Summary of Adjudication Tribunal Decision

IN THE MATTER OF: **Dr. Todd Kevin Young, Family Medicine**
Practice address: Main Street Medical Clinic, Springdale, NL

An Adjudication Tribunal of the College of Physicians and Surgeons of Newfoundland and Labrador has found Dr. Todd Kevin Young guilty of professional misconduct in relation to two complaints filed by the Registrar of the College.

The Tribunal's written decision was released on November 8, 2024.

The Tribunal accepted two agreed statements of fact that were jointly prepared by the College and Dr. Young. The dates, locations, and a brief description of the conduct of Dr. Young that was found to be deserving of sanction is as follows:

Charges 1-5

A patient ("Patient A") presented to their family physician on April 13, 2020, and was prescribed hydromorphone. On April 15, 2020, Dr. Young saw Patient A, via telemedicine. During that visit, he prescribed Maxeran, hydromorphone, and Tramacet.

In response to an allegation filed against him by the Registrar on May 12, 2020, Dr. Young provided a copy of his medical file for Patient A. This file contained a clinic note for the April 15, 2020, visit, a copy of a letter from Dr. Young to Patient A's family physician dated April 15, 2020, and copies of prescriptions for Maxeran, hydromorphone and Tramacet. The word "cancel" was handwritten on the hydromorphone prescription and the word "hydromorph" was crossed out. Dr. Young advised the College that "the hydromorph was cancelled" and that "the hydromorph prescribed by the family physician, referred to in the complaint, is not noted on HealtheNL nor was it mentioned by the pharmacists when I called."

The following information was detailed in the College's investigative report:

- Patient A's family physician did not receive correspondence from Dr. Young regarding his treatment of Patient A.
- The prescription written by Patient A's family physician for hydromorphone on April 13, 2020, was available for viewing in HealtheNL on April 15, 2020.
- There was no indication of a cancellation of the hydromorphone prescription at the pharmacy and that the prescription remained active in the pharmacy system.

- Dr. Young reported that he had communicated with the College in an "accurate and honest manner".
- An audit of Dr. Young's electronic medical record revealed that:

    - Dr. Young edited Patient A's clinic note on May 24, 2020, to add a subjective note, an objective note, and an assessment note.
    - Dr. Young authored the letter to Patient A's family physician, dated April 15, 2020, on May 25, 2020.
    - The hydromorphone prescription written for Patient A was uploaded to Dr. Young's Electronic Medical Record on June 9, 2020. The uploaded prescription did not include any handwritten annotations.

Charge 6

Patient B came under the care of Dr. Young beginning in June 2023 for treatment of opioid use disorder. Dr. Young started Patient B on methadone at 30 mg and titrated their dose up to 135 mg. Patient B received this medication through supervised doses on Monday to Saturday of each week, and an unsupervised dose on Sundays due to the pharmacy's closure on that day of the week.

In late June 2023, Patient B was scheduled to travel for work for a job where they performed duties which carried potential safety risks. Dr. Young switched Patient B from liquid methadone to Metadol tablets. Patient B was instructed to take three tablets three times a day, which had the effect of increasing Patient B's daily intake from 135mg to 225mg. Dr. Young prescribed a seven-day supply of Metadol tablets to take during upcoming work travel and continued this prescription for an additional eight days upon return. Patient B's medical record reflects that during this time, they advised Dr. Young that they had taken fentanyl.

Patient B was scheduled to travel again for work in early August 2023. Dr. Young continued the Metadol prescription for an additional 30 days, resulting in 270 tablets of Metadol 25 mg being dispensed to Patient B. Two days later, Patient B arrived at a remote worksite outside of the province. The following morning, Patient B was found unconscious. Several doses of Narcan were administered and Patient B was transported by Medevac to hospital for emergency medical treatment.

Charge 7

Patient C came under the care of Dr. Young beginning in June 2016 for treatment of opioid use disorder. From June 2016 through July 2023, Dr. Young prescribed Suboxone to Patient C. In late July 2023, Dr. Young substituted Patient C's prescription with methadone 30 mg. Dr. Young titrated the dosage of methadone up to 85 mg by early August 2023. Patient C received methadone through supervised dosage at the pharmacy.

In early August 2023, Patient C was scheduled to travel for work for a job where they performed duties which carried potential safety risks. Patient C's urine drug screening collected at this time showed the presence of morphine, fentanyl, and methadone. Dr. Young proceeded to switch Patient C from liquid methadone to Metadol tablets. Patient C was instructed to take one 25 mg tablet, three times a day and was provided with a 28-day supply. 84 tablets of Metadol 25mg were dispensed to Patient C. Two days later, Patient C travelled to a remote worksite outside of the province. Four days after arriving, Patient C was brought to the onsite medical clinic with signs of decreased or lost consciousness. After receiving several doses of Narcan, Patient C was transported by Medevac to hospital for emergency medical treatment.

The Tribunal accepted Dr. Young's plea of guilty of professional misconduct in respect of the complaints. In this plea, Dr. Young agreed that he:

1. prescribed two narcotic medications, being Tramacet and hydromorphone, to a patient without either personally examining the patient or being in direct communication with another licensed health-care practitioner who had examined the patient, contrary to the College's *Standard of Practice: Telemedicine (2017)*; and further that the departure from the *Standard of Practice: Telemedicine (2017)* was not made in accordance with the conditions set out in section 2(9) of *By-Law No. 5: Code of Ethics (2020)*;

2. signed and/or issued a document that Dr. Young knew, or ought to have known, was false or misleading, by providing to the College, during an investigation into an allegation against him, a letter to another physician authored by Dr. Young on May 25, 2020, which purported to be dated "April 15, 2020";

3. made a misrepresentation to the College investigator by providing an inaccurate copy of his clinic record dated April 15, 2020, to the College in the context of its investigation into an allegation, in that the said clinic record contained (i) a letter to another physician written on May 25, 2020, which bore the date of "April 15, 2020"; (ii) a prescription for hydromorphone dated April 15, 2020 which bore a handwritten alteration of "cancel", which prescription had been amended after it was sent to the pharmacy; and (iii) a non-contemporaneous clinic note which had been altered by Dr. Young on or about May 24, 2020;

4. altered a record relating to his medical practice other than in the manner prescribed by the CPSNL *By-Law No. 6: Medical Records (2020)*, when on May 24, 2020 he altered a clinic record relating to a visit with a patient on April 15, 2020 to remove, delete, erase, or render illegible each previously existing record, without retaining any indication of the previously existing record or the nature and date of the amendment;

5. falsified a record relating to his medical practice by writing "cancel" on a handwritten prescription numbered 4786266 issued by Dr. Todd Young for hydromorphone dated

April 15, 2020, and providing such false document to the College during an investigation into an allegation against him.

6. provided treatment to each of Patient B and Patient C with respect to their treatment with Metadol which did not meet the standard of care expected of a family physician in Dr. Young's circumstances.

The Tribunal accepted a submission for sanctions that was jointly prepared by the College and Dr. Young. It then ordered that:

1. Dr. Young's medical licence will be suspended for a duration of four (4) months, to be served in blocks with each not less than one (1) month at a time, within 12 months of the date of this Order.

2. Dr. Young will complete remedial education and professional development in the area of addictions medicine for a period of not less than three weeks, including the following:

    a) A two-week observership with a physician practicing in the area of addictions medicine;
    b) A one-week period of self-study and mentorship with a qualified physician, based on addictions medicine; and
    c) In-person attendance at the Canadian Society of Addiction Medicine Conference in November 2024.

3. Dr. Young's medical licence will contain a restriction which prohibits him from prescribing narcotics, including opioids, until he has provided the Registrar with written confirmation of completion of the requirements in paragraphs 2 a), b), and c) above.

4. Within 6 months of the date of the Adjudication Tribunal's decision or order, Dr. Young will complete continuing professional development courses acceptable to the Registrar on the following subjects:

    a) Professional ethics; and
    b) Medical record-keeping.

5. Dr. Young will undergo mandatory referral to the Physician Care Network program pursuant to the Memorandum of Understanding between the Newfoundland and Labrador Medical Association and the College.

6. The cost of implementing paragraphs 2, 4, and 5 will be borne by Dr. Young.

7. Dr. Young will pay the costs of the College's investigation and hearing in accordance with the College's *Tariff of Costs*.

8. The Adjudication Tribunal's decision and/or order will be published in keeping with the By-Laws of the College and section 50 of the *Medical Act, 2011*.

9. This sanction will take effect beginning not earlier than two weeks from the date of this hearing.

Tanis Adey, MD
CEO & Registrar, CPSNL
December 10, 2024