1998, from the grieving family was introduced as an exhibit. This statement spoke eloquently and movingly to the pain suffered by the family. It included a statement as follows: “Dr. Laws’ conduct has diminished our ability to trust the medical profession and physicians in particular”. Dr. Laws in a letter dated January 9, 1995, addressed to the CPSO, indicated that the family had been informed of the risk of liver failure and that blood work had been requested thus blaming the family for not taking proper precautions. The contents of this letter which was entered as an exhibit were subsequently acknowledged by Dr. Laws as being false.

Dr. Anthony Laws appeared as the first witness in the hearing. He gave a personal history and various reasons to try to explain his conduct. Dr. Laws testified that he was in the midst of separation from his wife at the time he was treating J.B. He had always had difficulty at school and hence left school at grade 10. He entered McMaster University as a mature student and graduated from McMaster Medical School in 1982. He had four years of post-graduate residency training at Queen’s University in paediatrics. He wrote the LMCC examination three times and required special assistance prior to passing this examination. He testified that he could not pass the written version of the Royal College Fellowship Examination in paediatrics on two occasions and hence did not receive a specialty certificate. He testified that he had a learning disability in the form of dyslexia and while he was at McMaster he was diagnosed as ADD. He began medical practice in Brampton in 1986. He was not practising as a consultant but he had a particular interest in learning and behaviour problems. He subsequently moved to Oakville and
was on staff at the Oakville Trafalgar Hospital as a family practitioner. He was also a member of the Department of Paediatrics.

He continued his special interest in children with learning disabilities, dyslexia and ADD and treated some adults with learning disorders as well. His practice included counselling and diagnosis of these disorders. He received referrals from a variety of sources including family physicians, paediatricians, psychologists, teachers and school boards. He testified that he had written and spoken on topics related to learning disorders and he had devised some specific assessment devices for ADD. Dr. Laws testified that his personal problems, including dyslexia and ADD, interfered with his performance at medical school. He has consulted a physician in Oakville on two occasions with regard to his ADD. He took medication in the form of Ritalin and Cylert sporadically and discontinued them using his own discretion. He testified that he has essentially managed his own ADD problem, which he says may have contributed to some of his difficulties. Dr. Laws testified that his son has ADD which requires medical attention. Dr. Laws testified that in addition to his ongoing marital difficulties, he had significant financial problems in 1994.

Dr. Laws testified that he first assessed J.B. on January 31, 1992, upon referral from his school, primarily because of a learning disability. His last assessment occurred on June 21, 1993, and J.B. died in August 1993. Dr. Laws testified that he first learned of J.B.'s death in March or April of 1994, when he received a copy of a letter of complaint that had been sent to him by the CPSO.

Dr. Laws further testified that when he received the letter of complaint from the College, which included allegations that he failed to inform the family with regard to the side effects of the medication including Cylert and that he had not ordered liver function tests, he panicked and was scared. He reviewed J.B.’s chart and realized that it was inadequate, in particular, he had not ordered or monitored his liver function tests relevant to the Cylert that he had prescribed in February 1992.
Dr. Laws admitted that he added false entries into J.B.’s chart that indicated he had requested blood work and that he had discussed possible side effects with the family. He also added two letters to the chart which were addressed to the family physician, Dr. F. These were dated February 27, 1992, and April 7, 1992. He testified that his reason was to convey what he normally does but did not do it in this case. He clearly acknowledged the false entries in the chart and the false letters that were put in the chart. He testified that he felt very ashamed and very embarrassed and felt badly on behalf of the patient's family, his own family, the College and his friends. Dr. Laws testified that he had recently been assessed by Dr. Graham Glancy, a psychiatrist, whose testimony was subsequently heard. Dr. Laws indicated that he was willing to continue seeing Dr. Glancy or someone else, if deemed appropriate. Dr. Laws testified that he has done voluntary work at the YMCA, McMaster University Board of Governors, Big Brothers and the Royal Regiment Reserve where he holds the rank of Captain.

Dr. Laws testified that the false entries in J.B.’s chart and the two letters that were created and back-dated, were done on the evening when he first received the CPSO letter with regard to the complaint. The two falsified letters purported to have been written to Dr. F. made reference to request for blood work. In a subsequent letter to the CPSO dated January 9, 1995, Dr. Laws referred to the two letters as well as the fact that he had requested blood work on at least two occasions which he understood was not available in Dr. F.’s records. This letter was drafted several months after the initial panic episode that had occurred upon receipt of the initial CPSO letter of complaint and, hence Dr. Laws had considerable time to consider the consequences of his falsification of the charts and the false letters. There appears to have been an effort to reflect the blame for Dr. Laws’ shortcoming upon Dr. F. and the deceased child’s parents. It was not until shortly before the initiation of the discipline hearing that Dr. Laws admitted that he had falsified his records, this being more than three years after the initial complaint. It was noted that J.B. had visited Dr. Laws approximately 14 times during which no blood tests were requested. Dr. Laws testified that it was not his routine to request blood tests in conjunction with a prescription for Cylert.

The second witness called by defence counsel was Dr. Graham Glancy, a psychiatrist with a particular experience in forensic psychiatry. Dr. Glancy was accepted as an expert witness. Dr. Glancy assessed Dr. Laws on two occasions and had prepared a report dated December 2, 1998. He testified that he had interviewed Dr. Laws for four hours during November 1998, and that he had had the opportunity to peruse Dr. Laws’ chart on J.B. as well as the Notice of Hearing, the Agreed Statement of Facts that was used on the guilty plea and the Joint Submissions filed with the Discipline Committee dealing with the issue of causation. Dr. Glancy’s report was entered as an exhibit.
Dr. Glancy referred to his written report and in addition testified that Dr. Laws was shocked by the death of J.B. and “could not face one more failure”. He referred to the financial problems and marital problems of Dr. Laws in the period when he had received the letter of complaint from the CPSO. Dr. Glancy testified that Dr. Laws was basically a loner and remembers feeling inferior all his life. He testified regarding the problems that Dr. Laws had in his early school years and subsequently at McMaster University. Dr. Laws was diagnosed as having dyslexia and ADD while he was at medical school. He had been taking Ritalin since 1986 on an “as-needed-basis” and he had taken Cylert at times. Here was no history of alcohol or substance abuse and he had no other psychological disorder.

Dr. Glancy testified although the ADD had an effect on Dr. Laws’ life, the fear of failure had the most important impact on his behaviour. There was no clinical depression and there was no evidence of suicidal thoughts. Dr. Laws described feeling guilty and being disappointed with himself. There was no evidence of psychotic symptoms such as delusions or hallucinations.

Psychometric testing revealed that he was “feeling life a failure and feeling guilty”. A structured clinical interview for personality disorders revealed that Dr. Laws had some aspects of obsessive/compulsive personality traits. He tended to be a perfectionist and had some narcissistic traits. Dr. Glancy testified that upon receiving the complaint from the CPSO, Dr. Laws feared another failure which led to his falsifying the documents and altering his records. Once having lied, he felt entrenched and felt that he could not change his position. Dr. Glancy testified that having taken responsibility for his behaviour and having experienced the shame and remorse concomitant with this, there is minimal risk that Dr. Laws would repeat the behaviours for which he appeared before the Committee.

A third witness for the defence was Dr. M.P. who was Director of Student Services at a nearby College. He testified that he had referred students to Dr. Laws with regard to adolescent issues and he regarded him with high respect. He testified that a suspension of Dr. Laws’ practice would have an impact on students with ADD as there was no replacement.

A fourth witness for the defence was W.D., co-founder of a local private school. She testified that Dr. Laws gave good professional advice to children as well as counselling and that he had an excellent reputation and the highest integrity. She testified that a suspension of Dr. Laws would have an impact on the students who were his patients.
There were three other witnesses who testified on Dr. Laws’ behalf. These included a family practitioner, the Registrar of the Ontario College of Pharmacy, and a high ranking officer in the Royal Regiment of Canada where Dr. Laws served as a medical officer. These witnesses testified to Dr. Laws’ integrity and also referred to his contribution to the ADD patients as well as to his role as medical officer in the Military community.

A brief of Character Letters was filed as an exhibit. These contained favourable comments with regard to Dr. Laws from patients, parents and physicians.

A letter from Dr. F.G. dated December 16, 1998, was also filed as an exhibit. This letter confirmed that Dr. Laws “came to me and asked if I would become his physician to take on his medical care for his ADD. I have seen Dr. Laws on two occasions and have reviewed his past medical and academic history which indicates that he has been diagnosed with dyslexia and Attention Deficit Disorder. I have discussed with him the medical management of Attention Deficit Disorder and have agreed to supervise him and monitor him for this condition. I have agreed to see him monthly for the next six to nine months to monitor his progress. I will at the request of the College, report to you if Dr. Laws fails to follow my recommended medical management plan for his Attention Deficit Disorder”.

**PENALTY ORDER SOUGHT**

Counsel for the College called for a penalty which would include:

1) a recorded reprimand

2) suspension of Dr. Laws’ certificate of registration for one year

3) upon Dr. Laws’ return to practice, certain terms and conditions would be imposed on his certificate of registration.

Counsel for the physician submitted that the penalty be:

1) a recorded reprimand

2) suspension of Dr. Laws’ certificate of registration for three months, two months of the suspension to be suspended if Dr. Laws satisfies several specific conditions which includes that Dr. Laws undergoes a course of treatment and management of his Attention Deficit Disorder with Dr. F.G. or another physician acceptable to the Registrar.

**DECISION AND REASONS FOR PENALTY**
Counsel for the College submitted and the Committee accepted that certain factors must be considered in terms of the appropriate penalty:

1) the nature of the misconduct
2) circumstances of the misconduct
3) the impact that the misconduct has had on individual members of the public, a member of the profession and the general reputation of the profession.

The Committee found that Dr. Laws has acted without regard for his ethical obligations. It is completely unacceptable for a physician to falsify documents regarding patients, another member of the profession and the College. Such conduct is inappropriate and deserving of a serious penalty. The Committee has a duty to decide upon a penalty that will achieve the following objects:

1) protection of the public and the profession
2) specific deterrence
3) general deterrence which would send a message from the governing body to the profession on how it regards a breach of ethics by a member
4) maintenance of the integrity of the profession and its ability to govern the profession in the eyes of the public

The Committee agreed with the submissions of counsel for the College that educational programs alone do not adequately address the specific concerns of dishonesty or unethical behaviour. The circumstances of the misconduct were the fabrication of records and letters as well as an attempt to deflect the responsibility of monitoring liver function tests to the parents and family physician.

The Committee was referred to a Brief of Authorities containing past decisions involving the falsification of records. These indicated a range of periods of suspension of certificates of registration of physicians for such misconduct. There was reference to the decision in CPSO and Dr. Kunwar Singh, January 1995, in which the penalty included a suspension of six months of which three months would be suspended if Dr. Singh completed a course of study in medical ethics. The Committee noted that in that case Dr. Singh did not blame others for his misconduct, as Dr. Laws did in this case, which impacted on the family as well as the family practitioner. Reference was also made to Bolton v. the Law Society, a judgment of the Court of Appeal, Great
Britain, 1993, with regard to the purpose of suspension, in that case involving a lawyer: “All these matters are relevant and should be considered, but none of these touches the essential issue, which is the need to maintain among members of the public a well-founded confidence that any solicitor whom they instruct will be a person of unquestionable integrity, probity and trustworthiness”. The Committee believes that this applies as well to physicians.

A review of cases from the Brief of Authorities provided by counsel for the physician included reference to CPSO and Dr. Victor I. Holder 1994. The penalty in that case which involved the falsification of a record included a nine-month suspension and a fine, seven months of the suspension and the fine to be suspended if Dr. Holder satisfied specific conditions including a PREP assessment and any remedial education required as a result. Reference was also made to CPSO and Dr. Andrew A. Otoo, 1996, which resulted in a three-month suspension, two months to be suspended if Dr. Otoo satisfactorily completed several specific conditions including a course on communication skills and dialogue with a medical ethicist. The Committee also had before it the case of CPSO and K. Singh 1995, in which Dr. Singh altered his certificate of professional conduct, and where a three-month period of suspension was imposed provided that the doctor complete a course in medical ethics.

The Committee considered the particular circumstances of the present case when reviewing the penalties imposed in other cases. The dishonesty of Dr. Laws in falsifying documents had an impact on the family and family practitioner, on whom he had tried to shift the responsibility for his failures to act appropriately.

The Committee is of the view that it is essential to send a clear unequivocal message that this form of unethical conduct will not be tolerated and that it is important at all times for members to maintain the integrity of the profession.

At the same time the Committee considered that this was Dr. Laws first offence and Dr. Laws had expressed his remorse to the family and the College. Unfortunately, this remorse appeared to have come late, occurring on the eve of the hearing.

The Committee also considered the evidence it heard about the adverse affect that a long suspension would have on Dr. Laws’ patients as well as on the community.

The Committee, having reviewed all of the evidence that had been presented and submissions made, imposes the following penalty, for the reasons stated above:

1) A reprimand with the fact of the reprimand to be recorded on the Register;
2) Dr. Laws’ certificate of registration is to be suspended for six (6) months commencing within sixty (60) days of this order becoming final, on a date to be fixed by the Registrar;

3) Three (3) months of the suspension referred to in paragraph 2 to be suspended provided that within twelve (12) months, Dr. Laws satisfies the following conditions:

a) Dr. Laws undergoes a course of treatment under the care of a psychiatrist acceptable to the Registrar, involving a session at least every two (2) months, for a period of twelve (12) months, and thereafter as a psychiatrist recommends;

b) the psychiatrist providing care to Dr. Laws will report on Dr. Laws’ progress to the Registrar at the conclusion of the sixth month, and at the conclusion of the twelfth month and will provide to the Registrar his or her recommendation of further care and reporting, which is to be complied with by Dr. Laws;

c) Dr. Laws undergoes a course of treatment in management of his Attention Deficit Disorder (ADD), with Dr. F.G., or another physician acceptable to the Registrar, for a period of at least twelve (12) months and proof of the fact of such treatment shall be provided to the Registrar;

d) Dr. Laws will complete a course in medical ethics and the Medical Records keeping Course for Physicians provided by the CPSO or a similar course that is satisfactory to the Registrar.

e) Any costs associated with any of the above requirements will be at the expense of Dr. Laws.

4) Failure to comply with the above terms in the opinion of the Registrar, subject to review by the Discipline Committee, will result in resumption of the suspension of Dr. Laws until such terms and conditions are met or until the completion of the balance of the six months suspension imposed under paragraph 2, whichever comes first.

The Committee is of the view that this penalty reflects the seriousness of the misconduct of Dr. Laws and achieves the proper objects for imposing a penalty in the circumstances of this case.