ALBERTA COLLEGE OF PHARMACY

IN THE MATTER OF
THE HEALTH PROFESSIONS ACT

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF

PIERRE RIZK
Registration number: 11721

DECISION OF THE HEARING TRIBUNAL

September 2, 2020

I. INTRODUCTION

[1] The Hearing Tribunal held a hearing into the conduct of Dr. Pierre Rizk. In attendance on behalf of the Hearing Tribunal were Brad Willsey, pharmacist and chairperson; Chris Heitland, pharmacist; Kamal Dullat, pharmacist and Dave Rolfe, public member.

[2] Gregory Sim acted as independent legal counsel to the Hearing Tribunal.

[3] The hearing was held over four days between August 13-16 and November 20, 2019. All of the hearing dates were held at the second-floor conference center, 8215 112 St. NW, Edmonton, AB. The hearing was held under the terms of Part 4 of the *Health Professions Act* ("HPA").

[4] In attendance at the hearing were James Krempien, Complaints Director for the Alberta College of Pharmacy (the "College"); David Jardine and Annabritt Chisholm, legal counsel for the Complaints Director. Dr. Rizk did not attend the hearing in person or through a representative at any point.

[5] There were no objections to the composition of the Hearing Tribunal or its jurisdiction to proceed with a hearing.

II. ALLEGATIONS

[6] The Hearing Tribunal held a hearing to inquire into the following complaints or matters with respect to Dr. Rizk, as set out in four Notices of Hearing, entered as Exhibits 1, 2, 3 and 4 and heard together:

[7] ACP Complaint 6463

IT IS ALLEGED THAT as both a registered Alberta pharmacist and the licensee of Supreme Health Drug Therapy Management Clinic & Pharmacy (ACP License #3085), you:

1. Failed, which providing care to your patient DL between May 17, 2017 and April 3, 2018 to:
    a. provide notification of your prescribing activities to DL's, primary care physician, KB;
    b. collaborate with other healthcare professionals in the care of your patient, DL, including KB;
2. Consistently increased DL's medication doses and prescribed additional medications for him despite the fact that:
    a. DL was meeting the treatment goals you established;
    b. You did not consider the concerns and professional advice provided to DL by KB as reported by DL and failed to discuss those reported concerns with KB;

   c. you did so without appropriately monitoring DL by ordering and reviewing objective data, including laboratory tests to assess organ function; and
   d. you did not consider alternatives to increasing the medication doses and prescribing additional medications, including collaboration with other health professionals and the use of non-drug therapies to assist in weight reduction.
3. Potentially placed DL at risk when you prescribed him five different prescription medications for weight loss concurrently, three of which are not indicated for that use by Health Canada;
4. Managed adverse events and treatment failures for DL, by prescribing additional medication rather than undertake further assessment and consider other alternatives, or collaborate with, or refer DL to, other healthcare practitioners;
5. Failed to provide KB with copies of the communication and notifications of prescribing information regarding your mutual patient DL, which she requested on May 1, 2018 and that you claimed to have sent her between May 2017 and April 3, 2018; and
6. Misled and failed to cooperate with an investigator appointed by the Complaints Director of the Alberta College of Pharmacy in this matter when you falsely claimed that you attempted to collaborate and provide KB with the documentation pharmacists are required to provide to other members of a patient's healthcare team following your decision to prescribe to DL, by:
   a. fax on 25 separate occasions; and
   b. phone on two occasions.

IT IS ALLEGED THAT your conduct in these matters:

a. Breached your statutory and regulatory obligations to the Alberta College of Pharmacy as an Alberta pharmacist;
b. Undermined the integrity of the profession;
c. Decreased the public's trust in the profession;
d. Created the potential for patient harm; and
e. Failed to exercise the professional and ethical judgment expected and required of an Alberta pharmacist.

IT IS ALLEGED THAT your conduct constitutes a breach of the following statutes and standards governing the practice of pharmacy:

- Standards 1 (sub-sections 1.1, 1.2, 1.4, and 1.7(b, c and d), 3 (sub-sections 3.1, 3.4, 3.5 and 3.6), 11 (sub-sections 11.6 and 11.9), and 14 (sub-sections 14.1, 14.3, 14.4, 14.5 and 14.10) of the Standards of Practice for Pharmacists and Pharmacy Technicians;
- Principles 1(1), 1(2), 1(14), 1(15), 10(1) and 10(2) and 12(2) of the Alberta College of Pharmacy's Code of Ethics;

and that your conduct set out above and the breach of some or all of these provisions constitutes unprofessional conduct pursuant to the provisions of sections 1(1)(pp)(i), 1(1)(pp)(ii), 1(1)(pp)(vii)(B) and 1(1)(pp)(xii) of the *Health Professions Act*.

[8] ACP Complaint 6774

IT IS ALLEGED THAT, as both a registered Alberta pharmacist and the licensee of Supreme Health Drug Therapy Management Clinic & Pharmacy (ACP License #3805), you:

1. Failed to collaborate with other health care professionals in your care of patient AH, including when you
    a. Failed to contact Dr. H, AH's primary care physician after you altered AH's medications;
    b. Failed, between February 2, 2018 and August 30, 2018, to provide updates to AH's second primary care physician, Dr. R, including after you prescribed azithromycin and levofloxacin to AH for bacterial pneumonia on July 5, 2018 and July 13, 2018, respectively;
    c. Failed to update AH's nephrologist, Dr. P, of the changes you were making to AH's insulin, which resulted in Dr. P instructing you not to manage the nephrology aspects of AH's care;
    d. Failed to disclose your assessment modalities to the complainant, GB, a clinical pharmacist who was part of AH's hospital care team after he was admitted to the Misericordia Hospital on July 13, 2018; and
2. Failed to exercise the clinical judgment expected of an Alberta pharmacist when you
    a. chose to prescribe an antibiotic (levofloxacin) to AH over the telephone even after you knew AH had previously failed on two courses of antibiotics (doxycycline and azithromycin);
    b. chose to prescribe oseltamivir to AH over the phone on July 13, 2018;
    c. adjusted AH's insulin doses without consulting his nephrologist, Dr. P and after Dr. P instructed you not to manage the nephrology aspects of AH's care;
    d. failed to consider standard diagnostic criteria when you assessed AH for AECOPD and pneumonia;
    e. failed to self-reflect or consider how your prescribing decisions contributed to the outcome of AH; and
    f. failed to respect the opinions of AH's hospital care team following his admission to the Misericordia Hospital on July 13, 2018, including when you said "[the hospital pharmacist] and her team showed incompetence and lack of knowledge about community acquired pneumonia and this jeopardized (sic) patient's health";

3. Demonstrated an ongoing pattern of behavior that displayed a failure to treat your colleagues with respect, including when you:
    a. stated or insinuated at least nine times in your written response to the complaint received October 11, 2018 that GB, the complainant, was "lying";
    b. stated AH's care team at the Misericordia Hospital was "incompetent";
    c. described Dr. R as "incompetent" in your written response to the complaint received October 11, 2018;
    d. described Dr. H as "incompetent" in your written response to the complaint received October 11, 2018;
    e. questioned GB's qualifications to serve as a clinical pharmacist in the ICU on the basis that she does not have a PharmD;
    f. stated GB "doesn't have the skills and knowledge", was a "mentally unstable individual, "condescending", "arrogant" and "unprofessional"; and
    g. were aggressive in a phone conversation with Dr. P;
4. Attempted to mislead and failed to cooperate with an investigator appointed by the Complaints Director of the Alberta College of Pharmacy when you
    a. falsely claimed that you faxed approximately 50 separate documents to other members of AH's medical team when only one physician, Dr. P, received one partial fax;
    b. falsely claimed that you did not personally fax documents before April 2018; and
    c. lied about editing the audio recordings you sent to the investigator.

IT IS ALLEGED THAT your conduct in these matters:

a. Breached your statutory and regulatory obligations to the Alberta College of Pharmacy as an Alberta pharmacist;
b. Undermined the integrity of the profession;
c. Decreased the public's trust in the profession;
d. Created the potential for patient harm; and
e. Failed to exercise the professional and ethical judgment expected and required of an Alberta pharmacist.

IT IS ALLEGED THAT your conduct constitutes a breach of the following statutes and standards governing the practice of pharmacy:

- Standards 1 (sub-sections 1.1, 1.2, 1.4 (a, c, d, and e), 1.5 and 1.7(b, c, d(ii) and d(iii)), 3, 11 (sub-sections 11.1(c), 11.2, 11.6 and 11.9), 14 (sub-sections 14.1, 14.2(c), 14.4, 14.5 and 14.10) of the Standards of Practice for Pharmacists and Pharmacy Technicians;
- Principles 1(1), 1(2), 1(3), 1(14), 1(15), 5(6), 9(6), 10(1), 10(2), 10(10) and 12(2) of the Alberta College of Pharmacy's Code of Ethics;

and that your conduct set out above and the breach of some or all of these provisions constitutes unprofessional conduct pursuant to the provisions of sections 1(1)(pp)(i), 1(1)(pp)(ii), 1(1)(pp)(vii)(B) and 1(1)(pp)(xii) of the *Health Professions Act*.

[9] ACP Complaint 6785

IT IS ALLEGED THAT, as both a registered Alberta pharmacist and the licensee of Supreme Health Drug Therapy Management Clinic & Pharmacy (ACP License #3805), you:

1. Failed to collaborate with other health care professionals in your care of patient DS when you
    a. Failed to notify Dr. B, DS's primary care physician, of your prescribing activities, including prescriptions for dexamethasone (IM and oral), Florinef, valproic acid, Effexor, Lipitor, ketorolac, gabapentin, cetirizine, clonidine, glyburide, repaglinide, anafranil, ranitidine, hydroxyzine, pyridoxine, thiamiject, cyanocobalamin, injectable and oral vitamins and supplements and over the counter sleep remedies;
    b. failed to include DS's neurologist in your prescribing process.

2. Failed to exercise the clinical judgment expected of an Alberta pharmacist when you
    a. prescribed clonidine to DS on March 28, 2017 after she presented with "hypertensive emergency" and multiple systolic blood pressure readings over 180 mm Hg;
    b. asked DS on March 28, 2017 to self-monitor her blood pressure after you determined she presented with a "hypertensive emergency" with multiple systolic blood pressure readings over 180 mm Hg;
    c. did not follow up with DS for six days after you prescribed clonidine on March 28, 2017;
    d. assessed DS on March 28, 2017 for organ damage in a community pharmacy setting;
    e. prescribed tramadol and venlafaxine (off-label) to DS on March 21, 2017 for diabetic neuropathy and then, on April 13, 2017, when DS mentioned she was experiencing "jerky movements" you assessed that DS had serotonin syndrome and without collaborating or referring DS to a physician decided to reduce the tramadol DS had been prescribed from 100 Mg three times daily to 50 Mg three times daily while simultaneously increasing the venlafaxine dose from 187.5 Mg daily to 225 Mg daily;
    f. did not follow up with DS for 12 days after you altered DS's tramadol and venlafaxine prescriptions;

g. prescribed atorvastatin for DS when it was contraindicated based on her medical history of a high CK level;
h. prescribed valproic acid for neuropathic pain when it was not indicated for this use by Health Canada based on a Mayo Clinic article in which it is used as a third-line medication;
i. prescribed clomipramine for myotonic dystrophy despite it not being indicated for this use by Health Canada based on a small crossover study mentioned in a review article;
j. prescribed and then refused to discontinue dexamethasone when DS's primary care physician Dr. B informed you there was no indication for it;
k. inappropriately informed DS that dexamethasone could not cause bleeding when you said "it doesn't cause any bleeding, nothing OK";
l. failed to respect the opinions of other healthcare professionals caring for DS, including Dr. B;
m. determined you were satisfactorily monitoring DS's hemoglobin A1c levels when they were >19%; and
n. failed to self-reflect or consider that your determination that DS diabetes was under control may have put DS at risk.

3. Failed to treat other healthcare professionals with respect, including when you chose to approach criticisms of your practice by calling Dr. B a "liar", "negligent", "incompetent" or questioning her competency.

4. Attempted to mislead an investigator appointed by the Complaints Director of the Alberta College of Pharmacy when you falsely claimed that you
    a. Faxed approximately 57 documents to Dr. B when she only received two documents from you on December 18, 2017 and January 23, 2018;
    b. Did not keep fax transmission logs before April 2018 when you had fax transmission logs for December 18, 2017 and January 23, 2018; and
    c. Did not personally fax documents before April 2018.

IT IS ALLEGED THAT your conduct in these matters:

a. Breached your statutory and regulatory obligations to the Alberta College of Pharmacy as an Alberta pharmacist;
b. Undermined the integrity of the profession;
c. Decreased the public's trust in the profession;
d. Created the potential for patient harm; and
e. Failed to exercise the professional and ethical judgment expected and required of an Alberta pharmacist.

IT IS ALLEGED THAT your conduct constitutes a breach of the following statutes and standards governing the practice of pharmacy:

- Standards 1 (sub-sections 1.1, 1.2, 1.4 (a, c, d, and e), 1.5 and , and 1.7(b, c, d(ii) and d(iii)), 3, 11 (sub-sections 11.1, 11.2, 11.6 and 11.9), 14 (sub-sections 14.1, 14.2(c), 14.4, 14.5 and 14.10) of the Standards of Practice for Pharmacists and Pharmacy Technicians;
- Principles 1(1), 1(2), 1(3), 1(14), 1(15), 5(6), 9(6), 10(1), 10(2), 10(10) and 12(2) of the Alberta College of Pharmacy's Code of Ethics;

and that your conduct set out above and the breach of some or all of these provisions constitutes unprofessional conduct pursuant to the provisions of sections 1(1)(pp)(i), 1(1)(pp)(ii), 1(1)(pp)(vii)(B) and 1(1)(pp)(xii) of the *Health Professions Act*.

[10] ACP Complaint 6940

IT IS ALLEGED THAT while you were both a registered Alberta pharmacist and the licensee of Supreme Health Drug Therapy Management Clinic & Pharmacy (ACP License #3085), a practice inspection ordered by the Registrar of the Alberta College of Pharmacy on May 23, 2018 resulted in a review of seven patient files, which demonstrated that you:

1. Failed to notify other healthcare professionals involved with the care of your patients in Cases 1-7 of your prescribing activities;
    a. there was a consistent pattern of failing to notify other health professionals involved in the care of your patients of your prescribing activities;
    b. there was little to no evidence that even one-way communication or notification had occurred.

2. Failed to collaborate with or appropriately refer to other health care professionals;
    a. there was no evidence in any of the 7 cases of the level of reciprocal communication required for patients with complex medical issues;
    b. you could not provide any specific examples of clinically significant interactions with other healthcare professionals;
    c. the absence of collaboration and communication with other health care professionals created situations where patient safety was placed at risk;
    d. you placed no value on the professional knowledge or contributions of other health care professionals;
    e. particulars of this failure to collaborate with or appropriately refer to other health care professionals include:
        i. In Case 1 when you diagnosed your patient with tonsillitis and did not consider referral to other healthcare professionals;
        ii. In Case 2 when you

a) did not collaborate with your patient's psychiatrist while treating the patient's depression disorder and migraines; and
b) did not refer or consider referring your patient to a physician to manage their chronic migraines.

iii. In Case 3 when you independently treated your patient for erectile dysfunction for approximately six months without referring the patient to a physician or other healthcare professional.

iv. In Case 6 when you
a) prescribed a second round of maxitrol eyelid gel and did not consider alternative therapy or referral to another healthcare professional;
b) prescribed a compounded prescription to treat actinic keratosis and did not consider the value of obtaining assessment from other healthcare professionals with dermatological experience; and
c) failed to document obtaining or considering information from other healthcare professionals.

3. Ordered unnecessary or clinically inappropriate laboratory tests and then failed to appropriately consider or interpret those tests or to document the rationale or results of the tests, including;
   a. In Case 1 when on or around May 19, 2017 you ordered 27 lab tests for your patient for routine screening without providing patient or condition specific rationale.
   b. In Case 4 when you ordered laboratory tests for C-reactive protein, FSH, LH and parathyroid hormone when your patient was seeking your assistance for weight loss.

4. Failed to consider appropriate information when assessing patients, including:
   a. In Case 1 when you
      i. Diagnosed your patient with tonsillitis without considering differential diagnoses;
      ii. Provided 10 cyanocobalamin (vitamin B12) injections to your patient between May 25 – June 7, 2017 despite recorded levels being within the normal range on May 25, 2017;
   b. In Case 3 when you failed to consider psychological factors contributing to your patient's erectile dysfunction.
   c. In Case 5 when you did not consider alternative diagnoses for the patient's premature ejaculation.
   d. In Case 7 when you did not appropriately prioritize your patient's drug problems.

5. Provided patients with information that was inadequate or inaccurate, including;

a. In Case 4 when you provided unrealistic expectations for drug therapy and weight loss to your patient.
b. In Case 6 when you failed to explain how the established goal of therapy, blood pressure of 115/75 mmHg, was determined or how meeting this goal would be of clinical value in resolving the patient's tiredness.

6. Engaged in prescribing practices that were not rooted in sound evidence, best practice or even common practice and differed from decisions made by other pharmacists or healthcare professionals including:
    a. routinely prescribing for indications that were not approved by Health Canada without using critical appraisal skills for evaluating evidence and without being able to provide adequate evidence or to support your decision, including;
        i. In Case 4 when you
            a) prescribed bupropion 100Mg SR for weight loss and your patient was not on caloric restriction and an exercise regimen;
            b) prescribed metformin as an appetite suppressant up to a maximum dosing of 2.5g/day;
            c) prescribed topiramate 12.5Mg HS for appetite suppression and weight loss.
        ii. In Case 5 when you prescribed duloxetine for premature ejaculation based on a single study of 20 patients.
        iii. In Case 6 when you prescribed fludrocortisone for orthostatic hypotension and fatigue.
        iv. In Case 7 when you prescribed topiramate for weight loss and did so without any comprehensive exercise or diet plan.

    b. prescribing treatments or medications in unsafe combinations, at unsafe doses or at doses that were not evidence-based in a manner contrary to best practices including;
        i. In Case 1 when you
            a) prescribed four medications concurrently to treat shoulder pain, including rectal diclofenac and injectable ketorolac; and
            b) diagnosed sinusitis and then after prescribing clarithromycin and beclomethasone and your patient developed systemic symptoms, you prescribed injectable dexamethasone followed by oral prednisone.
        ii. In Case 2 when you prescribed multiple dose changes and new agents at the same time without allowing sufficient time to assess the effectiveness or safety.
        iii. In Case 3 when you "prescribed" multiple herbal products (maca, Korean ginseng, tadalafil and tribulus terrestris) to treat your patient's erectile dysfunction that

were either at subtherapeutic doses or lacked evidence of effectiveness.

iv. In Case 4 when you
   a) recommended a caloric intake well below safe levels as determined by Health Canada;
   b) prescribed liraglutide without recommending it be used in combination with a calorie restricted diet and exercise regimen; and
   c) prescribed chitosan and injectable B vitamins despite no evidence or poor evidence of their effectiveness.

v. In Case 5 when you prescribed injectable tramadol, injectable ketorolac, oral baclofen and rectal diclofenac for joint pain.

vi. In Case 6 when you
   a) prescribed spironolactone for acne despite your patient being on medication to raise her blood pressure; and
   b) prescribed diclofenac at a dose that doubled the maximum dose recommended by Health Canada based on a proprietary NSAID dosing chart published by MagellanRx Management, a non-Canadian pharmacy benefit manager.

vii. In Case 7 when you
   a) did not consider drug therapy other than vitamin B12 for your patient's diabetic neuropathy;
   b) prescribed levofloxacin and budesonide/formoterol for your patient's bacterial bronchitis and pneumonia and added prednisone when your patient did not respond to the other drugs;
   c) diagnosed candida balanid on your patient's penis and instructed your patient to rub the area for 3-4 minutes four times daily;
   d) prescribed a combination of diclofenac, tramadol, injectable ketorolac and injectable dexamethasone concurrently with injectable lidocaine and did not use step therapy.

7. Failed to adequately consider over-the-counter or non-pharmacologic options for patient care, including:
   a. including lifestyle changes such as dietary modifications to address you patient's obesity in Case 1; and
   b. including lifestyle changes such as exercise, diet or referral to another healthcare professional in Case 4.

8. Responded inappropriately to drug therapy problems, including;
   a. In Case 2

i. when you responded to a complaint of grogginess by concurrently lowering zopiclone and raising amitriptyline and then at a later date by concurrently raising zopiclone and lowering amitriptyline;
ii. when you continued to treat a patient's migraines with naproxen despite noting that it appeared ineffective.

b. In Case 3 when you identified finasteride as a contributing factor to your patient's erectile dysfunction but did not consider stopping this medication.

9. Used inappropriate timeframes to assess efficacy of current therapy before making changes or adding additional therapy, including;
    a. In Case 4 when you rapidly added, discontinued or changed medications and doses for various conditions without sufficient time to assess the effectiveness and safety of these medications.

10. Failed to appropriately monitor your patients, including:
    a. In Case 1 when you did not monitor your patient for renal adverse effects from concurrent NSAID therapy or for adverse endocrine effects from concurrent corticosteroid therapy.
    b. In Case 6 when you
        i. prescribed fludrocortisone to treat hypotension and by extension drowsiness and did not appropriately monitor your patient for adverse effects, including potassium levels;
        ii. did not monitor your patient's potassium levels despite her being on fludrocortisone and spironolactone concurrently.
    c. In Case 7 when you did not address your patient's triglycerides in a timely manner and then once addressed, inappropriately monitored your patient for drug interactions and adverse effects.

11. Failed to adequately document treatment progress, outcomes, rationales, assessment and notification to other healthcare professionals, including;
    a. In Case 1 when the patient complained of fatigue and you did not document specific treatment outcomes.
    b. In Case 4 when you added, discontinued or changed medications or doses for various conditions without providing a rationale for doing so.
    c. In Case 5 when you
        i. prescribed zopiclone to treat the symptom of difficulty sleeping and subsequently raised the dose without documentation that your patient showed a positive response to the treatment;

ii. failed to document specific outcomes for your patient's premature ejaculation.

d. In Case 7 when you
   i. Failed to sufficiently document your patient's plan or progress with his diabetes and smoking cessation.

12. Failed to demonstrate self-awareness to determine the limitations of your practice and the need for communication and collaboration with other health care professionals or to reflect on the decisions that you made;

13. Administered drugs by injection in an unsafe manner, including by administering multiple injectable medications in quantities that exceed best practice maximum of 1-2ml per deltoid muscle and with the addition of lidocaine for pain relief, as:
    a. In Case 5 when you injected up to 8ml of six different injectable medications into your patient's deltoid muscles on February 22-23, 2018 and March 22-24, 2018 and prescribed and administered lidocaine to minimize pain without evidence to support this decision as being safe or effective.
    b. In Case 6 when you
       i. administered injectable lidocaine to manage injection pain; and
       ii. injected up to 3 ml into the deltoid muscle.
    c. In Case 7 when you injected ranitidine to prevent GI dyspepsia despite no clear rationale for administration by this route.

14. Failed to respond honestly, openly and courteously to complaints and criticism of your practice, including when in your responses:
    a. you were unable to accept any review or criticism from any source;
    b. you failed to acknowledge or take any responsibility for your conduct;
    c. you attacked the integrity and competence of anyone who raised concerns about your actions;
    d. you stated that the inspectors' opinion regarding the potential for patient harm was irrelevant because there had been no instances of patient harm; and
    e. you stated that lidocaine is very safe and "instead of being offensive and ignorant", the inspectors should have looked at your results.

15. Failed to treat your colleagues with respect when in your responses to the inspection and the complaint you suggested that M. Munchua and R. Patel were not qualified to assess your practice and described them as "lying", incompetent, having a "lack of experience", "lack of skills and knowledge" and suggesting that they could not read.

16. Attempted to mislead and failed to cooperate with an investigator appointed by the Complaints Director of the Alberta College of Pharmacy when you
    a. falsely claimed that you sent approximately 12 documents to Dr. Q;
    b. falsely claims that you sent approximately 15 documents to Dr. R;
    c. falsely claimed that you sent approximately 5 documents to Dr. E;
    d. falsely claimed that you sent approximately 15 documents to Dr. D when she received only one document from you;
    e. falsely claimed that you sent approximately 26 documents to Dr. S when he received only five documents from you;
    f. falsely claimed that you sent approximately 21 documents to Dr. Z during your treatment of your mutual patient M.S., when in fact you sent 13 of the 21 documents to Dr. Z's office on June 5, 2018, after the inspection was ordered; and
    g. falsely claimed that you did not personally fax documents before April 2018.

IT IS ALLEGED THAT your conduct in these matters:

a. Breached your statutory and regulatory obligations to the Alberta College of Pharmacy as an Alberta pharmacist and a pharmacy licensee;
b. Undermined the integrity of the profession;
c. Created the potential for patient harm; and
d. Failed to exercise the professional and ethical judgment expected and required of an Alberta pharmacist and a pharmacy licensee.

IT IS ALLEGED THAT your conduct constitutes a breach of the following statutes and standards governing the practice of pharmacy:

- Standards 1 (sub-sections 1.1, 1.2, 1.4, 1.5 and , and 1.7, 3 sub-sections 3.1(a), 3.7(b), 3.7(f), 3.8(a) and 3.8(c), 11 (sub-sections 11.1, 11.2, 11.6, 11.9 and 11.11), 14 (sub-sections 14.1, 14.4, 14.5, 14.8 and 14.10) and 18.4 of the Standards of Practice for Pharmacists and Pharmacy Technicians; and
- Principles 1(1), 1(2), 1(7), 1(8), 1(14), 1(15), 2(3), 2(4), 5(6), 9(5), 9(6), 10(2), 10(10), 12(2) and 12(6) of the Alberta College of Pharmacy's Code of Ethics;

and that your conduct set out above and the breach of some or all of these provisions constitutes unprofessional conduct pursuant to the provisions of sections 1(1)(pp)(i), 1(1)(pp)(ii), 1(1)(pp)(vii)(B) and 1(1)(pp)(xii) of the *Health Professions Act*.

III. PRELIMINARY MATTERS

[11] Neither Dr. Rizk, nor anyone on his behalf were present when the hearing began on August 13, 2019. Counsel for the Complaints Director, Mr. Jardine, began by applying to proceed with the hearing in Dr. Rizk's absence.

Ms. Margaret Morley, Hearings Director

[12] Mr. Jardine first called Margaret Morley, the College's Hearings Director to testify. Ms. Morley explained that her responsibilities include serving notices on regulated members of the College for conduct hearings. Ms. Morley swore an Affidavit of Attempted Service, which was entered into evidence.

[13] Ms. Morley's affidavit swore that she received the Complaints Director's referral of Complaint 6463 on October 17, 2018 and of complaints 6774 and 6795 on April 9, 2019. She received the referral of another complaint, 6940 on April 16, 2019. Ms. Morley then took steps to serve the Notices of Hearing and Notices to Attend and Notices to Produce for these complaint matters upon Dr. Rizk using the contact information provided by Dr. Rizk and retained in the official clinical pharmacist register of the Alberta College of Pharmacy.

[14] For Complaint 6463, Ms. Morley successfully served the Notice of Hearing package upon Dr. Rizk in October 2018. The Notice of Hearing provided the hearing would be held on January 23-25, 2019. Ms. Morley was able to verify service upon Dr. Rizk because on November 16, 2018 she received a letter from a lawyer then acting for Dr. Rizk, Mr. Richard Hajduk, confirming his retainer by Dr. Rizk and requesting an adjournment of the hearing. Those hearing dates were adjourned by agreement to new dates. Mr. Hajduk subsequently wrote to Ms. Morley indicating he no longer represented Dr. Rizk. Mr. Hajduk directed that further correspondence be provided to Dr. Rizk directly and he provided an email address for Dr. Rizk. That was the same email address on the College's clinical register. Ms. Morley emailed Dr. Rizk at the email address on the clinical register on April 29, 2019 to advise that Complaint 6463 would be rescheduled to the week of August 12, 2019 and that a new Notice of Hearing would be provided.

[15] On May 6, 2019 Ms. Morley sent by registered mail and regular mail to Dr. Rizk's mailing address the Notices of Hearing for Complaint 6463, 6774 and 6785 along with Notices to Attend and Notices to Produce for each complaint. These were both returned to Ms. Morley unclaimed.

[16] On May 7, 2019 Ms. Morley sent the same Notices of Hearing, Notices to Attend and Notices to Produce to Dr. Rizk's email address and flagged her email for tracking. Ms. Morley swore that she received an automated reply from postmaster@outlook.com indicating that her message to Dr. Rizk's email address had been delivered. Ms. Morley did not receive a confirmation that her May 7, 2019 email to Dr. Rizk had been read.

[17] Ms. Morley testified that on May 9, 2019 the Hearing Notice page of the College's website was updated with the August 13-16, 2019 hearing dates. She also testified that she engaged a process server on May 9, 2019 to attempt personal service on Dr. Rizk at his residential address

on the College's clinical register. The process server's efforts to serve Dr. Rizk were unsuccessful. The process server's affidavit also confirmed that he observed the location of Dr. Rizk's pharmacy was closed and all of the furniture appeared to have been removed from the storefront.

[18] Ms. Morley made further efforts to confirm service upon Dr. Rizk on June 20, 2019 by email. Ms. Morley emailed Dr. Rizk explaining that a new Complaint 6940 had been added to the August 13-16, 2019 hearing dates and she attached all four Notices of Hearing, Notices to Attend and Notices to Produce returnable on those August 2019 hearing dates. Ms. Morley then sent the same Hearing Notice package to Dr. Rizk by registered mail and regular mail. The registered mail package was returned to Ms. Morley unclaimed on July 15, 2019. The regular mail package was not returned.

[19] Ms. Morley also re-engaged the same process server to attempt personal service upon Dr. Rizk. The process server made multiple additional attempts, but these were also unsuccessful. Lastly, Ms. Morley telephoned Dr. Rizk's cell phone number and his home telephone number on the College's clinical register on July 29, 2019. The cell phone number went straight to an automated voice message indicating that the customer was not available, and Ms. Morley was not able to leave a message. Ms. Morley did leave a voice message at Dr. Rizk's home telephone number identifying herself as the Hearings Director at the Alberta College of Pharmacy and asked Dr. Rizk to return her call. Ms. Morley made further attempts to reach Dr. Rizk by telephone on August 8, 2019 with the same results.

Mr. James Krempien, Complaints Director

[20] Mr. Jardine next called Mr. Krempien to testify in relation to the application to proceed in Dr. Rizk's absence. Mr. Krempien explained that Dr. Rizk had conditions imposed on his practice in December 2018 prohibiting him from prescribing and injecting. He became non-compliant with those conditions and he was then suspended pursuant to section 65 of the HPA. He remained suspended as of the date of the hearing.

[21] Mr. Krempien testified that after Dr. Rizk received notice of his suspension, he emailed the College's Registration Manager on April 23, 2019 to say he was returning his license for his pharmacy and his practice permit. Dr. Rizk said he intended to close the pharmacy. The email address Dr. Rizk used to write to the Registration Manager was the same one Ms. Morley swore she had used to correspond with Dr. Rizk about the Notices of Hearing.

[22] Mr. Krempien also explained that the College's Registration Manager received a letter dated April 29, 2019 from a lawyer, Mr. Chivers, who was acting for Dr. Rizk in relation to the closure of his pharmacy. The letter was entered into evidence and confirmed Dr. Rizk's contact information, including the same email address and cell phone number that Ms. Morley swore she had used to correspond with Dr. Rizk about the Notices of Hearing, Notices to Attend and Notices to Produce.

[23] Finally, Mr. Krempien testified that he attended at Dr. Rizk's pharmacy location on April 24 at approximately 12:30pm and again on May 9, 2019 prior to 2:42pm and observed that the pharmacy was closed and locked on both occasions. Mr. Krempien wrote an email to College staff on May 9 indicating that the interior lights were off, and no one was seen inside. He also

commented that he observed no prescription or over the counter drugs on the pharmacy shelves or anywhere in the building. Mr. Krempien also noted that a sign that had been affixed to the pharmacy door on April 24 had been taken down by May 9. The sign informed patients that the clinic/pharmacy was permanently closed. The sign asked patients to call a telephone number and leave a message regarding the transfer of their medication files to another pharmacy. The telephone number on the sign was Dr. Rizk's home telephone number on the College's clinical register. It was one of the numbers that Ms. Morley had sworn she had used to try to contact Dr. Rizk.

Application to Proceed in Dr. Rizk's Absence

[24] Mr. Jardine then presented argument that the Hearing Tribunal should proceed with the hearing in Dr. Rizk's absence. Mr. Jardine suggested there was a high probability that the hearing materials Ms. Morley had sent were received by Dr. Rizk. The email address Ms. Morley used to attempt to contact Dr. Rizk was the same one that Dr. Rizk's lawyer had said could be used to contact him. There was evidence that Dr. Rizk had received and was aware of the referral of Complaint 6463 to a hearing, because Dr. Rizk had retained a lawyer to defend him.

[25] Mr. Jardine also highlighted that Dr. Rizk's response to his suspension indicated his intention to permanently close his pharmacy and apparently to follow through on that intention. Dr. Rizk had written to the College's Registration Department using the same email address that Ms. Morley had used to send the hearing notices to him.

[26] Mr. Jardine then argued that the hearing should proceed even without proof that Dr. Rizk had acknowledged receiving the hearing notices. Mr. Jardine explained that section 120(3) of the HPA provides that a notice required to be given to a person under Part 4 by a Hearings Director, such as a Notice to Attend, is sufficiently given if it is given by personal service, certified or registered mail at the person's address as shown on the register of the Registrar. Mr. Jardine argued that Ms. Morley's evidence demonstrated that she sent all four Notices of Hearing and Notices to Attend to Dr. Rizk's address on the College's register by registered mail. Dr. Rizk may not have signed for and received his registered mail, but at that point the Hearings Director had given the notices in accordance with section 120(3) of the HPA. Mr. Jardine also pointed out that Ms. Morley went above and beyond and sent copies of the notices by regular mail, email and she made multiple telephone calls to the telephone numbers Dr. Rizk had provided to contact him.

[27] Mr. Jardine then referred to section 79(6) of the HPA. It provides that if an investigated person does not appear at a hearing and there is proof they have been given a notice to attend, the Hearing Tribunal may proceed with the hearing and act or decide on the matter in their absence. Mr. Jardine said this was clear authority for the Hearing Tribunal to proceed despite Dr. Rizk's refusal to attend the hearing.

[28] Mr. Jardine argued that the issues before the Hearing Tribunal are serious matters. The Complaints Director will put forward evidence that Dr. Rizk was purporting to diagnose his patients and then to prescribe treatments for them, contrary to the standards that were put in place when pharmacists were given prescribing authority. The Complaints Director seeks to proceed with the case to obtain important decisions for the profession of pharmacy, as well as for other professions.

Decision of the Hearing Tribunal

[29] The Hearing Tribunal carefully considered the evidence of Ms. Morley and Mr. Krempien and the submissions by Mr. Jardine. The Hearing Tribunal was satisfied that Ms. Morley sent all four of the Notices of Hearing and Notices to Attend to Dr. Rizk by registered mail to his home address registered with the College's Registrar. Ms. Morley sent registered mail to Dr. Rizk several times, but on June 20, 2019 she sent a package with the Notices of Hearing and Notices to Attend for each of Complaints 6463, 6774, 6785 and 6940.

[30] Section 120(3) of the HPA provides that a notice required to be given under Part 4, like a Notice of Hearing and Notice to Attend, is sufficiently given if it is given by registered mail to the address as shown on the register of the College's Registrar. The notices that Ms. Morley sent on June 29, 2019 were therefore "sufficiently given" and proof of personal service upon Dr. Rizk was not required.

[31] In addition, there was evidence demonstrating that Dr. Rizk was very likely aware of the Notices of Hearing and the proceedings against him. There is no question Dr. Rizk was aware of the 6463 complaint because he had retained a lawyer, Mr. Hajduk to represent him in relation to it. Mr. Hajduk had ceased to act for Dr. Rizk by April 17, 2019. Mr. Krempien also explained that after Dr. Rizk was suspended, he emailed the College's Registration Manager on April 23, 2019 to say he was closing his pharmacy. The email address Dr. Rizk used to email the College was the same email address Ms. Morley was using to contact Dr. Rizk to send him the hearing notices over the same timeframe, in April, May and June 2019. It was also the same email address that Dr. Rizk's other lawyer, Mr. Chivers had confirmed the College could use to contact Dr. Rizk in Mr. Chivers' April 29, 2019 letter. Although Dr. Rizk chose not to reply to Ms. Morley's emails, it was more than likely that Dr. Rizk received those emails with the hearing notices.

[32] Finally, the Hearing Tribunal considered it significant that Dr. Rizk wrote the College to say he intended to close his pharmacy and he appeared to have done so. Mr. Krempien testified that a sign on the door as of April 24, 2019 confirmed the pharmacy was permanently closed. When Mr. Krempien again attended at the pharmacy on May 9, 2019 during business hours, he observed it was closed and locked, the lights were off and he could observe no prescription or over the counter drugs on the shelves or anywhere in the building. While this does not prove by itself that he was aware of the hearing, Dr. Rizk's apparent abandonment of his business makes his decision not to attend the hearing less surprising.

[33] Section 79(6) of the HPA permits the Hearing Tribunal to proceed with the hearing and act or decide on the matter if there is proof that Dr. Rizk was given a Notice to Attend. As above, there is proof that the Notices of Hearing and Notices to Attend were "sufficiently given" to Dr. Rizk, pursuant to section 120(3) of the HPA. In addition, the Hearing Tribunal considered that Dr. Rizk more likely than not received all four of the Notices of Hearing and Notices to Attend by email, more than 30 days before the Hearing began on August 13, 2019. The Hearing Tribunal therefore decided to proceed with the hearing despite Dr. Rizk's absence.

OPENING STATEMENTS

[34] Mr. Jardine made a concise opening statement. He explained the sequence of witnesses to be called in relation to each complaint. Mr. Jardine also explained that the Complaints Director, the College's Investigator Mr. Monty Stanowich, and two independent pharmacy experts, Dr. Patrick Mayo and Dr. Daniel Burton, would be called to testify in relation to each of Complaints 6463, 6774, and 6785. Mr. Jardine also explained that prior to the hearing Dr. Rizk had questioned the objectivity of the College and its staff.

IV. EVIDENCE

[35] A list of the exhibits entered and considered by the Hearing Tribunal are attached to this decision as Appendix A.

Complaint 6463:

Mr. James Krempien, Complaints Director

[36] Mr. Krempien explained that Complaint 6463 originated with a complaint from a physician, Dr. [KB]. Dr. [KB] initially spoke with Mr. Krempien by phone and then submitted a written complaint. Dr. [KB's] complaint concerned Dr. Rizk's treatment of their mutual patient, DL.

[37] Upon receiving Complaint 6463, Mr. Krempien determined that it should be investigated, so he appointed Mr. Monty Stanowich to conduct the investigation. Mr. Krempien subsequently reviewed Mr. Stanowich's investigation report and determined that Complaint 6463 should be referred to a hearing. Mr. Krempien identified the investigative report prepared by Mr. Stanowich, the investigative records Mr. Stanowich collected and Mr. Krempien's own record of decision referring the matter to hearing.

Dr. [KB], Complainant

[38] Dr. [KB] is a Family Physician and has been practicing in Edmonton for the past 20 years. She submitted Complaint 6463 about Dr. Rizk's care of their mutual patient DL

[39] Dr. [KB] had been DL's physician for at least 15 years when she discovered that he had been receiving prescriptions from Dr. Rizk for 18 months without her knowledge. Dr. [KB] described DL as a male, approximately 60 years old with mild obesity but no other medical concerns. Dr. [KB's] complaint stated that at a routine visit, DL disclosed to her that he was seeing a pharmacist for management of weight loss. When Dr. [KB] reviewed DL's prescriptions on Netcare and saw what Dr. Rizk had prescribed, she asked DL to see her again so she could understand why the medications had been prescribed. There were prescriptions for Xenical, Victoza, chitosan, topiramate, naltrexone, Wellbutrin XL, and zopiclone. Dr. [KB] wanted to know if the medications had been prescribed for weight loss or for some other purpose. Dr. [KB's] complaint noted that many of the prescriptions Dr. Rizk gave to DL were not indicated for the management of weight loss but DL told her that is what Dr. Rizk

was treating. The zopiclone was for insomnia. In addition, Dr. [KB] expressed concerns that Dr. Rizk had not ordered any laboratory investigations to monitor the metabolic effects or safety of DL's use of the medications. Dr. [KB] also said that DL told her that Dr. Rizk did not advise him the medications were being prescribed off-label, nor did Dr. Rizk advise DL of the risks or side-effects of the medications. Dr. Rizk never notified Dr. [KB] that he was treating her patient, DL, for weight loss or insomnia.

[40] Dr. [KB] explained that after Dr. Rizk received a copy of her complaint he contacted her. He called her office and told the receptionist he needed Dr. [KB's] personal cell phone number, citing a medical emergency. The receptionist complied and Dr. Rizk called Dr. [KB's] personal cell phone number. When he reached her, Dr. Rizk disputed Dr. [KB's] complaint. He then asserted that he had tried to contact Dr. [KB] about DL's care before, but he had been unable to reach her. Dr. Rizk told Dr. [KB] that he would prove this to her.

[41] Dr. [KB] said that she received a fax from Dr. Rizk on May 7, 2018. The fax was in evidence. Dr. Rizk had dated it 28Feb2018, but it began "This letter is in response to your concerns regarding our mutual patient below: …" Dr. [KB] had dated her written complaint to the College March 21, 2018 and it was post-marked March 23, 2018. Dr. Rizk's fax disputed Dr. [KB's] concerns about his prescriptions for DL. Dr. Rizk also suggested he had been faxing notifications about his care of DL to Dr. [KB] and calling her office asking to speak with her on previous occasions but Dr. [KB] had never called him back.

[42] Dr. Rizk's fax did not enclose copies of any prior correspondence to Dr. [KB]. Dr. [KB] testified that she uses an electronic medical record ("EMR"). Faxes to her practice are received and filed electronically as tasks for her to review individually. Faxes from pharmacists are a regular part of her workflow. In response to Dr. Rizk's suggestion that he had sent prior notifications to Dr. [KB] about DL's care, Dr. [KB] checked her EMR for any previous correspondence from Dr. Rizk. She also obtained the assistance of her EMR provider to ensure nothing had been missed. She was unable to locate any of the prior faxes Dr. Rizk said he had sent. Dr. [KB] explained that while occasionally a fax may not be received, she had reviewed her fax history and determined that there were only two times over the preceding six months that a fax had not been received. She was able to determine this because she received one fax that was labelled "Second Notice". In another case she was missing a consultant's report and upon contacting the consultant's office they said they had already faxed it. Her whole clinic receives approximately 100 faxes a day which would amount to thousands over a six-month period. Dr. [KB] was referred to an email she had sent to Mr. Stanowich in which she confirmed she had never had a cluster of faxes go missing.

Mr. Monty Stanowich, Investigator

[43] Mr. Stanowich worked as a community pharmacist from 1998 to 2012 prior to his role as a Compliance Officer and investigator for the College. Mr. Stanowich identified the investigation report and investigation records for Complaint 6463, including Dr. Rizk's written response to Complaint 6463.

[44] Dr. Rizk's response indicated that as a prescribing pharmacist, he could prescribe any drug as long as it was peer-reviewed and based on evidence. As a result, he felt that so long as off-label use or another extended use is based on scientific evidence, it falls within his scope of

practice and is considered safe. Dr. Rizk said he had already explained this to DL and that he had sent previous faxes to Dr. [KB] and attempted to contact her by phone on two previous occasions, but she did not respond. Dr. Rizk's response attached what he described as "evidence-based peer-reviewed literature" in support of his use of topiramate and naltrexone/bupropion. He also offered explanations for his use of vitamins and his prescription of zopiclone for DL In response to Dr. [KB's] concern about a lack of laboratory investigations to monitor DL's health, Dr. Rizk said that Dr. [KB] had tested DL in May 2017 a few days after DL first saw Dr. Rizk. Dr. Rizk also said that he gave DL a lab requisition in October 2017 and another one later on. Dr. Rizk said that DL was clinically stable and for the most part had no side effects. Dr. Rizk disputed Dr. [KB's] suggestion that he failed to obtain DL's informed consent to use the medications. Dr. Rizk said that he explained the medications' effects, pros and cons.

[45] Dr. Rizk's response to Complaint 6463 included a copy of a letter from DL "To whom it may concern". DL's letter was supportive of Dr. Rizk's care and critical of Dr. [KB's] response upon learning of it. Dr. Rizk's response also included documents entitled "Prescribing Notification/Managing Ongoing Therapy" concerning DL These documents had handwritten notes indicating they had been "faxed" to "Dr. [KB], [K]" with a handwritten fax number but they did not have fax headers confirming the date they were faxed, the fax number they were faxed to, or any indication that the faxes were successfully transmitted.

[46] Mr. Stanowich then described his review of Dr. Rizk's response to the complaint and DL's patient records. Dr. Rizk started DL on prescriptions for liraglutide and orlistat on May 17, 2017. Mr. Stanowich noted that within a period of about two weeks Dr. Rizk twice increased the dose of liraglutide and added ginger to control DL's nausea. There was no documented objective assessment or observations of DL's weight or other measures to justify the increase in dose.

[47] On June 16, 2017 Dr. Rizk documented that significant weight loss for DL would be 2-3 pounds over 2 weeks. Although DL had lost over 10 pounds by June 16, 2017 Dr. Rizk again increased his dose of liraglutide.

[48] By July 12, 2017 DL had lost 16 pounds over nine weeks. This exceeded Dr. Rizk's documented weight loss target for DL, but Dr. Rizk prescribed another medication, topiramate which is not indicated for weight loss by Health Canada. Mr. Stanowich noted it was unclear why Dr. Rizk had prescribed topiramate.

[49] By September 26, 2017 DL had continued to lose weight and was down a total of 27 pounds while Dr. Rizk had repeatedly increased the dose of topiramate. Dr. Rizk documented that DL asked about vitamins for weight loss so Dr. Rizk prescribed injectable pyridoxine, thiamine and again increased the dose of topiramate.

[50] On October 18, 2017 DL apparently complained of pain from the thiamine injection site. Dr. Rizk prescribed a diclofenac compound. At DL's next visit on November 10, 2017, Dr. Rizk documented that the injection site pain had "resolved completely", but Dr. Rizk discontinued the diclofenac compound and prescribed intramuscular lidocaine for the same problem. Mr. Stanowich noted that lidocaine can have systemic side effects, including cardiac effects. Dr. Rizk's notes indicate that he gave DL a laboratory requisition at this visit.

By December 6, 2017, DL had lost 4.2 pounds over the preceding 4 weeks. Mr. Stanowich noted that although this was at the upper limit of the target weight loss range, Dr. Rizk prescribed two additional medications, naltrexone and bupropion. Mr. Stanowich explained that neither of these medications were approved by Health Canada for obesity management. They are for smoking cessation and seizures.

[51] On December 20, 2017 DL had failed to reach his weight loss target for the first time since his treatment by Dr. Rizk began. Dr. Rizk doubled the daily dose of naltrexone at this appointment. Mr. Stanowich noted that the same thing happened on January 4 and January 18, 2018 when DL had experienced no further weight loss. On February 7, 2018 Dr. Rizk doubled DL's daily dose of bupropion in response to a slight increase in his weight.

[52] On February 28, 2018 Dr. Rizk noted that DL was reporting insomnia, irritability and blurred vision. Dr. Rizk attributed the insomnia and irritability to the bupropion and reduced the dosage. He attributed the blurred vision to the topiramate, despite that DL had been taking a stable dose of 50Mg of topiramate twice daily since September 26, 2017. Dr. Rizk began to taper DL's topiramate. Dr. Rizk added a prescription for zopiclone but there was no indication that he considered any differential diagnosis or a referral to another healthcare provider to assess DL's neurological symptoms.

[53] Mr. Stanowich was then asked about the "Analysis" section of his investigation report for Complaint 6463. He identified two main concerns. First, Dr. Rizk had indicated there were 25 occasions when he communicated with Dr. [KB] by fax about DL's care, and two attempts to call her by telephone, but Mr. Stanowich determined it was unlikely Dr. Rizk had actually done so. Mr. Stanowich explained that his reasons for this included that Dr. [KB] had no records of any communications from Dr. Rizk prior to May 1, 2018 and some of the correspondence that Dr. Rizk supposedly sent to Dr. [KB] referred to her in the third person and contained condescending statements about her.

[54] Mr. Stanowich explained that his second main concern was that Dr. Rizk's treatment modalities for DL were aggressive and far exceeded the Standards of Practice for medicine or pharmacy. Mr. Stanowich was also concerned that Dr. Rizk had collected no apparent objective data to monitor DL's condition. Mr. Stanowich was specifically concerned that despite DL meeting or exceeding the weight loss targets Dr. Rizk had set for him, Dr. Rizk was increasing dosages and adding medications, even in response to side effects. Some of these medications were not indicated by Health Canada for the uses Dr. Rizk was making of them. For example, Dr. Rizk repeatedly increased the doses of naltrexone and bupropion despite those medications appearing not to be effective for DL Further, when DL complained of insomnia, irritability and blurred vision Dr. Rizk omitted to notify Dr. [KB] or any other healthcare professional, failed to consider a differential diagnosis for these neurological symptom and purported to address those symptoms himself by altering DL's medications. Dr. [KB] had characterized Dr. Rizk's approach as far exceeding the normal standards of care for obesity management; potentially putting the patient at risk.

[55] Mr. Stanowich concluded his investigation report noting that Dr. Rizk was acting in many ways as a physician might. He had not provided notifications of his prescribing events or communicated or collaborated with Dr. [KB] despite being required to do so. Mr. Stanowich also concluded that Dr. Rizk did not take the necessary steps to ensure the safety of

his patient when prescribing. He failed to collaborate with other members of DL's healthcare team, failed to recognize the limitations of his own scope of practice and failed to take appropriate steps to monitor his patient using objective data. Mr. Stanowich said that it is important for prescribers to monitor their patients by ordering and reviewing lab test results to assess organ function. Organ function laboratory tests are important to ensure the medications being prescribed are not having a negative effect on the patient's organs. Dr. Rizk also exhibited a pattern of aggressive prescribing, outside the normal scope of pharmacy practice. Mr. Stanowich referred to a number of provisions of the Standards of Practice and the Code of Ethics.

Dr. Daniel Burton, Expert Witness

[56] The Hearing Tribunal qualified Dr. Daniel Burton, BScPharm, PharmD, APA, CDE, CBE as an expert in clinical pharmacy with advanced prescribing authority and a focus and experience in obesity and diabetes management.

[57] Dr. Burton explained his opinion concerning Dr. Rizk's compliance with the College's Standards of Practice and his professional and ethical judgment in relation to Complaint 6463. Dr. Burton was first asked to comment on Dr. Rizk's monitoring of DL in preparation for and during the treatment that he provided. Dr. Burton explained that obesity is a complex, multi-factorial disease that is best assessed, managed and monitored with a team-based approach.

[58] Dr. Burton said that many of the parameters that Dr. Rizk should have assessed prior to initiating obesity-management therapy, and particularly before starting medications for DL were not checked. Prior to initiating obesity therapy, a practitioner should be assessing laboratory parameters to identify potential obesity-related co-morbidities, monitor progress and rule out secondary causes of obesity. He said that these laboratory investigations would include at least:

1. weight, BMI and waist circumference;
2. lipid panel (total cholesterol, LDL, HDL, Triglycerides);
3. fasting blood glucose;
4. blood pressure;
5. liver enzymes (ALT);
6. renal function (SCr, eGFR);
7. urinalysis;
8. mental health screen (depression, anxiety, eating disorders, etc.);
9. complete blood count, TSH

[59] Dr. Burton said that it appeared that Dr. Rizk did not assess DL's organ function prior to initiating or while providing treatment with various medications to ensure his patient's safety. While there was some documentation suggesting that Dr. Rizk had given DL a laboratory requisition, there was no documentation that DL completed it. Then, despite DL not having gone for the laboratory tests, Dr. Rizk continued to add and increase the medications he was prescribing without assessing what was happening with DL's organs.

[60] Dr. Burton referred to the drug monographs for the medications Dr. Rizk had prescribed for DL and he pointed out that the monographs state that specific laboratory monitoring should be

completed before, and periodically during therapy with the medications. Dr. Burton also noted that for all medications, side effects and adverse reactions should be assessed at initiation and on an ongoing basis with continued therapy or any dose increases. Dr. Burton then noted that from his review of Dr. Rizk's documentation, he had not completed any of the necessary monitoring for DL Therefore, Dr. Burton opined that Dr. Rizk was not appropriately assessing or monitoring DL in terms of his obesity treatment or the status of DL's organ function before prescribing new therapies or escalating the therapies he was already using.

[61] Dr. Burton added that Dr. Rizk also failed to communicate and collaborate with other members of DL's healthcare team to determine what assessments and monitoring DL's family physician, Dr. [KB] had completed.

[62] Dr. Burton next commented on how in his opinion, Dr. Rizk had managed adverse events and treatment failures in DL's care. Dr. Burton began by noting that Dr. Rizk had attempted to manage DL's nausea with ginger and with the medication ondansetron. Dr. Burton said that a ginger supplement was a reasonably safe suggestion to manage this commonly expected side-effect of liraglutide, provided Dr. Rizk had also provided DL with appropriate patient counselling about nausea and how to manage it. Dr. Burton opined that adding ondansetron was not appropriate. He said that if DL's nausea was so significant that he required a medication as significant as ondansetron to manage it, then Dr. Rizk should instead have discontinued the liraglutide. Dr. Burton would also have expected Dr. Rizk to have notified Dr. [KB] that he was prescribing liraglutide, and that DL was experiencing nausea from liraglutide for which he was prescribing ondansetron. This would be important to communicate so Dr. [KB] could prevent liraglutide or similar medications from being prescribed in the future with similar adverse effects. Dr. Burton opined that Dr. Rizk's conduct was inappropriate, unethical and did not comply with the ACP Standards of Practice.

[63] Dr. Burton also commented on Dr. Rizk's management of DL's injection site pain. He noted that Dr. Rizk's records indicate that Dr. Rizk injected large volumes, upwards of 4.5 ml, of fluid into DL's deltoid muscles on a near weekly basis. These injections consisted of cyanocobalamin, thiamine, and pyridoxine. Dr. Burton said it was unclear whether Dr. Rizk was performing a single injection each time or whether he was performing multiple smaller injections, and whether he was rotating between the deltoid muscles. Dr. Burton explained that the Standards for the Administration of Immunizations published by Alberta Health Services recommends the maximum amount of fluid to be injected into an adult's deltoid muscle at one time is 2.0 ml. Dr. Burton said that there are a number of recommendations in the literature, but 2.0 ml would be the maximum amount he would be comfortable injecting into a deltoid muscle at one time, whether as a single injection or through multiple, smaller injections. Large volume injections can cause pain. Indeed, it appears that DL experienced injection site pain. Dr. Rizk managed this pain by prescribing a topical diclofenac/menthol compound. Subsequently, Dr. Rizk discontinued the diclofenac compound and instead added lidocaine to the injections. This would have further increased the volume of fluid being injected.

[64] Dr. Burton opined that instead of withdrawing the injections that were causing pain to DL and consulting DL's physician, Dr. Rizk proceeded to treat the injection site pain first with a topical diclofenac compound and then with intramuscular lidocaine. Dr. Burton said that this was inappropriate, unethical and did not comply with the Standards of Practice.

[65] Dr. Burton also noted that Dr. Rizk had frequently been injecting large doses of vitamins into DL. There was no record of DL having any vitamin deficiencies or medical conditions requiring supplemental vitamins, and Dr. Rizk did not order any lab tests to determine if there were any vitamin deficiencies. Dr. Burton said that the vitamins were water soluble and do not accumulate in the body, so they posed a low risk of harm, but they were unnecessary. Since the vitamins were unnecessary the injections caused unnecessary harm to DL

[66] Dr. Burton also commented on Dr. Rizk's management of DL's complaints of insomnia by adding the medication zopiclone. Dr. Burton noted that Dr. Rizk had been treating DL with bupropion XL. DL first complained of insomnia shortly after Dr. Rizk increased the dose of bupropion from 150 Mg once daily to 150 Mg twice daily on February 7, 2018. No other medication changes had recently been made. Dr. Rizk responded by prescribing a new medication, zopiclone and by decreasing the bupropion XL to 150 Mg once every other day and planning to taper off DL's dose of topiramate over the next 16 days. Dr. Rizk also switched the bupropion XL to bupropion SR 100 Mg daily no April 3, 2018.

[67] Dr. Burton opined that the bupropion was the likely cause of DL's insomnia. DL complained about it shortly after Dr. Rizk doubled his dose to 150 Mg twice daily. Dr. Burton explained that bupropion XL is generally dosed as a single dose in the morning, not twice a day. It can cause insomnia in 11-40% of patients. But rather than reducing and then discontinuing the bupropion, which should have been sufficient to address the insomnia, Dr. Rizk prescribed an additional medication. He also made these changes to DL's medications without consulting Dr. [KB]. Dr. Burton opined that adding a medication to treat an adverse effect caused by another medication and failing to consult with DL's physician was inappropriate and unethical. It did not comply with the Standards of Practice.

[68] Dr. Burton next commented on Dr. Rizk's response to DL's treatment failures. Dr. Burton explained that obesity treatment involves three "pillars" – 1) lifestyle interventions; 2) medication; and 3) bariatric surgery. Lifestyle interventions should be the foundation of all obesity management plans, but medications or surgery can become necessary as lifestyle interventions become difficult to maintain. Dr. Burton also explained that Dr. Rizk and DL should have established treatment targets for DL's weight loss. An initial goal of losing 5-10% of the patient's baseline weight within 6 months is generally considered desirable. If DL had reached a weight-loss plateau without reaching his target weight, then after a sufficient period of time, it may have been appropriate to escalate with additional therapy. However, in this case DL lost over 10% of his starting weight but it appeared Dr. Rizk was adding additional medications every 2-3 months, and DL was on 4 medications for weight-loss within 7 months of beginning treatment with Dr. Rizk. Dr. Burton opined that Dr. Rizk was not allowing an adequate period of at least 3 months before adding additional therapies. He also opined that it was not appropriate to add additional medication therapies without other elements such as nutrition, activity, mental health and habit therapy. Dr. Rizk also failed to communicate the treatment failures to Dr. [KB]. Dr. Burton opined that Dr. Rizk acted unethically and contrary to the Standards of Practice.

[69] Dr. Burton next commented on Dr. Rizk's prescription of medications off-label for DL's obesity-treatment. Dr. Burton explained that off-label prescribing is acceptable and permitted by the College's standard of practice 11.6 in certain situations. In this case Dr. Rizk prescribed Victoza (liraglutide). This medication is indicated by Health Canada for diabetes treatment,

not obesity-management but there is another medication containing liraglutide called Saxenda which is approved for obesity treatment. It was unclear why Dr. Rizk prescribed Victoza when Saxenda was available and the cost of the dose Dr. Rizk was using would be comparable. Dr. Burton said that Dr. Rizk failed to communicate the off-label nature of his prescribing to Dr. [KB], but the use of Victoza was acceptable.

[70] Dr. Rizk also prescribed Topamax (topiramate). Topiramate is approved in the United States for obesity treatment but only when used in combination with phentermine, which is not approved for use in Canada. Further, topiramate is known to cause cognitive deficits such as memory loss, confusion and lightheadedness. There is limited research supporting its use as a weight-loss agent without phentermine. Dr. Burton opined that Dr. Rizk failed to comply with standard 11.6 in prescribing topiramate for weight-loss, as prescribing this medication is not supported by best practice or peer-reviewed literature. Furthermore, Dr. Rizk failed to communicate his prescribing of this medication to Dr. [KB].

[71] Dr. Burton next described Dr. Rizk's prescriptions for bupropion and naltrexone. He explained that at the time Dr. Rizk prescribed these medications, a bupropion-naltrexone combination product known as Contrave had not yet been approved for use in Canada. Dr. Rizk separately prescribed bupropion XL and naltrexone off-label for obesity treatment. Dr. Burton opined that this was reasonable provided it was in the patient's best interests, supported by peer-reviewed literature and would abide by standard of practice 11.6. However, Dr. Burton noted that Dr. Rizk again failed to notify Dr. [KB] of his prescribing activities and this Contravened the Standards of Practice. These medications can have a negative impact on patients' mental health, and it is important to notify their physician so the physician can monitor for mental health concerns. There is also a risk of very serious interactions with any opioid medications.

[72] Dr. Burton concluded his opinion of Dr. Rizk's care of DL stating that in his opinion Dr. Rizk's conduct had the potential to cause and may have caused harm to DL while he was under Dr. Rizk's care.

[73] Dr. Burton explained that there were multiple instances where Dr. Rizk failed to communicate, consult and collaborate with Dr. [KB]. He also failed to communicate his assessments, monitoring plans, prescribing activities and the adverse reactions that DL experienced. Without this communication and collaboration Dr. [KB] was unaware of what medications had been prescribed, therapies that had been trialed and issues that had come up. This may have led Dr. [KB] to make incorrect diagnoses, prescribe duplicate therapies, cause drug interactions or harmful interventions. Dr. Burton said that in his opinion Dr. Rizk's lack of communication and consultation with Dr. [KB] could have resulted in significant harm.

[74] Dr. Burton also said that prescribing pharmacists must ensure they have appropriate information to make sound prescribing decisions. Dr. Rizk did not communicate with DL's physician and therefore did not gather a detailed medical history before initiating obesity treatment. Dr. Rizk omitted to order lab tests or evaluate the parameters he needed to develop an effective obesity management plan. He also failed to properly assess and monitor DL's organ function while prescribing multiple new medications and escalating therapies. Without this kind of information, a practitioner cannot know whether treatment is effective and safe. This had the potential to cause significant harm to DL.

[75] Dr. Burton also explained that Dr. Rizk failed to appropriately manage DL's drug related problems. While the standard of care required adverse drug effects to be managed by withdrawing the offending agent, Dr. Rizk prescribed additional medication or therapies instead. He also aggressively escalated the therapies he was prescribing even though it was unclear what weight-loss target he and DL were using. Dr. Burton said this was inappropriate as Dr. Rizk was not allowing adequate time to determine if a therapy was effective or not. Dr. Burton said Dr. Rizk did cause harm to DL and he failed to properly mitigate the drug-related problems that occurred while DL was under Dr. Rizk's care.

[76] Finally, for his off-label prescribing Dr. Rizk acted reasonably in prescribing medications off-label for obesity treatment with the exception of topiramate. However, Dr. Burton opined that Dr. Rizk should not have been prescribing these medications for obesity treatment as a solo clinician. DL could have experienced harm as his condition was not being managed by a team of practitioners who could support him with his medications but also with his nutrition, activity and mental health.

Dr. Patrick Mayo, Expert Witness

[77] The Hearing Tribunal qualified Dr. Mayo as an expert pharmacist with advanced prescribing authority and expertise in the design and review of trials for the efficacy of drugs.

[78] Dr. Mayo provided his expert opinion on whether Dr. Rizk carried out his practice in accordance with the Standards of Practice and the professional and ethical judgment expected of an Alberta pharmacist with advanced prescribing authority, and whether Dr. Rizk's conduct had the potential to cause harm.

[79] Dr. Mayo opined that Dr. Rizk prescribed medications and when anticipated side effects were encountered, he responded not by removing the offending medication, but by prescribing additional medications for the side effects. Known as a "prescribing cascade", this practice increases the risk of adverse effects. Dr. Mayo noted that by February 18, 2018 DL was taking five medications to promote weight loss. The combination of medications and dosages Dr. Rizk had prescribed has not been studied and Dr. Mayo said this was why the combination has not been approved for use by Health Canada. Dr. Mayo said that as adverse effects appeared, drug therapy should have been discontinued.

[80] Dr. Mayo explained that three of the medications, topiramate, bupropion and naltrexone are themselves not approved by Health Canada for weight loss. He further explained that off-label prescribing is not prohibited in Canada, but it places patients on medications without proven risk-benefit. The very reason that topiramate, bupropion and naltrexone have not been approved for weight loss in Canada is because there is insufficient clinical evidence in the form of randomized controlled trials to prove that the efficacy of these drugs outweighs the risk. He explained that combination drug therapy simply cannot be inferred from the safety and efficacy of monotherapy for different indications. Patients need to be apprised of the increased risk and more closely monitored when using medications off-label. It was not clear from the evidence that DL was advised of the risks of this kind of polypharmacy. In this case Dr. Rizk acted unilaterally to prescribe this untested combination of medications to DL. He also failed to inform DL's physician of what he was doing. Dr. Rizk therefore took upon himself the sole

responsibility to ensure this combination of medications was safe and to monitor his patient during treatment.

[81] Dr. Mayo opined that there was no evidence that Dr. Rizk performed appropriate clinical laboratory tests to determine baseline values, or during the treatment to ensure DL remained safe. While Dr. Rizk had stated that he gave the patient a laboratory requisition, there were no laboratory tests recorded and Dr. Rizk did not appear to have insisted that DL go for the tests.

[82] Dr. Mayo added that pharmacotherapy for weight loss should only be prescribed in conjunction with a planned weight management program. The efficacy of currently approved weight loss medications is modest, with losses of 5-10% in patients with moderate obesity. Cessation of weight loss medications usually results in the return of the weight lost. Yet the evidence did not suggest that Dr. Rizk worked with DL as part of an integrated plan involving a health care team to ensure safety and efficacy. As a result, if pharmacotherapy was Dr. Rizk's only plan to address DL's weight then DL faced the prospect of remaining on that drug combination for an extended portion of his life.

[83] Dr. Mayo specifically addressed some of Dr. Rizk's actions. He pointed out it was not clear why Dr. Rizk had added the seizure medication topiramate on July 12, 2017, since DL's weight loss by that point was documented as 6.2%, which was greater than the 5% recommended by the manufacturer of the approved weight loss medications. Dr. Mayo also pointed out that Dr. Rizk's decision to add lidocaine to DL's vitamin injections could be dangerous, since it may mask pain indicative of an infection or tissue damage.

[84] Dr. Mayo concluded that Dr. Rizk placed his patient DL at higher risk through the use of multiple, unapproved drugs. He placed himself in the position of being solely responsible for any harm to the patient, and the patient did suffer harm. Dr. Mayo noted that the patient suffered nausea for which he prescribed ondansetron which can prolong the QT interval leading to a life-threatening arrhythmia and should be used for the shortest time possible. The patient also suffered insomnia. Dr. Rizk prescribed zopiclone in a prescribing cascade. Dr. Mayo pointed out that zopiclone can induce sleep abnormalities and behavioural changes and should be used for the shortest possible time. The patient also suffered injection site pain due to the large volume of intramuscular injections Dr. Rizk was providing. Dr. Mayo explained that pain at an injection site that continues for days is a sign that something is wrong, such as tissue damage and inflammation. Masking that pain with anesthetics defeats the protective purpose of pain. If the cause of the pain was actually an infection, then serious side effects could have ensued.

[85] Lastly, Dr. Mayo noted that Dr. Rizk's approach missed the opportunity to actually help the patient. Dr. Rizk could have worked with Dr. [KB] and with experts on weight loss who were available to assist in the Edmonton area.

Complaint 6774:

Mr. James Krempien, Complaints Director

[86] Mr. Krempien explained that Complaint 6774 originated with a complaint from Ms. [GB], a pharmacist at the Misericordia Community Hospital Pharmacy. The complaint concerned Dr. Rizk's care of a patient, AH.

Ms. [GB], Complainant

[87] Ms. [GB] obtained her pharmacy degree in 2000. She spent 8 years working in community pharmacy before she began working at the Misericordia Hospital in general surgery, and later intensive care. She continues to work 1 shift per month in a community pharmacy and has a good relationship with community pharmacists and a good understanding of what community practice is like.

[88] Ms. [GB] described her work as a pharmacist member of the multidisciplinary intensive care team. She rounds each morning at the patients' bedsides with other members of the team, including an intensivist, nurse practitioner, charge nurse, bedside nurse, dietitian, and physical therapist. Ms. [GB] participates in the discussion of patients' systems, sedation, pain management, mobility and care plans. Ms. [GB] is responsible to assess the patients' medications and what should be continued or discontinued. She maintains advanced prescribing authority and can order medications and write transition orders as needed for ICU patients. She is also responsible for antimicrobial stewardship, looking at all cultures for all ICU patients before rounds and directing the team as to the most effective, narrowest antibiotics. Ms. [GB] emphasized that even with her advanced prescribing authority, whenever she writes prescriptions, she reports to her multidisciplinary team about what she has done. In addition, with transfer orders she consults with the nurses and other care team members to ensure what she has directed is appropriate.

[89] Ms. [GB] identified her complaint to the College about Dr. Rizk. Ms. [GB] explained that she made the complaint after she learned that a community pharmacist had prescribed Levaquin and oseltamivir to treat community acquired pneumonia in a patient, AH, who was ultimately admitted to the ICU. AH had been admitted to the hospital on July 13, 2018 with hypoxia and shortness of breath. He was being treated with antibiotics when on July 15, 2018 his oxygen saturation dropped to 88% and he began struggling to breathe. He was then brought to the ICU and put on a mechanical ventilator. This is where Ms. [GB] first encountered AH.

[90] Ms. [GB] met with the patient's family and learned of their concerns. These included that Dr. Rizk had been adjusting AH's insulin for his diabetes. The family reported that the patient's nephrologist, Dr. [P], had contacted Dr. Rizk and instructed him not to adjust the patient's insulin. The family expressed concern that Dr. Rizk had apparently told the patient that his kidney disease could be reversed if he managed his diabetes well. Dr. [P] had said its progression could only be slowed. Ms. [GB] was also told the family was upset that the patient had stopped seeing his regular physician, Dr. [H], when Dr. [H] became frustrated that Dr. Rizk was prescribing without notifying him. Dr. [H] had asked the patient to choose between him or Dr. Rizk and the patient chose Dr. Rizk. The family explained that they had

learned on July 13, 2018 that Dr. Rizk had prescribed antibiotics for the patient. This prompted the family to take the patient to another pharmacy and ask the pharmacist there if the prescriptions were appropriate. They were told the prescriptions were appropriate for chest infections, but the patient looked very unwell and they should take him to a hospital.

[91] Ms. [GB] then determined that she should speak with Dr. Rizk. She acknowledged that she attempted to call him several times but did not leave a message. Ms. [GB] felt it would be an involved discussion and she wanted to have her notes in front of her. Ms. [GB] did eventually reach Dr. Rizk and she asked that he call her when he could review the file and discuss the case. Dr. Rizk called Ms. [GB] while she was rounding in the ICU, so she was unable to speak with him at that time. They spoke in depth the following day, July 17, 2018.

[92] Ms. [GB] explained that prior to contacting Dr. Rizk, she had gathered that the patient had seen a family physician, Dr. [R] on June 11, 2018. Dr. [R] had sent the patient for a chest x-ray which was reported in Netcare as showing no acute intrathoracic disease. On June 18, 2018 Dr. [R] prescribed doxycycline and prednisone.

[93] The patient then saw Dr. Rizk on July 5, 2018 and he prescribed a different antibiotic, azithromycin. When Ms. [GB] asked Dr. Rizk why he had done that, Dr. Rizk said it was because the patient had chronic obstructive pulmonary disease and was still feeling unwell, with fatigue and increased yellow sputum. Dr. Rizk had felt this was a partial response to the doxycycline, so he prescribed a second line agent, azithromycin.

[94] Ms. [GB] said she asked Dr. Rizk about his criteria for diagnosing acute exacerbation of chronic obstructive pulmonary disease ("AECOPD") and for prescribing antibiotics. She explained that she felt this should only be done with the benefit of a chest x-ray and auscultation of the patient's chest. She asked if Dr. Rizk had done either of those things, or if he had any other independent pieces of information such as blood work or oximetry. Dr. Rizk only referred to the patient's symptoms of fatigue, increased cough and sputum.

[95] The patient saw Dr. [R] again on July 9, 2018. At this appointment Dr. [R] gave the patient a new inhaler prescription and a cough suppressant.

[96] Ms. [GB] then explained that on July 13, 2018 Dr. Rizk had contacted the patient at home to see how he was doing. The patient reported he was not doing well, so Dr. Rizk told the patient he probably had a bacterial infection and he asked the patient to come to his pharmacy for more prescriptions. Dr. Rizk prescribed oseltamivir and Levaquin. Ms. [GB] explained that there is some evidence that these medications can be used for viral infections, but this was happening in July and it was no longer flu season. Ms. [GB] again asked Dr. Rizk about his diagnostic criteria for prescribing these medications at this point. She asked him if he had obtained a chest x-ray, lab work, oximetry or if he had auscultated the patient's chest. Ms. [GB] said Dr. Rizk did not respond to these questions. Dr. Rizk said he had recommended the patient should go to the hospital, but the patient refused, so what was he to do? Ms. [GB] said that Dr. Rizk had several options like calling his family members, calling his physician or calling an ambulance if therapy was needed urgently. Dr. Rizk did not pursue any of these options and instead prescribed new antibiotics. Dr. Rizk also asked Ms. [GB] "how is what I did any different from what a physician would do?" Ms. [GB] responded and explained that when a patient is standing in front of a pharmacist coughing or short of breath, there is no way for the

pharmacist to know what is going on. The differential diagnosis of a patient with those types of symptoms includes serious diagnoses, such as new onset heart failure, extension of pulmonary embolism or pneumonia. Physicians use data gathered from chest x-rays, oximetry, chest auscultation or blood work to develop a diagnosis.

[97] Ms. [GB] also asked Dr. Rizk about managing the patient's insulin. Dr. Rizk maintained that Dr. [P] was managing the patient's insulin, but he said the patient had some difficulties managing his sugars during Ramadan.

[98] Ms. [GB] spoke with Dr. Rizk again on July 19, 2018. Dr. Rizk called wanting to discuss the patient's sputum culture and sensitivity, as he had been looking at Netcare. Dr. Rizk asked which antibiotics the ICU team was using and when Ms. [GB] told him, he told her she needed to change to a different antibiotic based on the culture. Ms. [GB] responded that the culture was from expectorated sputum, so it was contaminated by oral flora which they do not treat with antibiotics. Dr. Rizk responded that there are case reports of the bacterium causing infection and he strongly believed they should put the patient back on oseltamivir. Ms. [GB] declined on the basis that the patient did not have fever or myalgias, so this was not consistent with influenza, nor was it flu season. Dr. Rizk pressed Ms. [GB] to use oseltamivir, suggesting the patient did have myalgias and sore throat and influenza can present without fever. He also asked Ms. [GB] to produce copies of literature or policy supporting the ICU team's approach. When Ms. [GB] then suggested that the intensivist of 20 years' experience had determined that the chest x-ray was not consistent with influenza, Dr. Rizk asked for the intensivist to provide him with literature supporting their approach. Ms. [GB] explained that the ICU was too busy to conduct literature searches for Dr. Rizk.

[99] Ms. [GB's] complaint also recounted her discussions with the patient. She said she pointedly asked the patient who had been managing his insulin. The patient said it was Dr. Rizk. Ms. [GB] also asked the patient what had happened to his previous family physician, Dr. [H]. The patient explained that during an appointment, Dr. [H] had pulled up Netcare and noticed all of the prescribing by Dr. Rizk. Dr. [H] told the patient he would need to choose who would manage his prescriptions, and the patient chose Dr. Rizk.

[100] Ms. [GB's] complaint also described her discussions with Dr. [R]. Dr. [R] told Ms. [GB] he was concerned because Dr. Rizk had been adjusting the patient's insulin without notifying Dr. [R]. This had prompted Dr. [R] to call Dr. Rizk and reinforce that he needed to communicate if he would be adjusting medications. Dr. [R] also confirmed he did not know that Dr. Rizk had prescribed antibiotics for the patient on July 5 or 13, 2018.

[101] Ms. [GB] concluded her complaint by summarizing her concerns. She said that Dr. Rizk Contravened the Standards of Practice for Pharmacists and Pharmacy Technicians by treating her and her team with a lack of respect. He also prescribed for the patient without notifying the patient's physicians of the prescribing events. Dr. Rizk failed to maintain a collaborative relationship with his patient's other health care providers and he exceeded the pharmacist's scope of practice by diagnosing AECOPD or pneumonia.

[102] Ms. [GB] also described her review of Dr. Rizk's response to her complaint. She pointed out that she listened to the audio recordings of their conversations provided by Dr. Rizk, but

she said that large parts of the recordings were missing. She noted in particular that Dr. Rizk had deleted parts of their conversation in which she had asked him how he came to his diagnosis of the patient and about his adjustments of the patient's insulin. Dr. Rizk had also deleted the portion in which he asked Ms. [GB] how what he had done was any different from what a physician would do.

[103] Ms. [GB] confirmed she does not know Dr. [KB] or Dr. [LB] the complainants in complaints 6463 and 6785.

Monty Stanowich, Investigator

[104] Mr. Stanowich identified the investigation report and investigation records for Complaint 6774, including Dr. Rizk's written response to Complaint 6774.

[105] Mr. Stanowich explained that the records he collected for the investigation revealed that Dr. Rizk was treating a very complex patient with complex disease conditions. The patient's family physician had been Dr. [H]. His family physician at the time of the investigation was Dr. [R]. The patient also had a nephrologist, Dr. [P] for his diabetes and associated kidney issues.

[106] Mr. Stanowich then reviewed Dr. Rizk's response to Ms. [GB's] complaint. Mr. Stanowich first described Dr. Rizk's correspondence with Mr. Krempien regarding the preparation of his response. On September 18, 2018 Dr. Rizk had commented that the complaints against him were similar, and they showed "the level of hatred, prejudice and inferiority complex by the physicians/pharmacists who did an awful job taking care of their patients and now they are seeking revenge because they looked incompetent in front of their patients."

[107] Dr. Rizk's response to the complaint was conveyed to the Complaints Director by Dr. Rizk's then lawyer, Mr. Hajduk on October 11, 2018. Dr. Rizk's response began by noting that under his care AH's condition had improved significantly compared to the care he had received from Dr. [H]. Dr. Rizk said that AH's blood sugar was uncontrolled, and his kidney function had been deteriorating when Dr. Rizk became involved. Dr. Rizk asserted that he had been sending notifications to Dr. [H] about his prescribing decisions. Dr. Rizk also asserted that he had called Dr. [H] once and left a message for him to return, but he did not. Dr. Rizk also asserted that he had faxed prescribing notifications to AH's current physician, Dr. [R], and he and Dr. [R] had spoken at length about AH's care on the phone.

[108] Mr. Stanowich described how Dr. Rizk commented that Ms. [GB] was not qualified for her role in the ICU because she did not have a PharmD degree, like he did. Mr. Stanowich explained that Dr. Rizk has a PharmD degree from the University of Lebanon, but this is not really different from a BSc in pharmacy. Dr. Rizk does not have a PhD in pharmacy. Dr. Rizk was also critical of Ms. [GB] because she did not agree with his prescribing choices and his interpretation of the actions of the patient's physicians. Dr. Rizk's response to the complaint said that the care he had provided to AH exceeded the care that Ms. [GB] and other providers would ever give. Dr. Rizk said Ms. [GB] and her team were incompetent and this jeopardized AH's health. He also asserted his view that there was no evidence of patient harm from anything he had done.

[109] In response to Ms. [GB's] statement that she has attempted to call Dr. Rizk on July 16, Dr. Rizk asserted that she was lying. He said that she called 11 times in a row on July 16 and she did not want to accept that the pharmacy was closed that day. Dr. Rizk said he called Ms. [GB] the next day but she said she was rounding and unable to speak with him. Dr. Rizk also suggested that Ms. [GB] was dishonest about that.

[110] In response to Ms. [GB's] express concerns about Dr. Rizk's prescribing of arithromycin on July 5, 2018, Dr. Rizk accused her of being incompetent. He also accused her of lying when she asserted that he declined to answer some of her questions.

[111] Dr. Rizk asked why Ms. [GB] had not criticized Dr. [R] for waiting to prescribe doxycycline or criticized his decision to prescribe it without laboratory results. Dr. Rizk then suggested that Ms. [GB] should know that chest x-rays and blood work are of limited value for diagnosing chronic bronchitis. Dr. Rizk said the fact that Ms. [GB] was questioning him showed her lack of respect. He suggested that AH had previously had AECOPD and had taken azithromycin and levofloxacin before. Dr. Rizk also said that AH met the Anthonisen criteria for prescribing antibiotics.

[112] In response to Ms. [GB's] concern about prescribing levofloxacin and oseltamivir for AH on July 13, 2018 by telephone, Dr. Rizk again responded that Ms. [GB] was lying. Dr. Rizk suggested he was very professional with Ms. [GB], but she did not respond in kind. He then referred to literature that he said supported his decision to prescribe oseltamivir, and he said it supported that it should have been continued by the ICU team. Dr Rizk stated that AH had previously had lung infections including COPD and mild pneumonia. He prescribed levofloxacin/Levaquin and oseltamivir because in some cases mild community-acquired pneumonia can be assessed based on clinical findings alone by experienced clinicians like him, even though he acknowledged it is not the optimal course of action.

[113] In response to Ms. [GB's] suggestion that Dr. Rizk should have insisted that AH go to the hospital on July 13, 2018, Dr. Rizk said that AH didn't want to go to the hospital. Dr. Rizk said that AH wasn't critically ill or in need of an ambulance and he was capable of making his own decisions. Dr. Rizk said he made the right decision to start treatment based on literature evidence.

[114] In response to Ms. [GB's] suggestion that she had asked Dr. Rizk who was managing AH's insulin, Dr. Rizk said Ms. [GB] was lying and denied that they had ever discussed the patient's insulin. Dr. Rizk also said that he had stopped taking care of AH's conditions, including his diabetes in April 2018 when Dr. [P] took over.

[115] In response to Ms. [GB's] description of her second telephone discussion with Dr. Rizk he responded that her attitude was "repulsive". Dr. Rizk again suggested that Ms. [GB] was lying and she was unwilling to share her literature with him because she lacked knowledge about what she was dealing with.

[116] In response to Ms. [GB's] concern that Dr. Rizk had asked how his actions were any different from what a physician would do, Dr. Rizk denied that he ever said that. Dr. Rizk suggested that Ms. [GB] was seeking another way to disrespect and denigrate his clinical experience, adding "especially that she doesn't have a PharmD."

[117] In response to Ms. [GB's] account of her discussion with AH and his spouse, Dr. Rizk again suggested Ms. [GB] was lying. He denied that he ever assessed AH over the phone. He said that he assessed AH when he came to the pharmacy.

[118] In response to Ms. [GB's] account of her discussion with Dr. [R], Dr. Rizk asserted that he had been faxing all of his prescribing decisions to Dr. [R] and he had discussed AH's care with Dr. [R] by phone.

[119] After receiving Dr. Rizk's response to Ms. [GB's] complaint, Mr. Stanowich contacted Dr. [H], Dr. [R] and Dr. [P]. Mr. Stanowich wrote to Dr. [H] on December 6, 2018 enclosing copies of documents entitled "Prescribing Notification/Managing Ongoing Therapy" and "Renewal Notification of Rx Medication" and asking if Dr. [H] had received them from Dr. Rizk, as Dr. Rizk claimed. Mr. Stanowich then spoke with Dr. [H] on December 10, 2018. Dr. [H] said his practice is that all faxes addressed to him are placed on his desk for him to review. They are then placed in the patient's chart and retained. He had reviewed his chart, but he had not received any of the documents Dr. Rizk said he had faxed. Dr. [H] also told Mr. Stanowich that he had never spoken with Dr. Rizk that he could recall, nor received any written form of communication or collaboration from him. Dr. [H] followed up with a letter confirming this dated December 18, 2018.

[120] Mr. Stanowich also wrote to Dr. [R] on December 6, 2018, seeking verification that Dr. [R] had received faxes that Dr. Rizk suggested he had sent. Mr. Stanowich also spoke with Dr. [R] on December 6. Dr. [R] first explained that AH was a very complicated patient. He has an extensive medical history including COPD, primary lung tumour, a wedge resection, diabetes, hypertension as well as other issues. Dr. [R] then said he had two phone calls with Dr. Rizk. The first was in the fall of 2017 after he became aware that Dr. Rizk had made changes to AH's medications. Dr. [R] contacted Dr. Risk because he had never before seen a pharmacist practicing in that manner and wanted to determine if Dr. Rizk had prescribing authority. The second call was in October 2018. Dr. Rizk had called Dr. [R] to see if he had received fax communications from him. Dr. [R] told Dr. Rizk that he had not. Mr. Stanowich asked Dr. [R] if he was aware that Dr. Rizk had seen AH and written prescriptions for him on July 5 and 13, 2018. Dr. [R] saw AH on July 9, 2018 but he was not aware that Dr. Rizk had also been seeing him during this period. On December 13, 2018 Dr. [R] provided written confirmation to Mr. Stanowich that he had not received any of the faxes Dr. Rizk suggested he had sent.

[121] Mr. Stanowich also wrote to Dr. [P] on December 6, 2018 seeking to verify that Dr. [P] had received the faxes that Dr. Rizk said that he sent. Mr. Stanowich then spoke with Dr. [P] on December 7. Dr. [P] said his staff scans faxes for him to review electronically. He had reviewed his patient file but could find no evidence of paper or electronic copies of the faxes Dr. Rizk suggested he sent, other than one faxed medication list dated 27-6-2018. Dr. [P] also explained that he had been a pharmacist before becoming a physician. He said he would have remembered receiving notes as detailed as those allegedly sent by Dr. Rizk. Dr. [P] told Mr. Stanowich that he recalled one phone conversation with Dr. Rizk. Dr. Rizk had paged Dr. [P] and then questioned changes Dr. [P] had made to AH's drug regimen. Dr. [P] described Dr. Rizk as aggressive and he felt Dr. Rizk was insinuating that he knew more than Dr. [P] and that Dr. [P] was interfering with what Dr. Rizk was doing. Dr.

[P] said he asked Dr. Rizk not to make any further changes and that he would manage AH's care going forward. Dr. [P] confirmed his interactions with Dr. Rizk in a letter dated December 10, 2018.

[122] Mr. Stanowich then described audio recordings received from Dr. Rizk as part of his response to Complaint 6774. Mr. Stanowich prepared a memorandum in which he described each of the recordings and his observations of them. One of the recordings was largely in Arabic. Another was an excerpt of a conversation between Dr. Rizk and Ms. [GB] beginning part-way through. Mr. Stanowich noted the conversation was about AH and Dr. Rizk said he had instructed AH to go to the hospital, but he had said he didn't want to go. Dr. Rizk then indicated he gave AH two prescriptions in case he did not go to the hospital, but he didn't know if AH had taken the medications or not. Mr. Stanowich noted that yet another recording appeared to correlate with the July 19, 2018 call between Dr. Rizk and Ms. [GB]. Mr. Stanowich noted that in this recording Dr. Rizk pressed Ms. [GB] for literature supporting the ICU team's decision not to use oseltamivir for AH Mr. Stanowich said he noted that the background audio in this recording suggested it had been edited and that a portion of it was missing. A further recording was noted to be a partial conversation between Dr. Rizk and Dr. [R]. Mr. Stanowich noted that in this recording Dr. [R] indicated he wanted to "get on the same page" as Dr. Rizk because changes were occurring with AH's medications and Dr. [R] didn't always know why. Dr. [R] expressed concern because AH had a very complex history with complex conditions.

[123] Mr. Stanowich conducted an interview with Dr. Rizk on January 18, 2019 and prepared a memorandum summarizing the interview that was entered into evidence. Mr. Stanowich's memorandum indicated that during the interview, he asked Dr. Rizk about AH, his differential diagnosis and the objective data he observed. Dr. Rizk indicated that he had considered COPD, chronic bronchitis and used a CURB 65 form. Dr. Rizk then indicated he needed to check his notes and Mr. Stanowich offered to provide follow-up questions in writing for Dr. Rizk to respond to. Mr. Stanowich asked Dr. Rizk if he had ever had a patient who required a referral to the hospital. Dr. Rizk said that critical patients do not usually go to the pharmacy and AH was no exception. Dr. Rizk said he told AH he should go to the hospital if his condition got worse.

[124] Mr. Stanowich did follow up with written questions to Dr. Rizk on January 23, 2019. In relation to Complaint 6774 Mr. Stanowich asked Dr. Rizk to comment on the differential diagnosis and objective data he evaluated when prescribing levofloxacin and oseltamivir on July 13, 2018. Mr. Stanowich also requested the fax transmission logs for faxes Dr. Rizk said he had sent in May, June and July 2018 as well as better quality copies of certain documents. Dr. Rizk responded to these questions on February 6, 2019 through Mr. Hajduk's office. Regarding AH's differential diagnosis and the objective data he considered, Dr. Rizk referred to viral/bacterial pneumonia, mild pneumonia and AECOPD. As for the objective data he considered, Dr. Rizk referred to the lack of fever, heart rate, respiratory rate, blood pressure, CEA, CURB-65, CRB, lack of peripheral edema and mental status. Dr. Rizk attached one "Renewal Notification of Rx Medication" addressed to Dr. [P] that had a fax transmission log indicating it was faxed on 2018-07-10, but the document did not identify any particular patient. Dr. Rizk also included a copy of the same "Renewal Notification of Rx Medication" which someone had seemingly faxed back to him with the question "Who is this for???" written on it. Dr. Rizk also enclosed prescriptions and documents entitled "Prescribing

Notification/Managing Ongoing Therapy" but none of these bore any evidence that they were actually transmitted by fax.

[125] Mr. Stanowich concluded his investigation report noting that Dr. Rizk displayed a pattern of behavior where he consistently denigrated and questioned the ethics and competence of other healthcare professionals, including Ms. [GB].

[126] Mr. Stanowich also noted that Dr. Rizk's response to the complaint asserted that he faxed 50 separate pieces of correspondence to Drs. [H], [R], [P] and to a Dr. [M] on 40 dates about AH However Dr. [H], Dr. [R] and Dr. [M] indicated they did not receive any of Dr. Rizk's faxes. Dr. [P] indicated he had only received one. Even when Dr. Rizk was asked to provide proof of faxes he said he had sent after April 2018, when he said there would have been no faxing mistakes, he was unable to provide more than one. Dr. Rizk had also asserted that he attempted to collaborate with other members of AH's care team, but this was not borne out after speaking with Drs. [H], [R] and [P]. Mr. Stanowich concluded that Dr. Rizk did not routinely notify other healthcare professionals of his prescribing activities. He also concluded that Dr. Rizk had misrepresented his fax process and documentation to the College to give the impression that he was collaborating when he was not.

[127] Further, Mr. Stanowich concluded that Dr. Rizk did not appear to understand the scope of his practice and he engaged in activities for which the patient would have been better managed by, or collaboratively with a physician. In particular, Mr. Stanowich concluded that Dr. Rizk chose to diagnose and treat a complex patient, AH, for community-acquired pneumonia even after the patient had already failed on antibiotics twice. Dr. Rizk elected not to consult the patient's physician or insist that the patient see a physician or attend at the hospital. Ms. [GB] and the ICU intensivist Dr. [TB] were reportedly of the view that Dr. Rizk's actions delayed AH's treatment and jeopardized his health. As a result, that patient ended up intubated in the ICU. Even then Dr. Rizk failed to self-reflect and consider how his actions contributed. Rather he argued with Ms. [GB] and questioned the ICU staff's approach.

[128] Mr. Stanowich stated that Dr. Rizk's conduct created an environment in which his care for his patients could be compromised. As examples, Mr. Stanowich cited Dr. Rizk's willingness to diagnose and prescribe contrary to best practices and established clinical norms. He also cited Dr. Rizk's failure or refusal to establish and maintain appropriate professional and collaborative relationships with other healthcare providers.

Dr. Daniel Burton, Expert Witness

[129] Dr. Burton also testified in relation to Complaint 6774. Dr Burton began by explaining that in his opinion, Dr. Rizk practiced in an unethical manner and failed to comply with the Standards of Practice. Dr Rizk failed to effectively and professionally communicate, consult and collaborate with AH, his family, AH's family physician, his nephrologist and the care team at the Misericordia Hospital. When he was provided the opportunity to collaborate, he failed to properly do so in a team-based manner. Dr. Rizk also failed to communicate his assessments, monitoring plans, prescribing activities and the patient's adverse reactions to the rest of his care team. Dr. Rizk failed to gather an appropriate amount of information prior to prescribing and managing AH's care and he prescribed unnecessary medications and medications that were

not indicated. Dr. Rizk also failed to appropriately refer AH for adequate assessment and management.

[130] Dr. Burton then discussed the basis for his opinion. Regarding the prescription of azithromycin, Dr. Burton noted that Dr. Rizk prescribed this when he deemed that AH had failed on another antibiotic, doxycycline and prednisone prescribed by his family physician, Dr. [R], for AECOPD. Azithromycin is an appropriate second-line therapy, but Dr. Rizk decided AH had failed on doxycycline based on AH's report of increased yellow sputum production and fatigue. Dr. Rizk did not use any other diagnostic modality to determine whether the treatment prescribed by Dr. [R] had failed, nor did he complete a differential diagnosis. Dr. Burton explained that he would not have prescribed in this situation. Dr. Rizk did not complete the initial assessment that led to Dr. [R's] prescription, so he could not have performed any comparison to see whether AH was getting worse. In addition, if AH had failed on the initial therapy, Dr. Burton would have suspected other possible causes for AH's symptoms, such as heart failure, fluid overload secondary to CKD, or pneumonia. Dr. Burton said he would not have had the tools or skills to properly assess and diagnose these in a community pharmacy. Dr. Burton opined that Dr. Rizk should have referred AH back to his physician, or to an emergency department depending on the severity of his symptoms rather than prescribing. Dr. Rizk also failed to communicate his prescribing and observations to AH's physician. Dr. Burton concluded that Dr. Rizk failed to comply with the Standards of Practice.

[131] Dr. Burton next commented on Dr. Rizk's prescriptions of levofloxacin and oseltamivir. Dr. Burton noted that AH saw Dr. [R] on July 9 and Dr. [R] diagnosed AECOPD caused by a viral infection. Dr Rizk then contacted AH on July 13 and deemed AH was suffering from a bacterial infection instead. Dr. Rizk prescribed levofloxacin and oseltamivir. Dr. Burton said it was unclear how Dr. Rizk determined that AH had a bacterial infection, since he stated first that the patient had no myalgias or fever, then later asserted that the patient did have myalgias. It was later confirmed at the hospital that the patient had no myalgias prior to admission but regardless, myalgias alone would not indicate a bacterial infection. Dr. Burton said that Dr. Rizk seemed to indicate that he prescribed levofloxacin and oseltamivir because AH refused to go to the hospital and Dr. Rizk therefore had no other options. Dr. Burton opined that this was inappropriate. Dr. Rizk should have insisted that AH go to the emergency department, called him an ambulance or contacted AH's family if Dr. Rizk was concerned about worsening symptoms. Dr. Burton also explained that oseltamivir was unnecessary as there was no indication for it. AH had no documented flu symptoms and this occurred in July, outside of influenza season. Dr. Burton acknowledged that while it was not impossible that AH had influenza, it was highly unlikely. Dr. Burton also noted that Dr. Rizk failed to communicate his observations and prescribing activities to AH's family physician.

[132] Regarding AH's diabetes management, Dr. Burton noted that AH's children said Dr. Rizk was managing it. On July 9, AH was found unresponsive and treated by EMS for measured blood sugar of 2.0. Dr. Burton also noted that Dr. Rizk told Ms. [GB] that AH had been struggling to manage his sugars during Ramadan, so it appeared that Dr. Rizk was at least monitoring AH's diabetes. However, if Dr. Rizk was prescribing medications, or adjusting AH's insulin regimen he should have informed Dr. [P] and Dr. [R]. Dr. Burton concluded that Dr. Rizk had failed to collaborate and communicate with AH's healthcare team and this was contrary to the Standards of Practice.

[133] Dr. Burton next commented on Dr. Rizk's professionalism. He opined that Dr. Rizk was argumentative, condescending and rude towards Ms. [GB] and her team. He also failed to collaborate with members of AH's care team, even after he was requested to do so. This was contrary to the Standards of Practice.

[134] Dr. Burton then addressed whether Dr. Rizk's conduct in respect of AH had the potential to cause harm. Dr. Burton opined that there were multiple instances where Dr. Rizk failed to effectively communicate, consult and collaborate with AH's family physician and other members of his care team. Dr. Rizk also failed to communicate his assessments, monitoring plans, prescribing activities and adverse reactions experienced by AH. Even when provided with an opportunity to collaborate, Dr. Rizk failed to follow through and properly consult in a team-based manner. Without those communications, Dr. Rizk was without a complete medical history for AH and this may have led to avoidable adverse reactions. AH's physician and care team would also be unaware of the medications Dr. Rizk had prescribed, therapies that were tried, and any issues that arose under Dr. Rizk's care. This may have led to incorrect diagnoses, duplicate therapies, drug interactions or therapies that had previously been tried and found ineffective, or possibly harmful.

[135] Dr. Rizk also diagnosed bacterial pneumonia and AECOPD without proper information, such as confirmatory blood work, a chest x-ray and physical examination. Without this kind of data Dr. Rizk was unable to complete an appropriate differential diagnosis and determine what exactly AH was experiencing in both instances where he prescribed antibiotics. Furthermore, Dr. Rizk's prescribing may have delayed treatment, especially where he prescribed levofloxacin and oseltamivir because AH was unwilling to go to the hospital. Dr. Burton noted that AH was actually admitted to the hospital on the day Dr. Rizk prescribed levofloxacin and oseltamivir. He was ultimately admitted to the ICU. Dr Rizk should have arranged more appropriate follow-up for AH rather than prescribing further therapy. Dr Burton concluded that Dr. Rizk's actions had the potential to cause significant harm to AH

Dr. Patrick Mayo, Expert Witness

[136] Dr. Mayo opined that Dr. Rizk was not in compliance with the Standards of Practice and the Code of Ethics in his assessment and treatment of AH. Dr. Mayo noted that Dr. Rizk was belligerent and condescending towards Ms. [GB] of the Misericordia ICU. He therefore failed to treat others with respect, as required by the standards. Dr. Mayo also noted an alarming pattern of prescribing drugs without informing AH's primary care physicians, which undermined patient care, contrary to the standards. Dr. Rizk also initiated antibiotic therapy without proper cultures and sensitivities and without performing the requisite physical assessment for the diagnosis, treatment and management of AECOPD. Dr. Mayo noted a specific concern that there was no information suggesting that Dr. Rizk had separated his prescribing for AH from his dispensing of drugs to AH. Dr. Mayo said the prescribing and dispensing functions should be separate, through the involvement of multiple professionals. Only in an emergency or isolated setting should a pharmacist prescribe and then also fill and dispense a medication, as this can lead to a conflict of interest in which the pharmacist directly benefits financially from the act of prescribing.

[137] Dr. Mayo also considered whether Dr. Rizk's conduct with respect to AH had the potential to cause the patient harm. Dr. Mayo concluded that it did. Dr. Rizk prescribed antibiotics and

antivirals for AH without obtaining the information provided by proper diagnostic tests. The proper management of COPD requires an appropriate history, physical exam including auscultation by an experienced practitioner and chest x-rays. Dr. Mayo noted there was no evidence that Dr. Rizk had obtained any of this information, but he prescribed additional antibiotics anyway.

[138] Dr. Mayo also noted that Dr. Rizk provided unnecessary weekly vitamin injections. The vitamins could have been administered in oral doses large enough to ensure bioavailability, so injections posed an unnecessary risk. Further, Dr. Rizk's mismanagement of AH's insulin led to severe hypoglycemia and a blood sugar of 2.

[139] Dr. Rizk's decision to diagnose and treat AH himself provided the patient with false hope that medical attention would be unnecessary. It delayed the patient from seeking medical help in a hospital environment where qualified medical, nursing, respiratory and pharmacy personnel were available. Dr. Mayo also noted that Dr. Rizk mismanaged AH's insulin dosing and this resulted in severe hypoglycemia and decreased consciousness. Dr. Rizk had denied that he was managing the patient's insulin, but the patient told Ms. [GB] that he was.

[140] Dr. Mayo noted that when asked about his prescribing, Dr. Rizk stated "How is what I did any different than what a physician would do". Dr. Mayo said it was deeply disturbing that Dr. Rizk failed to recognize that a trained physician would have superior assessment skills and access to laboratory, diagnostic and treatment equipment that would be unavailable in a community pharmacy. Dr. Mayo opined that Dr. Rizk had demonstrated a cavalier attitude towards pharmacotherapy, as if drugs are harmless and can simply be added and subtracted as a means to diagnose patients one drug trial after another. Dr. Mayo said this attitude places the patient at extreme risk.

Complaint 6785:

Mr. James Krempien, Complaints Director

[141] Mr. Krempien testified that Complaint 6785 originated with a complaint from a physician, Dr. [LB] concerning Dr. Rizk's care of their mutual patient, DS.

Dr. [LB], Complainant

[142] Dr. [LB] is a family physician practicing at a large clinic of 20 physicians, including some specialists in Edmonton. Dr. [LB] explained that she submitted her complaint to the College about Dr. Rizk after he called her about a patient, DS. Dr. [LB] explained that DS was a complex patient Dr. [LB] had been seeing in her practice since 1996. Dr. [LB] had sent DS for a cortisone injection after diagnosing her with hip pain. DS had subsequently gone to see Dr. Rizk when her pain did not improve.

[143] Dr. [LB] testified that Dr. Rizk said the patient should be referred to an orthopedic surgeon and asked if she would arrange it. Dr. [LB] told Dr. Rizk that the patient should follow-up with her, as she had advised DS. Dr. Rizk then informed Dr. [LB] that he was managing DS's pain. Dr. [LB] asked what Dr. Rizk was giving to DS and he said oral Dexamethasone. When Dr. [LB] asked about the indication for that medication, Dr. Rizk replied severe pain

and that nothing else had been tried first. Dr. [LB] expressed concern that DS had poorly controlled diabetes and the Dexamethasone would throw her blood sugars out and should be stopped. Dr. Rizk declined to stop the Dexamethasone and said he would monitor DS's blood sugar and contact Dr. [LB] about any problems. After the call with Dr. Rizk, Dr. [LB] contacted DS, expressed concern about her blood sugars and asked her to come in for an appointment to see what was going on.

[144] When Dr. [LB] met with DS, she explained she was quite concerned about her care and about Dr. Rizk's unwillingness to adjust the treatment. Dr. [LB] suggested DS obtain a new pharmacy, which she did.

[145] Dr. [LB] explained that with the assistance of DS's new pharmacy, they obtained a list of multiple medications Dr. Rizk had started her on with no clear indications and significant potential for harm. These medications were oral and intramuscular dexamethasone, Florinef, valproic acid, high dose Effexor, Lipitor, ketorolac, gabapentin, cetirizine, clonidine, glyburide, repaglinide, Anafranil, ranitidine, hydroxyzine, pyridoxine, thiamiject, cyanocobalamin, Mg, glucosamine, oral vitamins and over the counter sleep remedies. Dr. [LB] noted particular concerns with Dr. Rizk's prescription of valproic acid given that DS had a neurologist and was on topiramate for seizures, the prescription for Effexor since DS denied any depression, and Lipitor, since DS had high C.K. due to myotonic dystrophy. Dr. [LB] also expressed concern that none of DS's family doctor, her neurologist or her diabetic specialist were contacted or consulted about the medications Dr. Rizk prescribed.

[146] Dr. [LB] explained that she had to have multiple calls and faxes with DS's new pharmacy about how to safely reduce the medications she was on. Dr. [LB] also expressed concern that when she ordered laboratory work, DS's hemoglobin A1C was greater than 19.0%, even though Dr. Rizk had said he was monitoring DS's sugars. Dr. [LB] testified that hemoglobin A1C is a measure of how well diabetes is controlled in the body. A number of less than 7% is considered good control. Dr. [LB] said she had never before seen a hemoglobin A1C in excess of 19%. It indicates that the real number is not even measurable and therefore out of control.

[147] Dr. [LB] next described the communications between Dr. Rizk and her office. Her general practice is to review faxes from pharmacies and only to call the pharmacist if there is a need to correct something or to discuss something. Dr. [LB] said she had received a couple of faxes from Dr. Rizk that made very reasonable alterations to her prescriptions, so she saw no need to respond to those. They were received on December 18, 2017 and January 22, 2018.

[148] Dr. Rizk's response to Complaint 6785 asserted that he had sent 56 faxes to Dr. [LB] about DS. Dr. [LB] said her practice uses an EMR. Faxes received by the practice are not printed, they are automatically filed in the patient chart and may also be sent to the physician for review. They cannot be deleted. Dr. [LB] said that she and her administrative staff had gone through every section of DS's chart but only the two faxes from Dr. Rizk dated December 18, 2017 and January 22, 2018 were received. Dr. [LB] said she is not aware of any lost faxes, but she also checked with the EMR provider and verified that there is no way that all but 2 out of 56 faxes could have been lost.

[149] Dr. [LB] also reviewed Dr. Rizk's response to Complaint 6785, which contained a number of documents entitled "Prescribing Notification/Managing Ongoing Therapy" with handwritten notations indicating they had been faxed to "[LB]" with a fax number. Dr. [LB] testified that she had not received the documents attached to Dr. Rizk's response that he said he had faxed to her. There was no fax header on these documents indicating the date they were faxed, the number they were faxed to or any information confirming they were successfully transmitted.

Mr. Monty Stanowich, Investigator

[150] Mr. Stanowich identified the investigation report and investigation records for Complaint 6785, including Dr. Rizk's written response to Complaint 6785.

[151] Mr. Stanowich summarized Dr. Rizk's response. Dr. Rizk's response was quite critical of Dr. [LB's] care of DS. He responded that when he first saw DS she "was in serious conditions (sic), incompetently treated and neglected by her primary care physician [LB]". DS presented with untreated diabetic nerve pain, untreated myotonic dystrophy, symptoms of sleepiness and confusion due to "[LB] incompetence", an inability to walk and untreated dyslipidemia.

[152] Dr. Rizk asserted that under his care DS's diabetic nerve pain had disappeared, her "blood pressure and diabetes were perfectly controlled unless there was a concomitant infection or drinking sugary beverages" and her bowel movements and sleep were normal. Dr. Rizk said that the hemoglobin A1C greater than 19% doesn't represent the real value because DS ate the night before the test and her blood sugar was 23 mmol/L in his office and this is a known interfering factor. Mr. Stanowich advised the Hearing Tribunal that this was incorrect. Hemoglobin A1C measurements represent a 3-month average and do not require the patient to fast before the test.

[153] Dr. Rizk also asserted that Dr. [LB] had lied when she accused Dr. Rizk of saying that oral dexamethasone was the only medication he would use to treat DS's bursitis pain and that NSAIDs would not be an option. He said Dr. [LB] had also lied about DS's diabetes control, and he asserted that her diabetes was controlled under his care. Dr. Rizk said that Dr. [LB] had wanted to stop DS's dexamethasone due to a risk of bleeding, not the risk to her blood sugar and in fact the dexamethasone posed no risk to the patient. He prescribed valproic acid and Effexor for diabetic neuropathy, not for seizures and he did contact DS's neurologist to obtain a transfer of DS's medical records and this helped him find a treatment for her myotonic dystrophy.

[154] Mr. Stanowich did not agree that DS's diabetes was controlled under Dr. Rizk's care. Mr. Stanowich pointed out that DS's hemoglobin A1C was tested at greater than 19% on January 3, 2018 and April 18, 2018 and this showed a critical lack of glucose control for a period of up to six months which she was under Dr. Rizk's care. Dr. Rizk's assertion that DS's diabetes was well-controlled was without regard for her health or the long-term effects of failing to properly manage it. Mr. Stanowich said DS's condition was out of control for at least 6 months and this likely caused her some significant harm.

[155] Regarding communications with Dr. [LB] Dr. Rizk responded that he faxed her, but she never replied to him. Dr. Rizk's response to the complaint included documents entitled "Prescribing Notification/Managing Ongoing Therapy" dated between March 21, 2017 and April 16, 2018. Mr. Stanowich noted that these appeared to indicate they were faxed. These documents had handwritten notations that they were faxed to Dr. [LB] with a handwritten fax number. As above, there was no fax header showing the date they were faxed, the number they were faxed to or any notation that the transmission was successful.

[156] Dr. Rizk's response also included documents entitled "Renewal Notification of Rx Medications" with dates ranging from June 10, 2017 to April 4, 2018. These were addressed to a physician with handwritten notations and indicated they were faxed to a fax number, but there was no fax header indicating when they were faxed, the number they were faxed to or any notation of a successful transmission.

[157] Mr. Stanowich interviewed Dr. Rizk's assistant, Ms. [S] as part of his investigation on January 8, 2019. Ms. [S] indicated she had worked at the pharmacy for approximately 1.5 years, but they had just started sending faxes to doctors in April or May of 2018. Prior to April 2018 she had not sent any faxes and she had no idea what was being sent. If anything had been sent before April 2018 it would have been sent by Dr. Rizk himself. Beginning in April or May of 2018 Ms. [S] kept a transmission log of all of the faxes that were sent. Ms. [S] also explained that their practice was to physically print faxes and then send them. There was no direct software to fax capability. Dr. Rizk's response to the complaint included a statement signed by Ms. [S] that she had been faxing prescription notifications and renewals of prescriptions to Dr. [LB] Ms. [S] said the statement was accurate as of April or May of 2018, but not before that.

[158] Mr. Stanowich interviewed Dr. Rizk on January 18, 2018. Dr. Rizk confirmed that his fax procedures were not standardized before April 2018 and fax transmission logs were not being kept. Dr. Rizk said that his assistant, Ms. [S] may have missed sending some faxes before that time. Dr. Rizk denied that he sent the faxes himself prior to April 2018. He also said he had been previously unaware he was required to keep fax transmission logs.

[159] Mr. Stanowich then described five audio recordings that Dr. Rizk provided as part of his response to the complaint. During his interview with Mr. Stanowich Dr. Rizk said he provided these to demonstrate that he was collaborating.

[160] The first recording was a conversation between Dr. Rizk and DS. Dr. Rizk and DS discussed DS's general health, hip pain, blood pressure and blood sugar and upon noting that her blood sugar readings were high, Dr. Rizk advised DS to lower her dose of dexamethasone and increase her insulin. Dr. Rizk also indicated he was going to inject DS with vitamins, tramadol and another anti-inflammatory drug. Mr. Stanowich indicated that it appeared to him that part of this recording was missing.

[161] The second recording was a telephone conversation between Dr. Rizk and DS. Dr. Rizk and DS discussed her blood sugar readings and Dr. Rizk indicated he wanted DS to decrease her dexamethasone and increase her insulin. DS responded that Dr. [LB] had advised her to stop the dexamethasone until an upcoming appointment. Dr. Rizk said he had already spoken with Dr. [LB] and he didn't know what she wanted to discuss. DS then said Dr. [LB]

had told her that steroids could cause bleeding in her stomach. Dr. Rizk responded "it doesn't cause any bleeding, nothing OK".

[162] The third recording was a telephone conversation between Dr. Rizk and Dr. [LB] Dr. Rizk and Dr. [LB] discussed DS's hip pain, Dr. [LB's] diagnosis of bursitis and the cortisone treatment that had been provided. Dr. Rizk asked if DS should contact an orthopedic surgeon herself. Dr. [LB] said she would need a referral, but Dr. [LB] was waiting to assess the results of the cortisone injection. Dr. Rizk then indicated he was managing DS's pain with dexamethasone and monitoring her blood sugars. Dr. [LB] said that systemic steroids were not indicated for DS as a steroid injection had been provided. Dr. Rizk then said that he was concerned about local side effects of a cortisone injection and that she had not responded after two weeks. Dr. [LB] said it would take some time to see improvement and that there are no concerns with local side effects. Dr. [LB] advised that she would stop the dexamethasone but that other medications like Tylenol would be appropriate. Dr. Rizk said he would wait a few days due to the severity of DS's pain. Dr. [LB] reiterated that there was no indication for oral steroids. Dr. Rizk said that he would keep Dr. [LB] posted.

[163] The fourth recording was a 10-minute partial conversation between Dr Rizk and DS during which they discussed DS's appointment with Dr. [LB] DS said that Dr. [LB] told her dexamethasone was not the right medication for her and it could cause bleeding. DS further said that it raised her blood sugar and didn't make her feel right. Dr. Rizk responded that DS was protected from bleeding and that because of her medical history she should use the steroid. DS said Dr. [LB] had started her on Tylenol but Dr. Rizk replied "…that's her opinion but I have to give you my opinion as well and Tylenol doesn't do anything".

[164] The fifth recording Dr. Rizk provided was a 1-minute conversation between Dr. Rizk's assistant and a female. No patient name was spoken. Dr. Rizk's assistant agreed to send a compliance label to the female caller in response to her request.

[165] At the conclusion of their interview, Mr. Stanowich informed Dr. Rizk that he would provide further questions in writing so Dr. Rizk could respond after reviewing his notes. Mr. Stanowich wrote to Dr. Rizk with additional questions relating to Complaint 6785. Mr. Stanowich also requested fax transmission logs for certain dates between May 3, 2018 and July 13, 2018 and photos or high quality colour scans of documents originally provided in Dr. Rizk's response.

[166] Dr. Rizk responded to Mr. Stanowich's additional questions about Complaint 6785 on February 6, 2019. Mr. Stanowich had asked for Dr. Rizk's rationale for discontinuing dexamethasone, injectable vitamins and injectable ketorolac on April 16, 2018. Dr. Rizk replied that DS decided to stop taking it because her physician misinformed her that it causes gastric bleeding. Dr. Rizk said the patient was on a gastric protection regimen of Ranitidine and Lansoprazole. In addition, Dr. Rizk said that DS's blood sugar was still high despite her insulin intake due to her eating habits. Dr. Rizk said that discontinuing the dexamethasone was safe because DS had taken it for less than 14 days and tapering wasn't required. The vitamins were discontinued as DS decided to stop getting them. The injectable ketorolac was only given once, on April 4, 2018 so discontinuing it was not applicable.

[167] Mr. Stanowich had next asked when DS was prescribed dexamethasone and when it was discontinued. Dr. Rizk replied that dexamethasone was prescribed on April 4, 2018 and given

as an intramuscular dose on that date with oral tablets to be continued the next day onwards. The dexamethasone was discontinued by Dr. [LB] on April 5, 2018 and Dr. Rizk discontinued it from his end on April 16, 2018.

[168] Mr. Stanowich next asked for the indication for Dr. Rizk's prescription of fludrocortisone for DS. Dr. Rizk said this was given for orthostatic hypotension, caused most likely by DS's history of myotonic dystrophy. Dr. Rizk said this was to prevent falls and subsequent injury due to syncope.

[169] Mr. Stanowich next asked for the indication for injectable vitamins Dr. Rizk gave to DS. Dr. Rizk responded that DS was prescribed injectable vitamins because of her history of painful diabetic neuropathy and the evidence showing the effectiveness of vitamins B1, B6, and B12 in treating it.

[170] Mr. Stanowich next asked Dr. Rizk to describe the steps he had taken to assess DS when she presented to him with a "Hypertensive Emergency", as noted in a "Prescribing Notification/Managing Ongoing Therapy" document he created on March 28, 2017. Dr. Rizk responded that the term "hypertensive emergency" is defined as a systolic blood pressure of more than 180 mm hg or a diastolic blood pressure of more than 120 mm hg. He added that if the blood pressure is not accompanied by evidence of target organ damage then the event would be called a "hypertensive urgency".

[171] Dr. Rizk said that when he measured DS's blood pressure at 184/92 mm hg and then again at 188/96 mm hg, he first assessed her to rule out target organ damage. To do this he asked DS if she was complaining of eye pain or any sight disturbances. He also checked for any signs of bleeding in her eyes and noted none. Dr. Rizk asked DS if she was experiencing chest pain, which she denied. He then assessed her for any signs of stroke by asking if she or her husband had noticed any difficulties with her articulation of words or with talking, or any signs of weakness. She denied these signs. Dr. Rizk asked her if she was experiencing shortness of breath which she denied. He also asked her about headaches, dizziness and tinnitus but none were present. Based on these assessments Dr. Rizk said he concluded DS was experiencing only pain and not target organ damage. He therefore decided to start her on clonidine, with the patient to monitor her own blood pressure at home.

[172] Dr. Rizk's response also said that at a follow-up appointment on April 3, 2017, DS's blood pressure was down to 146/89 mm hg and her pulse was 77 bpm, which he said proved that the clonidine had effectively controlled her blood pressure. He said there were also no new complaints from which he inferred there were no signs of target organ damage. Dr. Rizk concluded that the most likely cause of DS's increased blood pressure was her uncontrolled pain and the resulting physiological pain response. He said the clonidine treated this effectively. Dr. Rizk said the patient should have been referred to the emergency department if her elevated blood pressure was accompanied by target organ damage or if her blood pressure had continued to escalate with evidence of target organ damage.

[173] Mr. Stanowich said he was concerned by Dr. Rizk's response to this question about DS's hypertensive emergency. Mr. Stanowich said he was not aware that a pharmacist could assess for target organ damage in a community pharmacy setting and because Dr. Rizk had apparently not followed up with DS between March 28 and April 3, 2017, even though he had noted that

she should be followed up after 1-2 days. Mr. Stanowich noted that pharmacists are not trained as physicians to assess and diagnosis medical conditions. Yet Dr. Rizk did not seem to understand the scope of practice of a pharmacist.

[174] Mr. Stanowich next asked Dr. Rizk to comment on the data he considered when he wrote a "Prescribing Notification/Managing Ongoing Therapy" document dated April 13, 2017 in which he indicated that DS had possible serotonin syndrome and presented with "jerky movements" described as "involuntary twisting of the whole body and upper limbs backwards and sideways". Mr. Stanowich asked Dr. Rizk to comment on the differential diagnoses he considered and the steps he had taken to manage this issue.

[175] Dr. Rizk responded that he had previously prescribed tramadol with venlafaxine XR for DS for diabetic neuropathy on March 21, 2017. Dr. Rizk said this medication combination was not contraindicated provided the patient is monitored for signs of serotonin syndrome. Dr. Rizk then said that he had seen DS on March 23 and April 3, 2017, but she had forgotten to mention to him that she had been experiencing jerky movements since being prescribed the medications. She disclosed this to Dr. Rizk when he saw her again on April 13, 2017.

[176] Dr. Rizk explained that he then considered differential diagnoses, which were neuroleptic malignant syndrome, cocaine or other substance abuse, thyroid storm, infection such as encephalitis and alcohol or opioid withdrawal. Dr. Rizk ruled out these possibilities since DS was not taking neuroleptics, she had no history of alcohol or drug addiction and the opioid she was taking was slowly tapered down, she had no history of thyroid disorder and no signs of hyperthyroidism, and there were no signs of fatigue, mental confusion or severe headache.

[177] Dr. Rizk reduced DS's tramadol regime to 50 Mg orally three times a day to reduce the intensity and frequency of the jerky movements. He said the gradual tapering of tramadol was warranted to reduce the risk of seizures while reducing the serotonin syndrome manifestation. Dr. Rizk told DS to monitor the frequency/intensity of the jerky movements after this change.

[178] Dr. Rizk said that DS didn't complain about jerky movement between April 13 and 25, 2017. He said that on April 25, 2017 D.S said that the jerky movements had come back since her last appointment with Dr. Rizk on April 17, 2017. Dr. Rizk again reduced DS's tramadol regime.

[179] Dr. Rizk had a follow-up visit with DS on May 1, 2017. He noted that the intensity and frequency of the jerky movements had decreased significantly but he maintained his diagnosis of serotonin syndrome.

[180] Dr, Rizk said he saw DS again on May 8, 2017 and there was an absence of jerky movements because she wasn't taking tramadol anymore. He said DS hadn't experienced any jerky movements since May 8, 2017.

[181] Mr. Stanowich was also concerned by Dr. Rizk's response to this question about the assessment and treatment of serotonin syndrome. Dr. Rizk had prescribed venlafaxine off-label to treat diabetic neuropathy. Dr. Rizk said he suspected DS was suffering from serotonin syndrome, which is a serious and potentially fatal condition. Dr. Rizk failed to even collaborate with an appropriate physician, let alone refer DS for assessment. Dr. Rizk made no apparent efforts to warn DS about when to go to the emergency department and no attempts to notify her primary

care physician about the issue. Dr. Rizk said he considered differential diagnoses but ruled out everything else he considered. Serotonin syndrome is caused by duplicating medications, but Dr. Rizk addressed it by lowering the dose of tramadol while increasing the venlafaxine at the same time. Mr. Stanowich said this would have made it very difficult to assess what was causing DS's symptoms. Mr. Stanowich concluded that Dr. Rizk was not giving DS's condition the attention that it warranted.

[182] Mr. Stanowich also interviewed Dr. [LB] Her main concern was Dr. Rizk's lack of communication and collaboration. She had only received two faxes from Dr. Rizk. She was unaware of what Dr. Rizk was prescribing for DS and this could have interfered with her treatment. Dr. Rizk was also prescribing off-label; adjusting medications and prescribing medications that were contraindicated for DS. This put DS at great risk.

[183] Mr. Stanowich concluded with two main concerns about Dr. Rizk's conduct arising from Dr. [LB's] complaint. First, Dr. Rizk had failed to collaborate with Dr. [LB] and other physicians, including by failing to notify them of his prescribing for DS.

[184] Dr. Rizk said he had faxed 57 separate documents to Dr. [LB] about DS. Dr. Rizk could produce transmission logs for only 2 of these, which were the same 2 documents that Dr. [LB] actually had a record of receiving. Dr. Rizk said that he was not the one sending faxes from his practice, his assistant was, and they had not saved fax transmission logs from before April 2018. Yet Dr. Rizk provided the fax transmission logs for the two documents Dr. [LB] actually received and these were dated December 17, 2017 and January 4, 2018. In addition, Dr. Rizk's assistant Ms. [S] said Dr. Rizk had sent his own faxes prior to April or May of 2018. Mr. Stanowich concluded that Dr. Rizk did not fax or require to be faxed any of the documents he said he had faxed to Dr. [LB] in his response. Mr. Stanowich also concluded that Dr. Rizk had likely misrepresented his fax communications to give the impression that comprehensive correspondence was being shared with other health providers when in fact it was not.

[185] The second main concern Mr. Stanowich identified was that Dr. Rizk acted outside the scope of practice of a pharmacist by diagnosing, prescribing and treating DS. Mr. Stanowich noted that Dr. Rizk treated DS with multiple medications that were not indicated for her medical conditions and that had the potential to negatively impact her health. Mr. Stanowich noted that DS would have been better managed by, or collaboratively with, a physician. In addition to the issues described above, Mr. Stanowich noted that Dr. Rizk had prescribed atorvastatin, a medication that was contraindicated for DS due to her medical history. If Dr. Rizk has properly communicated with Dr. [LB] about his prescription of this medication Dr. [LB] could have immediately addressed the issue. He failed to comply with his duty to notify Dr. [LB] about his prescribing and this put DS at risk of serious complications. Mr. Stanowich said Dr. [LB] had pointed out that Dr. Rizk's prescription of atorvastatin put DS at risk of rhabdomyolysis, a potentially fatal condition.

[186] Mr. Stanowich concluded his investigation report noting that Dr. Rizk had failed to collaborate with other healthcare providers in any substantive manner; failed to recognize the limits of his scope of practice; failed to prescribe and provide care to his patients within the normal scope of pharmacy practice and within his ability as a pharmacist; failed to recognize the value of other clinical opinions and that they may be informed by higher levels of evidence; and he had

demonstrated a willingness to mislead and misrepresent information to an investigator. Mr. Stanowich characterized this as a serious matter and noted that Dr. Rizk seemed to have failed to acknowledge or take any responsibility for his conduct. Mr. Stanowich referred to a number of provisions of the Standards of Practice, the Code of Ethics and the HPA.

Dr. Daniel Burton, Expert Witness

[187] Dr. Burton also testified in relation to Complaint 6785. Dr. Burton began by explaining that in his opinion, Dr. Rizk had failed to effectively communicate, consult and collaborate with DS's family physician Dr. [LB] her diabetes specialist, and her neurologist. When he was provided an opportunity to follow through and properly consult in a team-based manner he failed to do so. In particular, Dr. Rizk failed to communicate his assessments, monitoring plans, prescribing activities and adverse reactions that DS experienced to the rest of her care team. He also failed to gather an appropriate amount of information prior to prescribing and managing care for DS and he failed to appropriately identify, monitor and manage drug related problems that DS experienced. He failed to appropriately refer her to an emergency room or to her physician when she required assessment and management. He prescribed unnecessary medications that were not indicated, not evidence-based, and potentially harmful.

[188] Dr. Burton then explained the basis for his opinions. Dr. Burton noted that Dr. Rizk prescribed atorvastatin without communicating or consulting with Dr. [LB] Dr. Burton noted Dr. [LB's] complaint that DS had previously suffered an elevated creatinine kinase ("CK") while taking a statin and this had resolved when the statin medication was discontinued. If Dr. Rizk had consulted with Dr. [LB] he would have learned that statin therapy had been tried before and was not appropriate. Dr. Burton also noted that DS had myotonic dystrophy and that statins should be used with caution in such individuals, as it can lead to elevated CK, myalgias, myopathies and even rhabdomyolysis. Dr. Risk nevertheless prescribed atorvastatin and failed to monitor DS's CK levels and organ function before and during the therapy. Dr. Burton opined that this was unethical and contrary to the Standards of Practice.

[189] Dr. Burton noted that Dr. Rizk prescribed dexamethasone and fludrocortisone for DS's diabetic neuropathic pain. He explained that neither medication is indicated by Health Canada for this purpose, nor did DS have any other conditions that would warrant using these medications. Dr. Rizk was using them off-label. Dr. Burton opined that the off-label use of these medications for DS was inappropriate. Both medications are corticosteroids with similar mechanisms of action, and it is unclear why they were prescribed concurrently. Dr. Burton said this was duplicative and should not have been done. He also said that it appeared Dr. Rizk did not monitor DS's organ function prior to or during this therapy or assess DS's history of diabetes and he failed to develop an appropriate monitoring plan for her sugars while on corticosteroid therapy. Dr. Rizk chose to ignore Dr. [LB's] concerns about the risk of gastrointestinal bleeding, which is a known risk of corticosteroid treatment. If Dr. Rizk told DS there was no risk of bleeding, he was wrong. Dr Burton again opined that Dr. Rizk's actions were unethical and contrary to the Standards of Practice.

[190] Dr. Burton opined that Dr. Rizk attempted to treat DS's chronic neuropathic pain as a solo practitioner and this was inappropriate. Chronic neuropathic pain is a complex syndrome that often requires a team-based approach. Dr. Rizk prescribed multiple medications for this condition, including dexamethasone, fludrocortisone, valproic acid, venlafaxine, ketorolac IM,

tramadol, gabapentin, and pregabalin, many of them concurrently. Yet while Dr. Rizk was doing this he failed to properly communicate and consult with Dr. [LB] about his prescribing and he chose to ignore Dr. [LB's] express concerns. Dr. Burton also noted that Dr. Rizk failed to properly assess DS's organ function prior to or during this therapy as he had no laboratory values ordered or completed by DS It was also unclear to Dr. Burton how Dr. Rizk was monitoring DS's pain and whether it was improving. Dr. Burton noted that a 30% reduction in baseline pain is considered an acceptable goal but Dr. Rizk was not tracking this.

[191] Dr. Burton commented that Dr. Rizk was using multiple medications, but this increased DS's risk of suffering adverse effects with only limited further improvement to her pain. Dr. Burton also commented that many of the medications Dr. Rizk prescribed have limited evidence supporting their efficacy in treating neuropathic pain, and even less when used concurrently. While there is some evidence that gabapentin and pregabalin are useful for neuropathic pain, using them together is generally advised against as they have similar mechanisms of action and both depress the patient's central nervous system, which can lead to adverse events. Dr. Burton opined that he would not prescribe gabapentin, pregabalin or venlafaxine for neuropathic pain management without consulting the patient's other health care team members. Ketorolac IM and tramadol are not recommended for long term use and ketorolac IM in particular is generally reserved for more acute settings, such as in the hospital. DS had high blood pressure and chronic kidney disease and ketorolac is a powerful non-specific anti-inflammatory drug which can negatively affect these conditions and increase the risk of bleeding. Dr. Burton opined that he would not have prescribed ketorolac IM or tramadol for DS's neuropathic pain. Dr. Burton indicated that using valproic acid for neuropathic pain is an off-label use, although it may be used as a third-line agent according to the literature Dr. Rizk provided to the College. Dr. Burton opined that the evidence for using valproic acid for neuropathic pain is of very low quality and if it were to be used it should only be by a specialist in a team-based environment. Dr. Burton concluded that Dr. Rizk prescribed a number of unnecessary and potentially harmful medications without proper monitoring and without consulting the rest of DS's care team. This was unethical and contrary to the Standards of Practice.

[192] Dr. Burton next commented on Dr. Rizk's management of DS's high blood pressure. He explained that hypertensive emergencies are exceedingly rare and when they occur it is often due to secondary causes, such as pulmonary edema or cerebral infarction. Dr. Burton noted that it appeared Dr. Rizk diagnosed DS with a hypertensive emergency based on blood pressure readings taken in the pharmacy. He then prescribed clonidine to manage her blood pressure, though DS was already on amlodipine for high blood pressure management. Dr. Burton said that if it was a true hypertensive emergency with evidence of end-organ damage, then Dr. Rizk should have immediately referred DS to the nearest emergency department for assessment and treatment. Dr. Burton opined that DS was more likely experiencing a hypertensive urgency, which occurs when patients with significantly elevated blood pressure are otherwise asymptomatic. Dr. Burton said that regardless, at the very least Dr. Rizk should have referred DS to her physician for assessment. Clonidine can be used as a short-acting agent to temporarily lower blood pressure, but patients should then be switched to longer acting blood pressure agents that are more tolerable and effective for long-term management. Dr. Rizk continued treating DS with clonidine for a number of months. Dr. Rizk also failed to follow up with DS for 6 days after prescribing her clonidine to manage a hypertensive emergency. Dr. Burton opined that Dr. Rizk should have been arranging follow-up care for DS within 1-2 days. If she did have a hypertensive emergency, it could have been a life-threatening condition.

[193] Dr. Burton next commented on Dr. Rizk's management of DS after he diagnosed her with serotonin syndrome. Dr. Burton explained that serotonin syndrome is associated with increased serotonergic activity in the central nervous system and can be life threatening. It is exceedingly rare, and generally occurs with medication overdoses and inadvertent drug interactions. Symptoms of serotonin syndrome can include confusion, agitation, headache, dilated pupils, blood pressure changes, temperature changes, diarrhea, sweating and tremor. Dr. Rizk appeared to diagnose DS with serotonin syndrome based on the reported "jerky movements." Dr. Rizk responded to this diagnosis by reducing DS's tramadol and increasing her venlafaxine. He failed to communicate with DS's physician, Dr. [LB]. Dr. Burton opined that if DS had serotonin syndrome then Dr. Rizk should have referred her to the nearest emergency room for assessment and treatment. Dr. Rizk's actions were inappropriate. Rather than withdraw the likely offending agent, Dr. Rizk increased the dose of venlafaxine to 225Mg daily indefinitely. This had the potential to worsen DS's serotonin syndrome. Then Dr. Rizk waited 12 days after making these changes to follow up with DS. Dr. Burton opined that follow-up should have been arranged in 1-2 days as serotonin syndrome can be fatal.

[194] Dr. Burton next commented on Dr. Rizk's management of DS's myotonic dystrophy. Dr. Burton explained that myotonic dystrophy is a rare and complex genetic disease characterized by muscle weakness and abnormally slow muscle relaxation following normal contractions. It should be managed in a team environment in conjunction with a neurologist. Dr. Rizk treated DS's myotonic dystrophy by prescribing clomipramine. Dr. Rizk appeared to do this based on a review paper that cited a small crossover study. However, Dr. Burton pointed out that another review using the same small crossover study concluded that due to insufficient good quality data and the lack of randomized studies it was impossible to determine whether drug treatment is safe and effective in treating myotonia. Dr. Burton noted that clomipramine is not indicated by Health Canada to treat myotonia and so Dr. Rizk was using it off-label. Dr. Burton opined that clomipramine is not recommended to treat myotonia and its use may be unsafe and lead to harm. Dr. Rizk's use of it was therefore inappropriate. He also failed to assess DS's organ function on the therapy and he failed to collaborate or consult with Dr. [LB] or DS's neurologist to inform them of his prescribing.

[195] Dr. Burton next commented on Dr. Rizk's management of DS's diabetes. Dr. Burton explained that in March 2017 DS's diabetes was under control with her A1C was within target at 6.6%. Dr. Rizk initiated fludrocortisone and dexamethasone treatment in July 2017 and DS's blood sugars became poorly controlled. There were no A1C measurements between March 2017 and April 2018. Her A1C was reported as no longer readable at greater than 19% in April and August of 2018. Dr. Burton confirmed that A1C measurements are not affected by the patient's food consumption the day before. Dr Rizk had stated that he was managing DS's diabetes and based on Netcare records Dr. Burton determined that Dr. Rizk had prescribed metformin, repaglinide, glyburide, Humalog and gliclazide. Dr. Burton explained that gliclazide and glyburide are both from the same drug class of sulfonylureas with the same mechanism of action. They both trigger the pancreas to "squeeze out" more insulin. Therefore, using gliclazide and glyburide together would be duplicative and provide no additional benefit. Dr. Burton also explained that Repaglinide has a similar mechanism of action to gliclazide and glyburide, so using them together would have limited benefit for blood sugar control. Using them all together may have put DS at risk of adverse effects, such a hypoglycemia, especially when used in conjunction with Humalog. Dr. Burton concluded that Dr. Rizk was not adequately monitoring and managing DS's diabetes and organ function. In fact, her diabetes

control worsened under Dr. Rizk's care. He failed to communicate to DS's other healthcare providers about his prescribing activities and he also failed to refer DS for assessment and further management.

[196] Dr Burton then discussed whether Dr. Rizk's conduct in respect to DS had the potential to cause her harm. He concluded that it did. Dr. Burton explained that Dr. Rizk failed to effectively communicate, consult and collaborate with DS's family physician. He failed to notify Dr. [LB] of his assessments, monitoring plans, prescribing activities and the adverse events that DS experienced. Without proper consultation Dr. [LB] would have been unaware of what Dr. Rizk was doing. This could have led to incorrect diagnoses, duplicative therapies, drug interactions or using therapies that had already been tried and found ineffective, or possibly harmful.

[197] Dr. Burton also concluded that Dr. Rizk failed on multiple occasions to compile an adequate amount of information in order to properly treat and ensure the therapies he was prescribing would be safe and effective. He did not gather a detailed medical history on DS from her physician. He also did not order any lab tests for DS. He failed to follow-up in a timely fashion and ensure the ongoing safety and effectiveness of his therapies. All of this had the potential to significantly harm DS.

[198] Dr. Burton concluded that Dr. Rizk failed to appropriately manage DS's drug-related problems on multiple occasions. Dr. Rizk attempted to manage two potentially life-threatening conditions on his own, without collaborating with Dr. [LB] or sending DS to the emergency room. He also failed to appropriately manage her diabetes and may have caused DS long-term damage, such as kidney damage, retinopathies and neuropathies, as DS's A1C was greater than 19% for at least 4-6 months. Dr. Burton commented that with an A1C over 19%, DS's blood sugars were upwards of 27.0 or greater which may put her at risk of ketoacidosis or hyperosmolar hyperglycemia, both of which can lead to hospitalization. Dr. Burton explained that in his practice he has never seen an A1C greater than 14% and patients suffer symptoms of hyperglycemia even at that level.

[199] Dr. Burton also opined that Dr. Rizk should not have prescribed medications off-label to treat DS, even where there is some evidence of their effectiveness, as a solo clinician. The medications that Dr. Rizk used off-label have the potential to cause harm and prescribing them outside of a team-based environment was inappropriate and may have worsened DS's condition.

Dr. Patrick Mayo, Expert Witness

[200] Dr. Mayo opined that Dr. Rizk had failed to collaborate with DS's primary care physician and her neurologist, and he thereby assumed full responsibility for her ongoing assessment, care and monitoring. This alone placed her at risk.

DS was harmed by Dr. Rizk's addition of a potent steroid, dexamethasone, used as an anti-inflammatory agent. This exacerbated her poor diabetic control and resulted in DS suffering sustained hyperglycemia with a hemoglobin A1C greater 19%. Dr. Mayo also explained that using steroids systemically risks toxicity in the body. It is preferable to inject steroids directly into the bursa, as Dr. [LB] had arranged for DS as this minimizes the risk of systemic toxicity.

[201] When DS presented with systolic blood pressure greater than 180 mmHg, a known medical emergency, Dr. Rizk prescribed clonidine and sent her home to self-monitor. This placed DS at risk of a stroke, heart attack, and end-organ damage to her heart, kidneys, liver and eyes. Dr. Rizk should have referred DS for immediate assessment by a medical team in a hospital emergency setting. A community pharmacy setting is not equipped to manage this condition, nor should DS have been placed on another drug, clonidine and told to self-monitor at home.

[202] Further, Dr. Rizk prescribed both venlafaxine and tramadol concurrently, which he should have known was duplicative. Dr. Mayo suggested this demonstrated Dr. Rizk's ignorance of the pharmacology and pharmacokinetics of both drugs and may have led to symptoms consistent with serotonergic syndrome, a known sequela of this combination. Dr. Rizk's omission to follow up with DS after determining she was suffering from serotonin syndrome was also concerning.

[203] Dr. Rizk also prescribed valproic acid and clomipramine based on small sample randomized trials demonstrating them to be third line medications. Dr. Mayo opined that this demonstrated Dr. Rizk's poor understanding of the interpretation of the quality of clinical evidence and how to interpret generalizability from a study to a specific patient.

Complaint 6940:

Mr. James Krempien, Complaints Director

[204] Mr. Krempien testified that he received a complaint based on an inspection report of Dr. Rizk's practice conducted by the Registrar of the Albert College of Pharmacy, Mr. Greg Eberhart. Mr. Krempien appointed Mr. Stanowich to investigate the complaint and prepare an investigation report. Upon reviewing the investigation report Mr. Krempien prepared a record of decision referring this complaint to the Hearings Director.

Mr. Greg Eberhart, Registrar, Alberta College of Pharmacy

[205] Mr. Eberhart testified that he has been the College's Registrar for just under 30 years. In May 2018, Mr. Eberhart ordered that Dr. Rizk's practice undergo an inspection by two inspectors from the College. The inspection was due to concerns that had arisen in 2017 and that led the Complaints Director to refer certain matters to the Hearings Director for a hearing before the Hearing Tribunal. The Registrar was concerned for public safety because the College had continued to receive concerns about Dr. Rizk and what he was doing in his practice remained unclear.

[206] The inspectors, Mr. Munchua and Ms. Patel conducted the inspection and prepared an inspection report in September 2018. Upon receiving the report, Mr. Eberhart provided a copy of it to Dr. Rizk and gave him the opportunity to respond. Dr. Rizk did respond, but Mr. Eberhart did not feel that Dr. Rizk had actually responded to the identified concerns. Mr. Eberhart felt the responsible thing to do would be to refer the matter to the Complaints Director, Mr. Krempien. It would then be for Mr. Krempien to follow up on the matters of concern and decide whether they should be referred to the Hearing Tribunal.

[207] Mr. Eberhart was then asked to speak to the College's expectations for prescribing pharmacists. He explained that pharmacists are knowledgeable about drug therapy and can enhance public access to drug care, but the premise for prescribing pharmacists is that they do not work in isolation. Pharmacists must collaborate and work in conjunction with other members of the health team. Every member of that team is responsible to understand their personal competence and limit their practice accordingly. Mr. Eberhart explained that collaboration can occur in different ways, but at a minimum, pharmacists must communicate their decisions to other members of the health care team. Other care providers must know what types of prescribing decisions have been made and why.

Mr. Mark Munchua and Ms. Rakhee Patel, Alberta College of Pharmacy Inspectors

[208] Mr. Munchua and Ms. Patel testified together, as a panel. Ms. Patel obtained her pharmacy degree from the University of Alberta in 2012 and thereafter practiced in community pharmacy before becoming a pharmacy practice consultant with the College. She maintains her practice in a community pharmacy 1-2 shifts each month. Ms. Patel also obtained additional prescribing authority and authority to administer drugs by injection. Ms. Patel explained she has completed practice reviews on approximately 250 pharmacies and met with hundreds of pharmacists. Her inspection of Dr. Rizk's pharmacy was the first practice inspection she had undertaken.

[209] Mr. Munchua has been a pharmacy practice consultant with the College since 2015. He previously worked in community pharmacy and also obtained additional prescribing authority and authority to administer drugs by injection. Mr. Munchua explained that he is typically involved in 350 pharmacy practice reviews each year. This was also the first pharmacy inspection Mr. Munchua had undertaken.

[210] Ms. Patel and Mr. Munchua received a direction from Mr. Eberhart to conduct an inspection of Dr. Rizk's pharmacy. Dr. Rizk was notified of the upcoming inspection and he was asked to provide five patient files for review. Dr. Rizk was asked to provide files in the areas of practice he was advertising on the pharmacy's website, namely weight loss, sexual health, chronic pain, congestive heart failure, COPD and psychiatric (mood) disorders, so that the inspectors could review Dr. Rizk's management of the cases over a six month period.

[211] Dr. Rizk provided the five patient files. Ms. Patel and Mr. Munchua each reviewed the files themselves, and then discussed their findings and impressions. It was then determined that an in-person inspection would also be conducted. This was done on July 25, 2018. Mr. Munchua and Ms. Patel met with Dr. Rizk to review the five patient charts, including additional documentation that Dr. Rizk deemed to show to them. Ms. Patel and Mr. Munchua also selected and copied two additional patient files at random to review.
Ms. Patel and Mr. Munchua noted that Dr. Rizk cooperated fully with the inspection and he permitted their meeting to be recorded. They then prepared an inspection report comparing Dr. Rizk's patient files to the College's Standards of Practice, code of ethics, and the key activities and indicators of pharmacist practice for additional prescribing authorization.

[212] Through their inspection, Ms. Patel and Mr. Munchua identified shared concerns with Dr. Rizk's lack of collaboration, his injection of medications in amounts exceeding clinical guidelines, the inappropriate ordering of laboratory tests and the critical appraisal of evidence

for clinical and prescribing decisions. They concluded his practice was unsatisfactory and unsafe and ineffective in some respects. It represented a marked departure from what they typically see in community pharmacies.

[213] Ms. Patel and Mr. Munchua then reviewed their investigation report which described the deficiencies in Dr. Rizk's practice. The first of these was Dr. Rizk's lack of collaboration with other health care professionals. They had attempted to contact other health care professionals to verify Dr. Rizk's claims that he had communicated about his clinical decision-making. While not all of the other health care professionals could be reached, two of them confirmed that they had received no such communications from Dr. Rizk. Ms. Patel's and Mr. Munchua's report concluded that Dr. Rizk consistently demonstrated a lack of appropriately involving other health professionals in the care of his patients. During the in-person inspection, Dr. Rizk was unable to provide specific examples of any clinically significant interactions with other health professionals for any of the cases they reviewed.

[214] In their testimony, Ms. Patel and Mr. Munchua referred to Case 3 as an example of this. In Case 3 Dr. Rizk independently managed a 36-year-old male patient complaining of insomnia, erectile dysfunction and requiring assistance with smoking cessation for 6 months. The patient did not have a primary care physician but Dr. Rizk made no attempts to assist the patient to find a physician over that period of treatment. Another example was Case 7. In Case 7 Dr. Rizk treated a patient with complaints of obesity and a yeast infection on his penis. Dr. Rizk gave no apparent consideration to including other professionals in the patient's obesity treatment. Dr. Rizk also conducted his own physical assessment of the patient's groin without considering that another health care professional would have been a better choice to do this.

[215] The second main deficiency was Dr. Rizk's judgment pertaining to the ordering of laboratory tests. Ms. Patel and Mr. Munchua concluded that Dr. Rizk ordered multiple unnecessary tests and there was insufficient rationale for ordering or considering the test results to guide his treatment decisions. As an example, they referred to Case 7 from their inspection report. In Case 7, Dr. Rizk was treating an adult male complaining of obesity and bloating. Dr. Rizk ordered unnecessary lab tests including homocysteine levels, rheumatoid factor, urinalysis, urine calcium and sodium, INR, and C reactive protein. Ms. Patel and Mr. Munchua found there was insufficient documentation that Dr. Rizk had considered or interpreted the results of most these tests that he ordered in making clinical decisions. They characterized Dr. Rizk's use of laboratory tests as having little regard for using health resources responsibly.

[216] The third main deficiency was in Dr. Rizk's prescribing of evidence-based treatment regimens. Ms. Patel and Mr. Munchua concluded that Dr. Rizk did not effectively use critical appraisal skills when evaluating evidence for many of the treatments he prescribed. He consistently prescribed medications for indications not approved by Health Canada and not considered best practice. He also failed to consider more conservative, or step-wise therapy options, the risk vs. benefit of add-on therapies, or evaluate the differential diagnoses when assessing his patients. Ms. Patel and Mr. Munchua concluded these failures put Dr. Rizk's patients at significant risk of harm.

[217] As an example of this Ms. Patel and Mr. Munchua referred to Case 3 again. They concluded that Dr. Rizk prescribed multiple agents for erectile dysfunction at the same time and contrary to the indications in the records. They said there was insufficient reliable evidence for his

decision to prescribe the agents and for the dosing that he used, and they added that it is very uncommon for pharmacists to try to treat erectile dysfunction. Another example was Case 4. In Case 4 Dr. Rizk was treating a 37-year-old female patient seeking assistance with weight loss. Dr. Rizk prescribed four different agents for weight loss and appetite suppression but he prescribed off-label with dosing that was not recommended. He prescribed bupropion for weight loss; but weight loss is not an approved indication of this drug. While there is some evidence it is effective in patients on caloric restrictions and an exercise regimen, Dr. Rizk did not include either of those in his plan for this patient. Dr. Rizk prescribed metformin for appetite suppression at its maximum dose, but appetite suppression is not an approved indication for metformin. He also prescribed chitosan for decrease fat absorption, but the evidence suggested that this drug may not be clinically significant. Ms. Patel and Mr. Munchua concluded that overall Dr. Rizk's prescribing practices were not appropriate.

[218] The fourth main deficiency was in Dr. Rizk's injection practice. Ms. Patel and Mr. Munchua concluded that Dr. Rizk's files contained consistent examples of him injecting multiple medications concurrently, in injection volumes of up to 4 ml. into the deltoid. Typically, 1-2 ml is the limit for a deltoid injection. Ms. Patel and Mr. Munchua were concerned that Dr. Rizk often lacked any rationale for administering medications by injection rather than oral therapy. They were also concerned that on multiple occasions he had prescribed and administered lidocaine into the deltoid to minimize pain from subsequent injections he administered. Ms. Patel and Mr. Munchua found Dr. Rizk did not provide sufficient good quality evidence to justify his treatments as safe and effective.

[219] As an example of this, Ms. Patel and Mr. Munchua referred to Case 1. Dr. Rizk prescribed and administered 6.3 ml of five medications into this patient's deltoid muscles. This was well in excess of what would be considered safe. In Case 5, which was a 52-year-old male patient with chronic joint pain, Dr. Rizk injected up to 8 ml. daily of six injectable medications into the patient's deltoids on February 22-23 and March 22-24, 2018. Dr. Rizk was therefore injecting up to 4 ml. in each deltoid muscle. He did not document which muscles he was injecting. Ms. Patel and Mr. Munchua also explained that some of Dr. Rizk's patients had injection administration records, but they were often incomplete and lacking a therapeutic assessment record.

[220] Ms. Patel and Mr. Munchua then reviewed each allegation in the Notice of Hearing for Complaint 6940 and referenced their findings in their inspection report.

Mr. Monty Stanowich, Investigator

[221] Mr. Stanowich explained he was appointed by Mr. Krempien to investigate complaint 6940. Mr. Stanowich identified the investigation report that he prepared. Mr. Stanowich explained that in the course of his investigation he first reviewed Mr. Eberhart's complaint letter and the attached inspection report from Ms. Patel and Mr. Munchua along with the supporting documentation they had reviewed. This supporting documentation was not in evidence.

[222] Mr. Stanowich then obtained Dr. Rizk's response to complaint 6940. Mr. Stanowich explained that Dr. Rizk responded by adding rebuttal comments to a copy of the inspection report. The general nature of Dr. Rizk's response was to disagree, attack and disparage the inspectors, suggesting they were lying and unable to assess him since they did not have PharmD

credentials. He also purported to provide clinical information about the cases and the drug therapies he had provided, such as the patients' responses to therapy, that he acknowledged was not documented in the patient files.

[223] Dr. Rizk asserted that all of the faxes contained in his files had been sent, but he acknowledged that fax confirmations were not retained. He also asserted that he had verbal communications with his patients' physicians, but failed attempts at this were not documented on a few occasions. He said there was collaboration and notifications of all of his prescribing decisions. Dr. Rizk also provided some literature that he said supported his claims, and correspondence from some physicians. Dr. Rizk did not attend the hearing to testify and be cross-examined about the quality of the literature as guidance for clinical practice, or about the correspondence on his files.

[224] Mr. Stanowich reviewed each of the seven patient files Ms. Patel and Mr. Munchua had obtained from Dr. Rizk. He wrote to each patient's physician with summaries and copies of all of the documentation that Dr. Rizk suggested he had sent to the physicians. Mr. Stanowich explained he received responses from six of those physicians.

[225] Dr. [Q] indicated he had reviewed his chart, but he had never seen Dr. Rizk's patient, nor had he ever received any of the documents Dr. Rizk's patient file suggested had been sent or even spoken with Dr. Rizk. Mr. Stanowich then determined that the number Dr. Rizk said he had used to fax documents to Dr. [Q] was not in service

[226] Dr. [R2] responded to Mr. Stanowich that he had not seen Dr. Rizk's patient since 2016. Dr. [R2] had not received any of the 15 documents that Dr. Rizk's patient file suggested he had faxed. Dr. [R2] had not received any other correspondence from Dr. Rizk about the patient either.

[227] Dr. [D] responded confirming that Dr. Rizk's patient was also her patient in the relevant time frame, but she had received only one of the sixteen documents Dr. Rizk's file suggested he had faxed to her.

[228] Dr. [S] responded to Mr. Stanowich that Dr. Rizk's patient was also his patient. Dr. [S] had received only 5 documents out of the 26 that Dr Rizk's patient file suggested he had faxed to Dr. [S] during the period covered by the inspection report.

[229] Dr. [E] responded that Dr. Rizk's patient had also been his patient. Dr. [E] recalled one telephone conversation with Dr. Rizk about the patient, but Dr. [E] had not received any of the documents Dr. Rizk suggested he had faxed to Dr. [E].

[230] Dr. [Z] responded that he had not received any of the 20 documents Dr. Rizk's patient file suggested he had faxed during the inspection period. Dr. [Z] said he received one fax refill request from Dr. Rizk dated August 21, 2018. Dr. [Z] said he also received a fax from Dr. Rizk's pharmacy on June 5, 2018 containing 21 pages and a telephone consult with Dr. Rizk about a patient on the same date. Mr. Stanowich noted that June 5, 2018 was after the inspection of Dr. Rizk's pharmacy had been ordered.

[231] Mr. Stanowich then reviewed the allegations in the Notice of Hearing for complaint 6940 referring to his investigation report.

V. SUBMISSIONS and FINDINGS

[232] Mr. Jardine submitted that the onus is on the Complaints Director to prove the allegations in the Notices of Hearing on a balance of probabilities. The Complaints Director must prove both the factual basis for the allegations, and that the proven facts are sufficiently serious to rise to the level of unprofessional conduct.

[233] Mr. Jardine explained that the College had received three separate complaints from regulated health professionals who were unaware of each other, and who were concerned about what Dr. Rizk was doing.

[234] Mr. Jardine submitted that Dr. Rizk's conduct gave rise to five common areas of concern. First, his conduct demonstrated a lack of collaboration, consultation or notification of other health professionals when treating patients with medication for serious, sometimes life-threatening conditions. Mr. Jardine characterized Dr. Rick's conduct as a fundamental misuse of his prescribing authority. That authority cannot be used to exclude all other health professionals involved in a patient's care.

[235] Second, Dr. Rizk had demonstrated a lack of awareness of his own limitations and the scope of his practice as a pharmacist. His responses demonstrated that he believed he was exceptionally competent, experienced and trained to diagnose and treat patients without adequate testing, documenting and monitoring. Dr. Rizk fundamentally misconceived of his role.

[236] Third, Dr. Rizk demonstrated a lack of respect and courtesy for other health professionals with whom he interacted. His immediate response was often to question the competence, stability and ethics of anyone who differed from his view of how to best treat patients. Dr. Rizk repeatedly asserted that he has a PharmD credential and that no one else was competent to question him. Mr. Stanowich explained that Dr. Rizk does not have a PhD in Pharmacy and his PharmD credential is not superior to a Canadian bachelor's degree in pharmacy.

[237] Fourth, Dr. Rizk's approach to clinical care created serious risks of patient harm. He approached health conditions with multiple prescriptions. He did not refer patients to more appropriate practitioners for assessment and diagnosis. He failed to conduct or consider adequate testing and monitoring results for his patient's health and safety.

[238] Fifth, Dr. Rizk's conduct gave rise to a governability issue. He failed to comply with his fundamental duties to the College in at least three respects. He failed to comply with the College's Standards of Practice for prescribing. Those standards cannot be understood as allowing prescribing pharmacists to act independently and fail to collaborate with other members of the patient's care team. He also lied to the College's investigator. Dr. Rizk suggested he had been communicating with his patients' physicians, but this was proven to be false in many instances. Any attempt to mislead the College's investigator is a fundamental problem in a self-regulating profession. Finally, Dr. Rizk had failed to fully cooperate with

the College's inspectors attempting to determine whether he was compliant with a November 17, 2018 interim order restricting him from prescribing Schedule 1 drugs and blood products and from administering drugs by injection.

[239] Mr. Jardine submitted that the Hearing Tribunal should conclude that the additional prescribing authority for pharmacists is subject to certain fundamental rules. The failure to comply with those rules amounts to a fundamental breach and cannot be tolerated. Dr. Rizk's failures as outlined above are very serious and placed patients at risk. Mr. Jardine also reviewed the provisions of the Standards of Practice and code of ethics and discussed the evidence in relation to the allegations in the notices of hearing.

[240] The Hearing Tribunal has considered the Complaints Director's evidence and arguments that the allegations should be found proven. The Complaints Director introduced a substantial amount of evidence of Dr. Rizk's larger involvement with the College, beyond Complaints 6463, 6774, 6785 and 6940. This evidence was introduced to refute any suggestion of a lack of objectivity in the complaints process. Dr. Rizk chose not to attend the hearing so he did not lead any evidence or make any arguments that the College or any of its staff lacked objectivity. The Hearing Tribunal reviewed all of Dr. Rizk's correspondence with the College and his responses to the complaints in coming to its decision.

ACP Complaint 6463: Allegation 1

[241] Allegation 1 in Complaint 6463 alleged that Dr. Rizk failed, while providing care to his patient, DL between May 17, 2017 and April 3, 2018 to notify DL's primary care physician of his prescribing activities and to collaborate with other health care professionals, including DL's primary care physician.

[242] The Hearing Tribunal found this allegation to be factually proven and that Dr. Rizk's conduct was unprofessional.

[243] Dr. [KB] testified that she had been DL's physician for at least 15 years when she learned that Dr. Rizk had been prescribing multiple medications for DL for 18 months without her knowledge. These included several medications intended by Dr. Rizk for weight loss, namely Xenical, Victoza, chitosan, topiramate, naltrexone and Wellbutrin XL, as well as zopiclone for insomnia.

[244] Dr. [KB] said that upon learning of this she contacted Dr. Rizk and he offered to prove that he had tried to contact her about DL's care. He faxed her a letter on May 7, 2018 which was erroneously dated Feb 28, 2018 and which suggested he had been sending correspondence to her about DL. Yet Dr. Rizk did not enclose any copies of any correspondence he had sent to Dr. [KB]. Dr. [KB] testified that she uses an EMR. She checked the EMR and even obtained the assistance of her EMR provider to ensure nothing had been missed, but she could locate no previous correspondence from Dr. Rizk about DL.

[245] Mr. Stanowich reviewed Dr. Rizk's response to the complaint and his assertion that he had faxed a number of documents to Dr. [KB] about DL These documents had no fax headers confirming the date they were faxed, the number they were faxed to or any indication that they were successfully transmitted.

[246] Mr. Stanowich also interviewed Dr. Rizk. Dr. Rizk confirmed that his fax procedures were not standardized before April 2018 and he was not keeping fax transmission logs. Dr. Rizk said that his assistant, Ms. [S] may have missed sending some faxes before April 2018. Mr. Stanowich also interviewed Ms. [S]. She said that she had been working at Dr. Rizk's pharmacy since approximately mid-2017 but they had just started sending faxes to physicians in April or May of 2018. She had not sent any faxes prior to April 2018 and she had no idea what was being sent. She said that if any faxes had been sent before April 2018, they would have been sent by Dr. Rizk himself. Ms. [S] began keeping fax transmission logs in April or May of 2018.

[247] The records Mr. Stanowich reviewed confirmed that Dr. Rizk assessed DL and initiated weight loss and insomnia therapies himself. This was done without notifying or collaborating with Dr. [KB] or anyone else involved in DL's care.

[248] Subsections 1(1)(pp)(i), (ii), (vii) and (xii) of the HPA define "unprofessional conduct" as inclusive of the following:

> (pp) "unprofessional conduct" means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) Contravention of this Act, a code of ethics or Standards of Practice;
>
> …
>
> (vii) failure or refusal
>
> …
>
> (B) to comply with a request of or cooperate with an investigator,
>
> …
>
> (xii) conduct that harms the integrity of the regulated profession;

[249] The College's Standards of Practice for Pharmacists and Pharmacy Technicians provide at standard 1.4 that when required to serve the best interests of the patient, each pharmacist must work collaboratively with colleagues, including other regulated health professionals. This obligation includes making appropriate and efficient use of the expertise and availability of colleagues.

[250] Standards 11 to 15 are also applicable to pharmacists who prescribe. These standards demonstrate the fundamental importance that the College and the profession place on communication and collaboration in the prescribing practices of pharmacists with authorization to do so.

[251] Standard 11.1 provides that a pharmacist must understand the restrictions and requirements applicable to prescribing by pharmacists in the standards and in the Pharmacists and Pharmacy Technicians Profession Regulation. Standard 11.2 confirms that a pharmacist who chooses to engage in prescribing must prescribe in accordance with the standards.

[252] Standard 11.9 definitively provides that a pharmacist who prescribes a drug or blood product must communicate as soon as reasonably possible to any regulated health professionals whose care of the patient may be affected by their prescribing decision. A pharmacist who prescribes must notify the other regulated health professional that they have prescribed for the patient, the type and amount of drug prescribed, the rationale for prescribing, the date the drug was prescribed and instructions that they gave to the patient, if applicable.

[253] Standards 14.2 and 14.4 are also important. Standard 14.2(c) provides that a pharmacist who prescribes a Schedule 1 drug or blood product for a patient at initial access or to manage ongoing therapy must have a strong collaborative relationship with a regulated health professional acting within the scope of their profession who regularly sees the patient in person. Standard 14.4 requires a pharmacist who prescribes at initial access or to manage ongoing therapy to take reasonable steps to (a) determine which other regulated health professionals the patient is consulting, and (b) communicate as soon as reasonably possible to any regulated health professionals.

[254] Further, standard 14.5 provides that a pharmacist who prescribes at initial access based on the pharmacist's own assessment of the patient must (a) in the case of a previously diagnosed condition, endeavor to develop a collaborative relationship with other regulated health professionals identified under standard 14.4, and (b) in the case of a condition that as not previously diagnosed, refer the patient to another regulated health professional if diagnosis or further treatment by another regulated health professional is necessary.

[255] Finally, standard 14.10 provides that a pharmacist who prescribes at initial access or to manage ongoing therapy must, as soon as reasonably possible, contact the patient's usual prescriber, where applicable, to communicate the information required in standard 11.9.
Similar obligations are found in the College's Code of Ethics in principles 1(1), (14), (15) and 12(2).

[256] Dr. Rizk clearly Contravened Standards of Practice 1.4, 11.9, 14.2(c), 14.4 and 14.5(b). Dr. Burton testified as an expert in clinical pharmacy with a focus and experience in obesity and diabetes management. Dr. Burton explained that obesity is a complex, multi-factorial disease that is best managed and monitored with a team-based approach. Dr. Burton testified that Dr. Rizk had failed to communicate and collaborate with other members of DL's healthcare team as required. Without this communication and collaboration, Dr. [KB] was unaware of what medications had been prescribed, therapies that had been tried and issues that may have come up. This failure to communicate and collaborate may have led Dr. [KB], or Dr. Rizk to make incorrect diagnoses, prescribe duplicate therapies, cause drug interactions or harmful interventions. The Hearing Tribunal accepted Dr. Burton's evidence that Dr. Rizk's conduct posed a serious risk of harm to DL

[257] The Hearing Tribunal was also satisfied that Dr. Rizk's conduct demonstrated a lack of knowledge, skill and judgment in the provision of pharmacy services. Clinical pharmacists are an important part of patient's overall health care team, but they are just one part. Pharmacists must understand the limitations of their knowledge and clinical skills and recognize the importance of collaborating with their patients' primary care physicians and medical specialists. Dr. Rizk's conduct also tends to harm the integrity of the pharmacy profession in

the public's eye. The public should be able to expect pharmacists to diligently comply with Standards of Practice and to exercise evidence-based knowledge, skill and judgment.

Complaint 6463: Allegation 2

[258] Allegation 2 in Complaint 6463 alleged that Dr. Rizk consistently increased DL's medication doses and prescribed additional medications for him despite the fact that:

(a) DL was meeting the treatment goals Dr. Rizk established;
(b) Dr. Rizk did not consider the concerns and professional advice that Dr. [KB] provided to DL as reported by DL and failed to discuss those reported concerns with Dr. [KB];
(c) Dr. Rizk did so without appropriately monitoring DL by ordering and reviewing objective data, including laboratory tests to assess organ function; and
(d) Dr. Rizk did not consider alternatives to increasing the medication doses and prescribing additional medications, including collaboration with other health professionals and the use of non-drug therapies to assist in weight-reduction.

[259] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[260] Dr. [KB] testified that when DL disclosed to her that he had been seeing Dr. Rizk for assistance with weight loss, she reviewed his prescriptions on Netcare. She then asked DL to see her so she could understand why the medications had been prescribed. She said that DL told her that Dr. Rizk had not advised him that the medications were being prescribed off-label, nor that the medications could pose risks or cause side-effects.

[261] Mr. Stanowich testified about Dr. Rizk's response to the complaint. Dr. Rizk suggested that a prescribing pharmacist could prescribe any drug as long as its use was based on peer-reviewed evidence. As a result, he felt that so long as his off-label use of the drugs he prescribed for DL was supported by some evidence, their use was within his scope of practice and considered safe. Dr. Rizk suggested he had explained this to DL but he provided no charting of any such discussion. Dr. Rizk also suggested he had written to Dr. [KB] about it, but the suggestion that Dr. Rizk had corresponded with Dr. [KB] was addressed above.

[262] Dr. Rizk's response attached a letter from DL in which DL described his encounters with Dr. [KB]. DL's letter explained that when Dr. [KB] learned of Dr. Rizk's prescribing, she questioned DL about the purpose of the drugs he was taking. She expressed concern about his use of topiramate and possible cognitive issues. Dr. [KB] also questioned whether DL was addicted to drugs or suffering from depression, and when he denied these things she recommended DL stop taking naltrexone. Dr. [KB] also asked DL if Dr. Rizk had explained to him what the medications were for. DL replied that "Dr. Rizk was very thorough in his explanations and he answered all the questions regarding the benefits of these medications." While Dr. Rizk suggested the letter from DL confirmed that DL was aware of the risks and

side-effects of the medications, there was no mention by DL of Dr. Rizk disclosing that the medications were being used off-label, or of any risks or potential side-effects. DL later told Mr. Stanowich in an interview that Dr. Rizk had discussed the potential risks and side effects with him.

[263] Dr. Rizk's response to the complaint included what he described as "evidence-based peer-reviewed literature" supporting his use of topiramate and naltrexone/bupropion. In response to the concern about his failure to use appropriate laboratory tests he said he relied on testing that Dr. [KB] had performed. He also said that he gave DL lab requisitions in October 2017 and again later on, but there was no documentation of follow-up on these.

[264] Mr. Stanowich described Dr. Rizk's prescribing history for DL. Dr. Rizk started DL on liraglutide and orlistat on May 17, 2017. He twice increased the dose of liraglutide within a period of two weeks with no documented objective assessment or observations of DL's weight to justify the increased dose. On June 16, 2017 Dr. Rizk documented that significant weight loss for DL would be 2-3 pounds over 2 weeks. Even though DL had by that point lost 10 pounds over the preceding 4 weeks, Dr. Rizk again increased the dose of liraglutide. By July 12, 2017 DL had lost 16 pounds over the preceding 9 weeks but Dr. Rizk added a new medication, topiramate which was not indicated by Health Canada for weight loss. There was no documentation of why Dr. Rizk added this medication. By September 27, 2017 DL was down 27 pounds and Dr. Rizk had repeatedly increased the dose of topiramate and added injectable vitamins. Dr. Rizk added a diclofenac compound for injection site pain on October 18, 2017 but changed that to intramuscular lidocaine on November 10, 2017, even though he documented that the injection site pain had "resolved completely". As of December 6, 2017, DL had lost 4.2 pounds over the preceding 4 weeks, and he was at the upper limit of the target weight loss range. Dr. Rizk responded by prescribing two additional medications, naltrexone and bupropion. Mr. Stanowich testified that these are indicated by Health Canada for smoking cessation and for seizures. They are not indicated for weight management. On December 20, 2017 DL failed for the first time in his treatment with Dr. Rizk to reach his weight loss target. Dr. Rizk responded by doubling his dose of naltrexone on December 20, 2017 and increased it again on January 4 and January 18, 2018. On February 7, 2018 Dr. Rizk doubled DL's daily dose of bupropion. On February 28, 2018 Dr. Rizk attributed DL's complaints of insomnia and irritability to the bupropion and reduced its dose. He attributed an additional complaint of blurred vision to the topiramate, and began to taper it, despite that DL had been on a stable dose of topiramate since September 26, 2017. Dr. Rizk then added a new medication, zopiclone for sleep on February 28, 2018 but there was no indication that he considered any differential diagnoses or a referral to another health care provider to assess DL's neurological symptoms.

[265] Mr. Stanowich emphasized that throughout his treatment of DL, Dr. Rizk had collected no objective data to monitor DL's organ function and he omitted to notify Dr. [KB] or anyone else of what he was doing, or how DL was reacting.

[266] Dr. Burton explained that Dr. Rizk did not check many of the parameters for DL that should have been confirmed prior to staring weight-loss treatment. Dr. Burton also confirmed that Dr. Rizk did not appropriately monitor DL's organ function during treatment. He noted that Dr. Rizk continued to increase and add medications despite the lack of any evidence that DL was going for the necessary lab work.

[267] Dr. Burton also opined on Dr. Rizk's pattern of prescribing for DL. He explained that Dr. Rizk inappropriately prescribed ondansetron to manage DL's nausea from taking the liraglutide. Dr. Rizk also used a diclofenac compound and then injectable lidocaine to manage injection site pain instead of withdrawing the vitamin injections that were the cause of the pain and this was inappropriate and unethical. There was no record of DL having any vitamin deficiency or condition requiring supplemental vitamins. Dr. Rizk prescribed zopiclone to manage DL's insomnia rather than reducing the likely cause of the insomnia, which was the bupropion that Dr. Rizk had recently increased and instructed DL to take twice a day, instead of once in the morning as it is generally prescribed. Dr. Mayo described this as a "prescribing cascade" and explained that it is inappropriate and unethical, as it increases the risk of adverse effects. Dr. Burton and Dr. Mayo also explained more generally that obesity treatment should not be based on medication therapies alone. Lifestyle variations should be the foundation of all obesity treatments, but Dr. Rizk had omitted to consider including any such variations in the treatment plan for DL. Dr. Burton concluded that Dr. Rizk prescribed new medications and escalating therapies while failing to appropriately assess and monitor DL

[268] Dr. Mayo reviewed Dr. Rizk's response to the complaint and the treatment provided to DL. Dr. Mayo noted that by February 18, 2018 Dr. Rizk had DL on 5 medications for weight loss. Dr. Mayo explained that several of the medications Dr. Rizk prescribed for DL were not approved for weight loss use by Health Canada. These were topiramate, bupropion and naltrexone. The reason these medications have not been approved is that there is insufficient clinical evidence in the form of randomized controlled trials to prove that the efficacy of the drugs outweighs their risks. Further, the combination of medications and dosages Dr. Rizk was using had not been tested, and this is why the combination was not approved either. Dr. Mayo reviewed Dr. Rizk's prescribing and opined that Dr. Rizk had added medications like topiramate without apparent reason, since DL's weight loss exceeded the weight loss target recommended by the manufacturer of approved weight loss medications. Dr. Mayo concluded that Dr. Rizk placed DL at higher risk through the use of multiple, unapproved drugs. Dr. Rizk also placed himself in a position of being solely responsible for any harm to DL; and DL did suffer harm. As examples, Dr. Mayo referred to nausea, injection site pain, insomnia, potential cardiac consequences, potential sleep abnormalities and behavioral changes. The Hearing Tribunal also noted DL had complained of blurred vision, and Dr. Rizk attributed this to the topiramate and purported to manage this himself. This was very concerning as vision disturbances suggest possible adverse neurological effects.

[269] The College's standard of practice 3.1(a) requires pharmacists to consider appropriate information to assess the patient and the patient's health history and history of drug therapy each time the pharmacist prescribes a Schedule 1 drug, conducts a review of a patient's drug utilization or provides advice to a patient about a drug or drug therapy.

[270] Standard 11.6 provides that a pharmacist must not prescribe a drug unless the intended use is an indication approved by Health Canada, considered a best practice or accepted clinical practice in peer-reviewed clinical literature or part of an approved research protocol.

[271] Standard 14.1 provides that a pharmacist must not prescribe at initial access or to manage ongoing therapy unless the prescribing decision is in the best interests of the patient and the pharmacist has taken the appropriate steps to maintain patient safety. Standard 14.3 specifically requires a pharmacist who prescribes at initial access or to manage ongoing therapy

to conduct a patient assessment including consideration of physical qualities, laboratory values where applicable, diagnostic and other relevant health information.

[272] As above, Dr. Rizk did not comply with these standards. He failed to obtain and consider appropriate data about DL's health and heath history before embarking on a solo effort to treat DL with a complex and escalating drug treatment regimen for a complex medical condition and the resulting effects. Dr. Rizk also prescribed drugs for indications that were not approved by Health Canada and disregarded Dr. [KB's] concerns as reported by DL and omitted to attempt to discuss them with her. Despite Dr. Rizk's assertions to the contrary, Dr. Mayo opined that there was insufficient clinical evidence that the drug combinations and dosages that Dr. Rizk was using were accepted clinical practice. Dr. Rizk persisted in his escalating drug treatment regimen for DL despite the fact that DL was meeting and at times exceeding Dr. Rizk's own assessment of what would be significant weight loss. He also failed to consider and suggest that DL's weight loss goals would be best addressed through collaboration with other health professionals and the use of non-drug therapies to assist in weight-reduction.

[273] The Hearing Tribunal was also satisfied that Dr. Rizk's conduct demonstrated a lack of knowledge, skill and judgment in the provision of pharmacy services. Dr. Rizk's conduct suggested a lack of insight into the limitations of drug therapy and a concerning degree of insularity. The evidence demonstrates that Dr. Rizk's course of action exposed DL to significant risks, and that he actually experienced several of them. Dr. Rizk's conduct also tends to harm the integrity of the pharmacy profession in the public's eye. The public should be able to expect pharmacists to diligently comply with Standards of Practice and to exercise evidence-based knowledge, skill and judgment.

Complaint 6463: Allegation 3:

[274] Allegation 3 in Complaint 6463 alleged that Dr. Rizk potentially placed DL at risk when he prescribed him five different prescription medications for weight loss concurrently, three of which are not indicated for that use by Health Canada.

[275] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[276] Dr. Mayo opined that Dr. Rizk prescribed five medications for DL for weight loss, but three of these, topiramate, bupropion and naltrexone were prescribed off-label. This meant that these medications and the combination of drugs and dosages Dr. Rizk was using were not approved by Health Canada. Dr. Mayo further explained that there is insufficient clinical evidence in the form of randomized controlled trials to prove the efficacy of topiramate, bupropion or naltrexone in the combinations Dr. Rizk was using, versus their risks. Patients need to be apprised when they are exposed to additional risks and more closely monitored, but the evidence demonstrated that DL was not. Dr. Mayo concluded that Dr. Rizk placed himself in a position of being solely responsible for any risk of harm to DL, and then exposed DL to higher risks through the use of multiple, unapproved drugs.

[277] The Hearing Tribunal considered that Dr. Rizk's conduct Contravened standard of practice 11.6, as described above. He also Contravened principles 1(1) and (2) of the College's Code of Ethics. These require pharmacists to act in the best interests of the patient and provide

appropriate treatment and care. The Hearing Tribunal was also satisfied that Dr. Rizk's conduct demonstrated a lack of knowledge, skill and judgment in the provision of pharmacy services. Dr. Rizk's conduct suggested a failure to place his patient's health and safety above his own desire to treat complex health conditions with drug therapy. Dr. Rizk's conduct also tends to harm the integrity of the pharmacy profession in the public's eye. The public should be able to expect pharmacists to diligently comply with Standards of Practice, the code of ethics and to exercise evidence-based knowledge, skill and judgment.

Complaint 6463: Allegation 4

[278] Allegation 4 alleged that Dr. Rizk managed adverse events and treatment failures for DL by prescribing additional medication rather than undertake further assessment and consider other alternatives, or collaborate with, or refer DL to other healthcare practitioners.

[279] The Hearing Tribunal found this allegation proven and the conduct to be unprofessional.

[280] The evidence demonstrated that Dr. Rizk managed issues in DL's drug therapy by prescribing additional medications. He added ondansetron to manage nausea caused by liraglutide, but Dr. Burton opined that this was not appropriate. Dr. Burton said that if the nausea was so significant that a medication as significant as ondansetron was needed to manage it, then Dr. Rizk should instead have discontinued the liraglutide. Dr. Rizk added topiramate on July 12, 2017 with no apparent indication. He added injectable cyanocobalamin, pyridoxine and thiamine on September 27, 2017 despite the lack of any indication of a vitamin deficiency or other justification, and despite that the vitamins could have been taken orally. He added a topical diclofenac compound on October 18, 2017 to manage injection site pain rather than withdraw the pain-inducing injections. On November 10, 2017 Dr. Rizk switched the diclofenac to lidocaine for the same issue, despite that lidocaine can have systemic side effects. By December 6, 2017 Dr. Rizk added naltrexone and bupropion, neither of which are indicated by Health Canada for weight loss even though DL was already at the upper limit of the target weight loss range. Dr. Rizk also added zopiclone to partially address DL's reports of insomnia on February 28, 2018.

[281] Dr. Mayo described the use of additional medications to manage adverse side-effects as a "prescribing cascade". Dr. Mayo explained that the practice is problematic as it increases the risk of adverse effects. For example, he said that ondansetron can cause life-threatening arrhythmias and should therefore be used for the shortest time period possible. Zopiclone can cause sleep abnormalities and behavior changes and should also be used for the shortest possible timeframe. Further, injection-site pain is an important sign that something may be wrong, such as inflammation or tissue damage. Preventatively masking such pain using diclofenac or lidocaine defeats the purpose of pain, and it could lead to the patient being unaware of a serious concern. Dr. Mayo opined that when adverse effects appeared, Dr. Rizk should have discontinued the drug therapy.

[282] The Hearing Tribunal was satisfied that Dr. Rizk prescribed additional medications to manage adverse events and treatment failures, rather than undertaking further assessment and considering alternatives or collaborating. He failed in the best interests of his patient, and to provide appropriate treatment and care, contrary to principles 1(1) and (2) of the College's Code of Ethics. Dr. Rizk also failed to comply with standard 14.1, which provides that a

pharmacist must not prescribe to manage ongoing therapy unless the prescribing decision is in the best interests of the patient, and the pharmacist has taken the appropriate steps to maintain patient safety. Standard 14.3 supplements this and provides that to obtain adequate information, a pharmacist who prescribes to manage ongoing therapy must conduct a patient assessment, including physical qualities, lab values where applicable, diagnostic and other relevant health information and the date and extent of the last assessment of the condition by another regulated health professional and the results of that assessment.

[283] The Hearing Tribunal also considered Dr. Rizk's conduct to demonstrate a lack of knowledge, skill and judgment in the provision of pharmacy services. The evidence demonstrated that Dr. Rizk should have managed adverse events and treatment failures by withdrawing the offending agents and re-evaluating his approach. He failed to do so and proceeded without regard for his own limitations. This conduct would also tend to harm the pharmacy profession in the eyes of the public.

Complaint 6463: Allegation 5

[284] Allegation 5 alleged that Dr. Rizk failed to provide Dr. [KB] with copies of the communications and notifications of prescribing information regarding their mutual patient, DL, which she requested on May 1, 2018 and that Dr Rizk claimed to have sent her between May 2017 and April 3, 2018.

[285] The Hearing Tribunal found this allegation proven and to constitute unprofessional conduct. Dr. [KB] testified that after she made her complaint to the College, Dr. Rizk contacted her on May 1, 2018. He suggested he had been trying to correspond with her about DL's care. Dr. [KB] said that she requested Dr. Rizk to send her all of the prescribing notifications and other communications that he claimed to have sent in the past.

[286] Dr. Rizk faxed Dr. [KB] a letter on May 7, 2018 but incorrectly dated February 28, 2018. Dr. Rizk's letter asserted that he had been faxing Dr. [KB's] office with notifications about his care of DL and that he had called her office on two occasions and left messages for call-back but none was received. Dr. Rizk's letter enclosed no evidence that he had ever before written to Dr. [KB] or attempted to contact her.

[287] Dr. [KB] responded to Dr. Rizk on May 9, 2018. She pointed out that Dr. Rizk had still not provided any evidence that he had notified her he had been prescribing for DL. Dr. [KB] said she was concerned that Dr. Rizk had been prescribing for DL without notifying her. Dr. [KB] further stated that she had reviewed the patient's chart and spoken with her staff and she had no documentation of any faxes or phone calls from Dr. Rizk.

[288] The foregoing analysis described a number of Standards of Practice requiring prescribing pharmacists to communicate and collaborate with their patient's primary care physicians and other members of the health care team. Dr. Rizk's failure to comply with those obligations was described under allegation 1. In this instance, Dr. Rizk contacted DL's primary care physician to discuss her concerns with the care he was providing. When Dr. [KB] indicated she had been unaware of Dr. Rizk's actions and asked him to send copies of his prescribing notifications and other communications he had allegedly sent, Dr. Rizk failed to comply. Dr.

Rizk instead sent a letter in which he claimed to have complied with the Standards of Practice but provided no evidence.

[289] The Hearing Tribunal considered that Dr. Rizk's conduct tends to harm the integrity of the profession of pharmacy. Dr. Rizk failed to comply with a reasonable request from his patient's primary care physician for copies of his correspondence. He also attempted to mislead Dr. [KB] by suggesting he had been writing to her and calling her office, while providing no evidence of his correspondence. The public should be entitled to expect that pharmacists will communicate honestly and openly with other members of their health care teams, in order to promote the public's best interests as health care consumers.

Complaint 6463: Allegation 6

[290] Allegation 6 alleged that Dr. Rizk misled and failed to cooperate with an investigator appointed by the Complaints Director of the College when he falsely claimed that he had attempted to collaborate and provide Dr. [KB] with the documentation pharmacists are required to provide to other members of the healthcare team by fax on 25 separate occasions and by phone on two occasions.

[291] The Hearing Tribunal found this allegation 6 to be proven and that Dr. Rizk's conduct amounted to unprofessional conduct.

[292] Mr. Stanowich testified that Dr. Rizk's response to the complaint asserted that he had sent faxes to Dr. [KB] and attempted to contact her by phone on two occasions, June 15 and December 7, 2017, but she had not responded.

[293] Dr. Rizk's written response to the complaint attached a number of prescriptions and documents entitled "Prescribing Notification/Managing Ongoing Therapy" and "Renewal Notification of Rx Medication" with handwritten notes addressing them to Dr. [KB] and indicating a fax number. There were no fax headers on any of these documents indicating a date they had been faxed, the number they were faxed to or any indication of successful transmittal. Dr. Rizk's response provided no other evidence of the successful transmittal of these documents either, such as a fax transmission log.

[294] The Hearing Tribunal also noted Mr. Stanowich's evidence that when he interviewed Dr. Rizk, Dr. Rizk advised his fax procedures were not standardized before April 2018 and he did not keep fax transmission logs. Dr. Rizk had also acknowledged that his assistant, Ms. [S] may have missed sending some faxes before April 2018, but Ms. [S] had indicated she wasn't sending any faxes before April or May of 2018 and had no idea what was being sent.

[295] Dr. [KB] testified that she had checked her patient chart, with her staff and with her EMR provider, but prior to Dr. Rizk's fax on May 7, 2018 she had received no correspondence from Dr. Rizk about DL at all. Dr. [KB] had pointed this out to Dr. Rizk in her May 9, 2018 letter to him, but he made no effort to prove that he had actually been corresponding with her.

[296] The Hearing Tribunal concluded that Dr. Rizk's response to the complaint misled and failed to cooperate with Mr. Stanowich when he falsely claimed that he had attempted to collaborate and provide Dr. [KB] with documentation about the care he was providing to DL. Mr.

Stanowich was appointed an investigator by Mr. Krempien, and Dr. Rizk had a regulatory obligation to comply with the investigation. Dr. Rizk's misleading statements to Mr. Stanowich and his failure to cooperate and respond in a forthright, honest manner was unprofessional conduct as defined by section 1(1)(pp)(vii)(B) of the HPA. The Hearing Tribunal considers pharmacists' obligation to comply with the lawful regulatory investigations to be very important. Pharmacists who refuse to cooperate undermine the College's ability to regulate the pharmacy profession in the public interest and this places the public at risk.

Complaint 6774: Allegation 1

[297] Allegation 1 in Complaint 6774 alleged that Dr. Rizk failed to collaborate with other health professionals in his care of patient AH, including when he:

a. Failed to contact Dr. H., AH's primary care physician after altering AH's medications;
b. Failed, between February 2, 2018 and August 30, 2018, to provide updates to AH's second primary care physician, Dr. R., including after he prescribed azithromycin and levofloxacin to AH for bacterial pneumonia on July 5, 2018 and July 13, 2018, respectively;
c. Failed to update AH's nephrologist, Dr. P, of the changes you were making to AH's insulin, which resulted in Dr. P instructing you not to manage the nephrology aspects of AH's care;
d. Failed to disclose your assessment modalities to the complainant, G.B., a clinical pharmacist who was part of AH's hospital care team after he was admitted to the Misericordia Hospital on July 13, 2018;

[298] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[299] Mr. Stanowich testified about Dr. Rizk's response to the complaint. Dr. Rizk's response confirmed that he had taken over caring for AH from Dr. [H] and he asserted that AH had improved under his care, including prescriptions he had written for AH. Dr. Rizk asserted that he had sent some 50 pieces of correspondence, including notices of his prescribing decisions and renewal notifications to Dr. [H], and then to AH's next primary care physician, Dr. [R] as well as to AH's nephrologist, Dr. [P].

[300] Mr. Stanowich corresponded with each of Dr. [H], Dr. [R], and Dr. [P]. Dr. [H] confirmed that his practice is that all faxes are placed on his desk for him to review, then filed in the patient's chart. He had reviewed his chart for AH, but he had not received any of the documents Dr. Rizk had suggested he had faxed. Dr. [H] also said he had never spoken with Dr. Rizk, nor received any written communications or collaboration from him. Dr. [R] confirmed that he had two phone calls with Dr. Rizk. The first was in the fall of 2017, after Dr. [R] became aware that Dr. Rizk had made changes to AH's medications without informing him. This was confirmed in a partial telephone recording of a call between Dr. [R] and Dr. Rizk that Dr. Rizk provided with his response to the complaint. The second call was in October 2018. Dr. Rizk had called Dr. [R] to see if Dr. [R] had been receiving faxes from him. Dr. [R] said he had not. Dr. [R] also confirmed he had not been aware that Dr. Rizk had seen AH and prescribed

antibiotics for him on July 5 and 13, 2018. Mr. Stanowich also spoke with Dr. [P]. Dr. [P] said he could find no evidence of paper or electronic copies of the faxes Dr. Rizk had suggested he had sent, other than one faxed medication list dated June 27, 2018. Dr. [P] also recalled one phone conversation with Dr. Rizk in which Dr. Rizk questioned changes Dr. [P] had made to AH's drug regimen. Dr. [P] then instructed Dr. Rizk that he would manage AH's care going forward.

[301] Mr. Stanowich interviewed Dr. Rizk on January 18, 2019 and followed up with written questions. Dr. Rizk was asked to provide proof of the faxes he claimed to have sent to Dr. [H], Dr. [R] and Dr. [P]. Dr. Rizk was unable to demonstrate that he had sent more than one of them.

[302] Ms. [GB] testified that she had spoken with AH and pointedly asked him who was managing his insulin. AH said Dr Rizk. Ms. [GB] also said she learned from Dr. [R] that Dr. Rizk had been adjusting AH's insulin without notifying him. This prompted Dr. [R] to contact Dr. Rizk and reinforce that he needed to communicate if he would be adjusting AH's medications. Dr [R] also confirmed to Ms. [GB] that he had not known that Dr. Rizk prescribed antibiotics for AH on July 5 or 13, 2018.

[303] Ms. [GB] testified that after AH was admitted to the ICU, she contacted Dr. Rizk and asked him why he had decided to prescribe oseltamivir and Levaquin for AH on July 13, 2018. She specifically asked Dr. Rizk about the diagnostic criteria he had used to prescribe those medications, such as whether he had obtained a chest x-ray, lab work, pulse oximetry or if he had auscultated AH's chest. Ms. [GB] testified that Dr. Rizk did not respond to these questions. He responded that the patient did not want to go to the hospital so what else was he to do? Ms. [GB] testified that when a patient is standing in front of a pharmacist with shortness of breath, there is no way for the pharmacist to know what is going on. The differential diagnoses for a patient in that condition includes serious medical conditions and AH should have been referred to a physician for assessment.

[304] Based on the foregoing the Hearing Tribunal concluded that Dr. Rizk failed to collaborate with other health professions in his care of AH. The applicable Standards of Practice are described earlier in this decision. The Hearing Tribunal considered that Dr. Rizk's conduct Contravened standards 1.4, 11.9, 14.2(c), 14.4 and 14.5 and principles 1(1), (14), (15) and 12(2) of the Code of Ethics.

[305] The Hearing Tribunal was also satisfied that Dr. Rizk's conduct demonstrated a lack of knowledge, skill and judgment in the provision of pharmacy services. Dr. Rizk did not appear to recognize that clinical pharmacists are only one part of patient's overall health care team, and that each part must recognize their own limitations. Dr. Rizk's conduct also tends to harm the integrity of the pharmacy profession. The public should be able to expect pharmacists to diligently comply with Standards of Practice.

Complaint 6774: Allegation 2

[306] Allegation 2 in Complaint 6774 alleged that Dr. Rizk failed to exercise the clinical judgment expected of an Alberta pharmacist when he:

a. chose to prescribe an antibiotic (levofloxacin) to AH over the telephone even after you knew AH had previously failed on two courses of antibiotics (doxycycline and azithromycin);
b. chose to prescribe Oseltamivir to AH over the phone on July 13, 2018;
c. adjusted AH's insulin doses without consulting his nephrologist, Dr. P and after Dr. P instructed you not to manage the nephrology aspects of AH's care;
d. failed to consider standard diagnostic criteria when you assessed AH for AECOPD and pneumonia;
e. failed to self-reflect or consider how your prescribing decisions contributed to the outcome of AH; and
f. failed to respect the opinions of AH's hospital care team following his admission to the Misericordia Hospital on July 13, 2018, including when you said "[the hospital pharmacist] and her team showed incompetence and lack of knowledge about community acquired pneumonia and this jeopardized (sic) patient's health";

[307] The Hearing Tribunal determined that this allegation was factually proven and that Dr. Rizk's conduct was unprofessional.

[308] Ms. [GB] testified that prior to contacting Dr. Rizk, she determined that Dr. [R] had prescribed doxycycline and prednisone for AH on June 18, 2018. She noted that AH then saw Dr. Rizk on July 5, 2018 and he prescribed a different antibiotic, azithromycin. On July 9, 2018 AH saw Dr. [R] and he prescribed a new inhaler and a cough suppressant. On July 13, 2018 Dr. Rizk saw AH again and this time prescribed oseltamivir and Levaquin/ levofloxacin.

[309] Ms. [GB] testified that she asked Dr. Rizk why he had prescribed a different antibiotic for AH on July 5, 2018. He told her that the patient had chronic obstructive pulmonary disease and was still feeling unwell, with fatigue and increased yellow sputum. Dr. Rizk said he felt the patient was reacting to the doxycycline, so he prescribed a second line agent, azithromycin. When Ms. [GB] probed further, asking about the criteria Dr. Rizk had used to diagnose AH with AECOPD and for prescribing antibiotics, Dr. Rizk only referred to the patient's symptoms of fatigue, increased cough and sputum. Ms. [GB] said she explained to Dr. Rizk that the diagnosis and prescription of antibiotics should only be done with the benefit of a chest x-ray and auscultation of the patient's chest. She said she asked if Dr. Rizk had done either of those, or if he had acquired any other information such as blood work or pulse oximetry. Dr. Rizk only referred to the patient's increased fatigue, increased cough and sputum.

[310] Ms. [GB] then explained that on July 13, 2018 Dr. Rizk had contacted AH to see how he was doing. AH said he was not doing well, so Dr. Rizk asked AH to come to the pharmacy for more prescriptions. Dr. Rizk gave AH new prescriptions for oseltamivir and Levaquin/levofloxacin. Ms. [GB] testified that she asked Dr. Rizk for his diagnostic criteria to prescribe these medications on July 13, 2018, and whether he had obtained a chest x-ray, lab work, pulse oximetry or auscultated the patient's chest. Dr. Rizk did not respond to these questions. He responded that AH had refused to go to the hospital so what was he to do? He then asked, "how is what I did any different from what a physician would do?"

[311] Mr. Stanowich testified that he interviewed Dr. Rizk and asked him about his differential diagnoses and the objective data he observed when he prescribed oseltamivir and Levaquin on July 13, 2018. In the interview, Dr. Rizk said that he considered COPD, chronic bronchitis and he used a CURB-65 form. In his written response to a follow-up question, Dr. Rizk suggested that he also considered viral/bacterial pneumonia, mild pneumonia and AECOPD and that he had observed a lack of fever, heart rate, respiratory rate, blood pressure, CEA, CRB, a lack of peripheral edema and AH's mental status.

[312] Dr. Burton testified that azithromycin was an appropriate second line therapy, but Dr. Rizk prescribed it on July 5, 2018 when he believed that AH had already failed on another antibiotic, doxycycline and prednisone prescribed by Dr. [R]. In addition, Dr. Rizk decided that AH had failed on doxycycline based on AH's reports of increased yellow sputum and fatigue. Dr. Rizk didn't use any other diagnostic modality to determine whether the doxycycline had failed, nor did he complete a differential diagnoses. Dr. Burton explained that if AH had failed on doxycycline, Dr. Rizk should have suspected other possible causes, such as heart failure, fluid overload secondary to CKD, or pneumonia. Dr. Burton said that Dr. Rizk would not have had the tools or skills to properly assess and diagnose these conditions in a community pharmacy, so he should have referred AH to his physician or to an emergency department. Dr. Burton said he would not have prescribed in this situation.

[313] Instead, Dr. Rizk saw AH again on July 13, 2018 and this time prescribed oseltamivir and levofloxacin for what he believed to be a bacterial infection. Dr. Burton said it was unclear how Dr. Rizk could have diagnosed AH with a bacterial infection. Dr. Burton opined that Dr. Rizk seemed to prescribe these medications because AH refused to go to the hospital and he had no other options, but this was inappropriate. Dr. Burton said Dr. Rizk should have insisted that AH see his physician, attend an emergency department or he could have called him an ambulance if Dr. Rizk was concerned about AH's worsening symptoms. Dr. Burton said there was no indication to prescribe oseltamivir and it was unnecessary.

[314] Dr. Burton and Dr. Mayo both opined that Dr. Rizk diagnosed AECOPD and initiated antibiotic therapies without performing the requisite assessments for the diagnoses, treatment and management of those conditions. They said that Dr. Rizk should have obtained an appropriate patient history, physical exam, chest x-rays and auscultation by an experienced practitioner.

[315] Dr. Burton concluded that Dr. Rizk's conduct may have delayed AH from seeking appropriate medical treatment, and could have caused significant harm, especially by prescribing oseltamivir and levofloxacin instead of insisting that AH go to a physician or to the hospital for assistance with his worsening symptoms. Dr. Mayo agreed, explaining that Dr. Rizk's decision to diagnose and treat AH gave him false hope that medical attention would be unnecessary. AH ended up being admitted to the Misericordia Hospital later that same day, through the involvement of his children and two days later his condition worsened, and he was admitted to the ICU. Dr. Mayo opined that Dr. Rizk's prescribing decisions were at least partially responsible for AH's eventual ICU admission.

[316] Mr. Stanowich also noted that Dr. Rizk's response included correspondence he claimed to have sent to Dr. [H], Dr. [R] and Dr. [P] about changes he was making to AH's medications. As described earlier, none of that correspondence was actually received, other than one faxed medication list sent to Dr. [P] on June 27, 2018. These records demonstrated

that Dr. Rizk had been adjusting AH's insulin, even after April 2018, when Dr. [P] instructed him that he would look after AH's nephrology care going forward. For example, Dr. Rizk issued a prescription dated July 5, 2018 in which he prescribed insulin glargine for AH. Dr. Rizk's response also included a "Renewal Notification of Rx Medication" with a fax transmission log indicating it was faxed on July 10, 2018, but there was no indication of a patient name on it. Ms. [GB] also testified that when she met AH on July 15, 2018, she had asked him who was managing his insulin and he told her it was Dr. Rizk

[317] Mr. Stanowich also noted that prior to even responding to the complaint, Dr. Rizk had suggested that the complaints against him were similar, and showed "the level of hatred, prejudice and inferiority complex by the physicians/pharmacists who did an awful job taking care of their patients and now they are seeking revenge because they looked incompetent in front of their patients." In the response to the complaint Dr. Rizk provided later, he asserted that Ms. [GB] and her team at the Misericordia ICU were incompetent and that this had jeopardized AH's health. Dr. Rizk denied that anything he had done had harmed AH.

[318] The Hearing Tribunal concluded that Dr. Rizk did fail to exercise the clinical judgment expected of an Alberta pharmacist and this lack of judgment in the practice of pharmacy constituted unprofessional conduct. He adjusted AH's insulin doses without notifying or consulting the patient's nephrologist. Whether over the telephone or in person at his pharmacy, Dr. Rizk chose to prescribe levofloxacin for AH when Dr. Rizk knew that AH had already tried doxycycline and azithromycin. There was no indication that Dr. Rizk considered the need for a trained, experienced diagnostician to assess AH in a properly equipped clinical setting and rule out other, serious problems. Dr. Rizk also prescribed oseltamivir despite the lack of any indication for it. The Hearing Tribunal accepted Ms. [GB's] evidence supported by Dr. Burton, that there was no indication for oseltamivir for AH at that time of year. The evidence also demonstrated that Dr. Rizk purported to diagnose AH with AECOPD and then a bacterial pneumonia without utilizing standard diagnostic criteria that both Dr. Burton and Dr. Mayo described. Dr. Rizk's conduct and in particular his prescribing decisions may have discouraged AH from seeking out appropriate medical assistance and contributed to his outcome, yet Dr. Rizk's response to the complaint was to accuse Ms. [GB] and her team of incompetence. The Tribunal was satisfied that Dr. Rizk had failed to reflect on how his conduct contributed to AH's poor outcome. His response also demonstrated his lack of respect for his professional colleagues.

Allegation 3: Complaint 6774

[319] Allegation 3 in Complaint 6774 alleged that Dr. Rizk demonstrated an ongoing pattern of behavior that displayed a failure to treat his colleagues with respect, including when he:

a. stated or insinuated at least nine times in his written response to the complaint received October 11, 2018 that Ms. [GB] was "lying";
b. stated AH's care team at the Misericordia Hospital was "incompetent";
c. described Dr. [R] as "incompetent" in his written response to the complaint received October 11, 2018;
d. described Dr. [H] as "incompetent" in his written response to the complaint received October 11, 2018;

e. questioned Ms. [GB's] qualifications to serve as a clinical pharmacist in the ICU on the basis that she does not have a PharmD;
f. stated Ms. [GB] "doesn't have the skills and knowledge", was a "mentally unstable individual, "condescending", "arrogant" and "unprofessional"; and
g. was aggressive in a phone conversation with Dr. [P];

[320] The evidence demonstrated that Dr. Rizk's response to others' concerns about the care he provided was frequently to attack them and accuse them of lying, incompetence, inferior credentials and generally acting unprofessionally. Dr. Rizk's response to the complaint accused Ms. [GB] of lying several times, but he chose not to attend the hearing and cross-examine her or testify under oath himself. Dr. Rizk also accused Ms. [GB] and her team of incompetence, as well as Dr. [R] and Dr. [H]. He may also have acted aggressively in a telephone call with Dr. [P], but Dr. [P] did not testify and the call was not in evidence.

[321] Principle 10(10) of the College's Code of Ethics requires pharmacists to respond honestly, openly and courteously to complaints and criticism. Dr. Rizk failed in this. His responses to the concerns with his care demonstrated his lack of courtesy and respect. They also demonstrated his lack of insight into his own limitations. Civility and humility are both essential for pharmacists as members of a self-regulating profession. Without them pharmacists would be unable to place their patients' interests above all else. In addition, the Hearing Tribunal considered that Dr. Rizk's responses would tend to harm the integrity of the pharmacy profession in the eyes of the public. The public should be entitled to expect that pharmacists respond frankly and courteously to any questions or concerns about the care they provide.

Allegation 4: Complaint 6774

[322] Allegation 4 alleged that Dr. Rizk attempted to mislead and failed to cooperate with an investigator appointed by the Complaints Director, when he:

a. falsely claimed that he faxed approximately 50 separate documents to other members of AH's medical team when only one physician, Dr. [P], received one partial fax;
b. falsely claimed that he did not personally fax documents before April 2018; and
c. lied about editing the audio recordings he sent to the investigator.

[323] The Hearing Tribunal found this allegation proven, and that Dr. Rizk's conduct was unprofessional conduct.

[324] As described above, Mr. Stanowich conferred with Dr. [H], Dr. [R] and Dr. [P] about Dr. Rizk's assertions in his response to the complaint that he sent them approximately 50 pieces of correspondence concerning AH. Dr. Rizk had asserted that Dr. [H] and Dr. [R] had received his notifications and were aware of his prescribing decisions. He also asserted that "We have been faxing [Dr. [P]] all the prescribing decisions and it is unfortunate/sad that he is denying" it.

[325] Dr. [H] confirmed he had not received any correspondence from Dr. Rizk. Dr. [R] confirmed he had two telephone calls with Dr. Rizk, one of which was to ask if Dr. [R] had received his correspondence. Dr. [R] said he had not. Dr. [P] had received only one faxed medication list from Dr. Rizk.

[326] The Tribunal also considered Mr. Stanowich's interview with Dr. Rizk in which he maintained that his pharmacy assistant sent his faxes and that she might have missed sending some prior to April of 2018. He also asserted that his pharmacy did not keep fax transmission logs prior to April of 2018. The Tribunal noted that Dr. Rizk's assistant, Ms. [S] was also interviewed. She said that she had only begun working with Dr. Rizk in approximately mid-2017 and she had only started sending faxes for him in April or May of 2018. She said that before then she had no idea what was being faxed, but if anything was sent then it would have been Dr. Rizk who sent it.

[327] The Tribunal was satisfied that Dr. Rizk attempted to mislead and failed to cooperate with Mr. Stanowich when he falsely claimed that he faxed documents to Dr. [H], Dr. [R] and Dr. [P] including documents entitled "Prescribing Notification/Managing Ongoing Therapy".

[328] In addition, the Tribunal noted that Dr. Rizk's response to the complaint included several faxes that were accompanied by fax transmission logs. These faxes were sent between March of 2017 and February of 2018, refuting Dr. Rizk's suggestion that his pharmacy had not kept fax transmission logs in this timeframe. These faxes were sent to recipients including the [NEMC], a Dr. [B3], and Alberta Health Services. None of them were sent to Dr. [H], Dr. [R] or Dr. [P].

[329] In light of Ms. [S's] advice that she only began working for Dr. Rizk in mid-2017 and that any faxes sent prior to April of 2018 would have been sent by Dr. Rizk himself, and in light of Dr. Rizk's failure to identify anyone else who might have sent these faxes, the Tribunal concluded that Dr. Rizk personally sent fax documents before April 2018. His assertion that he did not personally fax documents before April 2018 is most likely false. The Tribunal was therefore satisfied that Dr. Rizk attempted to mislead and failed to cooperate with Ms. Stanowich when he falsely claimed he did not personally fax documents before April 2018.

[330] Dr. Rizk's response to Complaint 6774 also included several audio recordings that he had made. Dr. Ri[z]k suggested that the recordings disproved aspects of Ms. [GB's] complaint, such as her allegation that he had asked her "how is what I did any different from what a physician would do?"

[331] In her testimony to the Hearing Tribunal, Ms. [GB] explained that she had listened to the recordings and she had noted that large parts of them were missing. She noted that Dr. Rizk had deleted the part of their conversation in which she asked him how he came to his diagnosis of the patient, and about his adjustment of the patient's insulin. Dr. Rizk had also deleted the portion of the conversation in which he had asked Ms. [GB] how what he had done was any different from what a physician would do. In an email to Mr. Stanowich, Ms. [GB] had said that this statement by Dr. Rizk was "burned into [her] memory".

[332] Mr. Stanowich's evidence supported Ms. [GB's] testimony that Dr. Rizk had deleted parts of the conversations represented in the recordings. Mr. Stanowich testified that one of the recordings was a conversation between Dr. Rizk and Ms. [GB] but it began part-way through the conversation. The beginning and the end of the conversation were both omitted from the recording. In another recording purporting to represent the July 19, 2018 conversation between Dr. Rizk and Ms. [GB], Mr. Stanowich noted that the background audio appeared to indicate that the recording had been edited and that a portion of it was missing. A further recording of a conversation between Dr. Rizk and Dr. [R] ended before the end of the conversation.

[333] Mr. Stanowich's investigative records included a memorandum summarizing his interview with Dr. Rizk. In the interview, Dr. Rizk had denied editing or omitting the middle of any conversations, except where he had indicated that the beginning or end of the recording was omitted.

[334] Dr. Rizk did not attend the hearing and swear that the audio recordings were unaltered He did not expose himself to cross-examination or cross-examine any of the witnesses. The Hearing Tribunal has listened to the audio recordings and accepts Mr. Stanowich's evidence that the recordings appear to have been altered or edited so they do not reflect the entire conversations. The Hearing Tribunal also accepts Ms. [GB's] evidence that portions of her conversations with Dr. Rizk have been deleted from the recordings.

[335] The Hearing Tribunal was satisfied that Dr. Rizk attempted to mislead and failed to cooperate with Mr. Stanowich's investigation when he purported to refute the complaint with audio recordings of conversations that he had edited, and then denied that he had edited them.

[336] Failing to cooperate with an investigator is defined as unprofessional conduct by the HPA, as described above. Attempting to mislead an investigator also constitutes a failure to comply or cooperate. The College's ability to regulate the pharmacy profession depends upon pharmacists and pharmacy technicians cooperating with lawful investigations such as the investigation Mr. Stanowich was conducting into the complaints here. Failing to cooperate and attempting to mislead an investigator also tends to harm the integrity of the pharmacy profession in the public's eye. The public should be able to expect regulated members of the College to diligently cooperate with any College investigation into a complaint.

Complaint 6785: Allegation 1

[337] Allegation 1 in Complaint 6785 alleged that Dr. Rizk failed to collaborate with other health care professionals in his care of DS when he failed to notify Dr. [LB] of his prescribing activities and failed to include DS's neurologist in his prescribing process.

[338] The Hearing Tribunal found this allegation proven and that Dr Rizk's conduct was unprofessional.

[339] Dr. [LB] testified that she learned of Dr. Rizk's involvement in DS's care when Dr. Rizk called her. Dr. Rizk told Dr. [LB] that DS had come to see him for assistance with hip pain that had not improved following a cortisone injection Dr. [LB] had arranged. Dr. Rizk told Dr. [LB] he had been managing DS's pain with oral dexamethasone. Dr. [LB]

expressed concern that the dexamethasone would throw DS's blood sugars out of control and should be stopped, but Dr. Rizk declined to stop it and said he would monitor it.

[340] Dr. [LB] then contacted DS and arranged for her to come for an appointment. At the appointment Dr. [LB] expressed concern about DS's care and about Dr. Rizk's unwillingness to adjust the drug therapy. Dr. [LB] suggested DS should see a different pharmacist and she agreed. With the assistance of DS's new pharmacist Dr. [LB] then determined that Dr. Rizk had started DS on a number of medications. Dr. [LB] was concerned about these because there was no clear indication for them and they created a risk of harm to DS The medications were oral and intramuscular dexamethasone, Florinef, valproic acid, high dose Effexor, Lipitor, ketorolac, gabapentin, cetirizine, clonidine, glyburide, repaglinide, Anafranil, ranitidine, hydroxyzine, pyridoxine, thiamiject, cyanocobalamin, Mg, glucosamine, oral vitamins and over the counter sleep remedies.

[341] Dr. [LB] was very concerned about Dr. Rizk's prescribing of these drugs. She said that neither Dr. [LB] nor DS's neurologist, or her diabetic specialist were contacted or consulted about the drugs Dr. Rizk had prescribed. Dr. [LB] expressed particular concern that Dr. Rizk had prescribed valproic acid, since DS had a neurologist and was already on topiramate for seizures. Dr. [LB] was also particularly concerned about the prescribing of Effexor since DS denied any depression, and the prescription of Lipitor since DS had high CK due to her myotonic dystrophy.

[342] Dr. Rizk's response to Complaint 6785 asserted that he had sent some 56 faxes and called Dr. [LB's] office about DS with no response. Dr. [LB] confirmed that she had received a couple of faxes from Dr. Rizk dated December 18, 2017 and January 22, 2018. These notified her of reasonable alterations to her prescriptions and she had no concerns about those. She explained that she had not received the other communications. Dr. [LB] uses an EMR and faxes are automatically sent to the physician for review and filed in the patient chart. Dr. [LB] and her staff had verified that no other faxes had been received.

[343] Dr. Rizk's response also asserted that he had contacted DS's neurologist and asked for a transfer of her medical records. He also suggested he had discussed DS's myotonic dystrophy with her neurologist, but he said that DS was no longer under the neurologist's care at that point. Dr. Rizk's response included a copy of neurology records faxed to him from a Dr. Ahmed on October 24, 2017, but there was no evidence of Dr. Rizk providing any prescribing notifications to Dr. Ahmed or any other neurologists at any time in relation to DS.
As in the other complaints described above, the Hearing Tribunal concluded that Dr. Rizk failed to collaborate with Dr. [LB] and other health professionals in his care of DS. The applicable Standards of Practice are described earlier in this decision. The Hearing Tribunal considered that Dr. Rizk's conduct Contravened standards 1.4, 11.9, 14.2(c), 14.4 and 14.5 and principles 1(1), (14), (15) and 12(2) of the Code of Ethics.

[344] The Hearing Tribunal was also satisfied that Dr. Rizk's conduct demonstrated a lack of knowledge, skill and judgment in the provision of pharmacy services. Dr. Rizk did not appear to recognize that clinical pharmacists are only one part of patient's overall health care team, and that each part must recognize their own limitations. Dr. Rizk's conduct also tends to harm the integrity of the pharmacy profession. The public should be able to expect pharmacists to diligently comply with Standards of Practice.

Complaint 6785: Allegation 2

[345] Allegation 2 in Complaint 6785 was that Dr. Rizk failed to exercise the clinical judgment expected of an Alberta pharmacist when he:

a. prescribed clonidine to DS on March 28, 2017 after she presented with "hypertensive emergency" and multiple systolic blood pressure readings over 180 mm Hg;
b. asked DS on March 28, 2017 to self-monitor her blood pressure after you determined she presented with a "hypertensive emergency" with multiple systolic blood pressure readings over 180 mm Hg;
c. did not follow up with DS for six days after you prescribed clonidine on March 28, 2017;
d. assessed DS on March 28, 2017 for organ damage in a community pharmacy setting;
e. prescribed tramadol and venlafaxine (off-label) to DS on March 21, 2017 for diabetic neuropathy and then, on April 13, 2017, when DS mentioned she was experiencing "jerky movements" you assessed that DS had serotonin syndrome and without collaborating or referring DS to a physician decided to reduce the tramadol DS had been prescribed from 100 Mg three times daily to 50 Mg three times daily while simultaneously increasing the venlafaxine dose from 187.5 Mg daily to 225 Mg daily;
f. did not follow up with DS for 12 days after you altered DS's tramadol and venlafaxine prescriptions;
g. prescribed atorvastatin for DS when it was contraindicated based on her medical history of a high CK level;
h. prescribed valproic acid for neuropathic pain when it was not indicated for this use by Health Canada based on a Mayo Clinic article in which it is used as a third-line medication;
i. prescribed clomipramine for myotonic dystrophy despite it not being indicated for this use by Health Canada based on a small crossover study mentioned in a review article;
j. prescribed and then refused to discontinue dexamethasone when DS's primary care physician Dr. B. informed you there was no indication for it;
k. inappropriately informed DS that dexamethasone could not cause bleeding when you said "it doesn't cause any bleeding, nothing OK";
l. failed to respect the opinions of other healthcare professionals caring for DS, including Dr. B;
m. determined he was satisfactorily monitoring DS's hemoglobin A1c levels when they were >19%; and
n. failed to self-reflect or consider that his determination that DS diabetes was under control may have put DS at risk.

[346] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[347] Particulars a, b, c and d of allegation 2 relate to Dr. Rizk's assessment and treatment of DS for hypertensive emergency on March 28, 2017. Dr. Rizk described his approach in his written response to Mr. Stanowich's questions following their interview. Dr. Rizk said he measured

DS's blood pressure at 184/92 and then assessed her for target organ damage by asking her about any eye pain, sight disturbances, chest pain, shortness of breath, headaches, dizziness and tinnitus. He said he also checked for signs of bleeding in her eyes and checked for signs of stroke by asking DS and her husband if they had noticed any difficulties with DS's speech or any signs of weakness. All of these assessments were negative. Dr. Rizk then decided to start DS on clonidine and he asked her to monitor her own blood pressure at home. Dr. Rizk didn't assess DS again until April 3, 2017; six days later. He acknowledged that DS should have been referred to the emergency department if her elevated blood pressure had been accompanied by target organ damage, or if it had continued to escalate with evidence of organ damage.

[348] In his testimony, Mr. Stanowich questioned how Dr. Rizk could have adequately assessed DS for target organ damage in a community pharmacy setting. Mr. Stanowich explained that pharmacists are not trained as physicians to assess and diagnose medical conditions. Mr. Stanowich also expressed concern that Dr. Rizk had not followed up on DS's potentially very serious condition for six days after prescribing clonidine, even though he had noted it would be important to follow-up after 1-2 days.

[349] Dr. Burton and Dr. Mayo also testified in relation to this issue. Dr. Burton explained that hypertensive emergencies are exceedingly rare, but when they occur, they are often related to very serious causes such as pulmonary edema or cerebral infarction. Dr. Burton explained that if DS was actually suffering a hypertensive emergency then the condition could have been life-threatening. Dr. Mayo elaborated that Dr. Rizk's community pharmacy was not equipped to manage DS's condition. Dr. Rizk's conduct put DS at risk of stroke, heart-attack and end-organ damage to her heart, kidneys, liver and eyes. Dr. Rizk should have immediately referred DS to an emergency department. Dr. Burton explained that it was more likely that DS was experiencing a hypertensive urgency, which occurs when an otherwise asymptomatic patient experiences significantly elevated blood pressure. Even without evidence of target organ damage, Dr. Burton opined that Dr. Rizk should have at least referred DS to her physician for assessment. Dr. Rizk instead prescribed clonidine and recommended that DS monitor her blood pressure at home. Dr. Burton noted that DS was already on amlodipine for high blood pressure at this time. Dr. Burton also explained that clonidine can be used as a short-acting agent to temporarily lower blood pressure, but it should not be used long-term. Dr. Rizk treated DS with clonidine for a number of months. He also failed to follow up with DS for six days. Dr. Burton said this was inappropriate. Dr. Rizk should have arranged follow-up care for DS within 1-2 days.

[350] The Hearing Tribunal concluded that Dr. Rizk's decision to asses, diagnose and then treat DS in his community pharmacy setting demonstrated a critical lack of judgment. Dr. Rizk failed to recognize his own limitations and the importance of at least referring DS to a physician for assessment and management. He then asked her to self-monitor at home and failed to appropriately follow-up with her. His conduct was dangerous and unprofessional.

[351] Particulars e and f of allegation 2 relate to Dr. Rizk prescribing of tramadol and venlafaxine for diabetic neuropathy and his adjustments of those medications to address what he assessed as serotonin syndrome. In response to written questions from Mr. Stanowich, Dr. Rizk confirmed that he had prescribed tramadol and venlafaxine XR for DS on March 21, 2017. He suggested this drug combination was not contraindicated, provided the patient is monitored for

signs of serotonin syndrome. Dr. Rizk said he saw DS on March 23 and April 3, 2017, but she omitted to mention to him that she had been experiencing jerky movements since being prescribed the medications. She disclosed this to Dr. Rizk on April 13, 2017.

[352] Dr. Rizk said he then considered differential diagnoses, which included neuroleptic malignant syndrome, cocaine or other substance abuse, thyroid storm, infections and alcohol or opioid withdrawal. He ruled these possibilities out and then considered the jerky movements to be a manifestation of serotonin syndrome. He decided to gradually taper the dose of tramadol to reduce the risk of seizures while reducing the jerky movements. He reduced the tramadol dose again on April 25, 2017 when DS said the jerky movements had reoccurred.

[353] Mr. Stanowich explained that Dr. Rizk had prescribed tramadol and venlafaxine for DS's diabetic neuropathy, but this was an off-label use for venlafaxine. It was concerning that Dr. Rizk had done that without collaborating with Dr. [LB] It was even more concerning that Dr. Rizk then diagnosed DS with serotonin syndrome, which is a serious and potentially fatal condition, but he still failed to collaborate with Dr. [LB] or anyone else, let alone refer DS for assessment. He made no apparent effort to warn DS about when to go to the emergency department and no attempts to notify Dr. [LB] about his concerns.

[354] Mr. Stanowich also expressed concerns that Dr. Rizk had increased the dose of venlafaxine while he was simultaneously tapering the dose of tramadol. Serotonin syndrome is caused by duplicating these medications, so adjusting both medications at the same time would have made it very difficult to assess the cause of DS's symptoms.

[355] Dr. Burton and Dr. Mayo both opined that Dr. Rizk's use of tramadol and venlafaxine and his response after diagnosing DS with serotonin syndrome were inappropriate. Dr. Burton said it was inappropriate to use venlafaxine for neuropathic pain without consulting DS's other health care team members. He also said that tramadol is not recommended for long term use. Dr. Mayo said that Dr. Rizk should have known that using tramadol and venlafaxine concurrently was duplicative. Dr. Burton confirmed that serotonin syndrome can be life-threatening. If Dr. Rizk believed DS had serotonin syndrome he should have referred her to the nearest emergency department for assessment and treatment. Instead, Dr. Rizk tapered the tramadol while increasing the dose of venlafaxine indefinitely. This had the potential to worsen DS's condition. Dr. Burton and Dr. Mayo both noted that Dr. Rizk waited 12 days after diagnosing DS with serotonin syndrome and adjusting her medications to follow-up with her. This was concerning. Dr. Burton said he should have arranged a follow-up in 1-2 days given the severity of serotonin syndrome.

[356] The Hearing Tribunal also concluded that Dr. Rizk's decision to assess DS's symptoms and diagnose her with serotonin syndrome and then adjust multiple medications by himself in his community pharmacy represented a critical lack of judgment. Serotonin syndrome is a potentially life-threatening condition, but Dr. Rizk proceeded without regard for DS's best interests and his lack of training as a physician. This was also dangerous and unprofessional.

[357] Particular g to allegation 2 relates to Dr. Rizk prescribing atorvastatin for DS when it was contraindicated based on her medical history. Dr. [LB] testified that the drugs she learned that Dr. Rizk had prescribed for DS included atorvastatin, known as Lipitor. This was concerning to Dr. [LB] because she knew that DS had previously experienced high CK

levels while taking a statin drug. If Dr. Rizk had consulted her she could have told him that DS had previously tried a statin drug and her CK had spiked. Dr. [LB] would have explained that statin drugs were contraindicated for DS due to her medical history. Mr. Stanowich also explained that Dr. [LB] expressed the concern that Dr. Rizk's decision to prescribe a statin without consulting her and obtaining DS's medical history put DS at risk of rhabdomyolysis, a potentially fatal condition. Dr. Burton confirmed this was a risk for DS.

[358] Dr. Rizk's decision to prescribe without taking appropriate steps to consult the patient's physician and obtain a thorough medical history demonstrated a lack of judgment expected of an Alberta clinical pharmacist and was unprofessional. If Dr. Rizk had exercised proper judgment he would have recognized the need to consider the patient's medical history before prescribing drugs that can have serious adverse effects.

[359] Particular h to allegation 2 was that Dr. Rizk prescribed valproic acid for neuropathic pain when it was not indicated for this use by Health Canada, based on a Mayo Clinic article in which it is used as a third-line medication. Dr. [LB] was concerned when she learned that Dr. Rizk had prescribed valproic acid for DS without consulting or notifying her. She was particularly concerned because DS was also seeing a neurologist who had already prescribed topiramate for seizures. Topiramate and valproic acid are both indicated by Health Canada for seizures. Dr. Rizk prescribed the valproic acid to treat DS's neuropathic pain, but Dr. Burton confirmed this was an off-label use as the drug was not approved for this use by Health Canada. Dr. Burton acknowledged that Dr. Rizk had provided some literature suggesting valproic acid could be used as a third-line agent for neuropathic pain, but this evidence was of very low quality. Dr. Burton said that as a result, valproic acid should only be used to treat neuropathic pain by a specialist in a team-based environment. It was inappropriate for Dr. Rizk to use it, particularly without seeking to consult or collaborate with Dr. [LB] and DS's neurologist.

[360] Prescribing off-label without consulting the patient's physicians and considering the patient's medical history also represents a critical lack of judgment. Dr. Rizk prescribed a drug that was not indicated by Health Canada and was at best a third line therapy, according to some literature Dr. Rizk had located. Dr. Rizk's decision to proceed by himself lacked insight into his role, demonstrated disregard for the patient's best interests and was unprofessional.

[361] Particular i to allegation 2 was that Dr. Rizk prescribed clomipramine for myotonic dystrophy despite it not being indicated for this use by Health Canada, based on a small crossover study mentioned in a review article. Dr. [LB] noted that clomipramine, sold under the brand name Anafranil, was included in the drugs Dr. Rizk had prescribed for DS. Dr. Rizk's response to the complaint confirmed that he prescribed clomipramine for DS's myotonic dystrophy. Dr. Burton opined that myotonic dystrophy is a rare and complex genetic disorder. It should be managed in a team environment in conjunction with a neurologist. Dr. Rizk prescribed clomipramine based on a review paper that cited a small crossover study. Dr. Burton pointed out that this was not good quality evidence. He explained that another review including the same small crossover study had concluded that due to insufficient good quality data and the lack of randomized studies it was impossible to determine whether clomipramine is safe and effective to treat myotonia. Dr. Burton further explained that clomipramine is not indicated by Health Canada to treat this condition so Dr. Rizk was using it off-label with no collaboration and this was inappropriate.

[362] Dr. Rizk's decision to prescribe off-label for a rare genetic neurological condition without consulting the patient's physician and based on poor quality evidence represents another critical lack of judgment expected of an Alberta clinical pharmacist. It too was unprofessional conduct.

[363] Particulars j, k, l, m and n to allegation 2 relate to Dr. Rizk's management of DS's diabetes and his decision to continue treating DS's bursitis pain with the oral steroid dexamethasone, despite Dr. [LB's] advice that dexamethasone was not indicated and that it could throw DS's blood sugars out.

[364] Dr. [LB] testified that when Dr. Rizk contacted her, he informed her that he was managing DS's bursitis pain with oral dexamethasone. Dr. [LB] asked Dr. Rizk about the indication for dexamethasone and he replied only that DS was suffering severe pain. Dr. [LB] expressed her concern to Dr. Rizk that DS had poorly controlled diabetes. She said the dexamethasone would throw her blood sugars out of control and was not indicated and should be stopped. Dr. [LB] said that Dr. Rizk declined to stop the dexamethasone and said he would monitor DS's blood sugars. This unwillingness to adjust the treatment was what prompted Dr. [LB] to contact DS and ask her to come for an appointment.

[365] Dr. Rizk subsequently spoke with DS as well. Dr. Rizk's response to the complaint included audio recordings that he made of telephone conversations with DS. In one of these, Dr. Rizk and DS discussed her blood sugar and Dr. Rizk said that he wanted DS to decrease the dexamethasone and increase her insulin. DS responded that Dr. [LB] had advised her to stop the dexamethasone until an upcoming appointment. Dr. Rizk replied that he had already spoken with Dr. [LB] and he didn't know what she wanted to discuss. DS then said that Dr. [LB] had told her that steroids like dexamethasone could cause bleeding in her stomach. Dr. Rizk responded "it doesn't cause any bleeding, nothing OK".

[366] Dr. Burton opined that Dr. Rizk had failed to develop an appropriate monitoring plan for DS's blood sugars while on steroid therapy. Dr. Burton said that Dr. Rizk also chose to ignore Dr. [LB's] concerns about the risk of gastrointestinal bleeding, which is a known risk of corticosteroid treatment. Dr. Burton said that if Dr. Rizk told DS there was no risk of bleeding then he was wrong.

[367] Dr. Rizk provided a further recording of a telephone call between him and DS after DS had been to see Dr. [LB] In this call DS explained that Dr. [LB] had told her that dexamethasone was not the right medication for her, and it could cause bleeding. DS also said that she understood dexamethasone would raise her blood sugar and it didn't make her feel right. Dr. Rizk replied that DS was protected from bleeding and that she should use the steroid because of her medical history. DS said that Dr. [LB] had started her on Tylenol but Dr. Rizk said "that's her opinion but I have to give you my opinion as well and Tylenol doesn't do anything."

[368] Dr. [LB] also expressed concern that when she ordered lab work on DS, she discovered that her hemoglobin A1C was greater than 19%. Dr. [LB] said that she had never seen an A1C that high and it indicates that the true value cannot be measured, and that the diabetes is out of control.

[369] Mr. Stanowich's testimony confirmed that Dr. Rizk did not understand hemoglobin A1C testing. Dr. Rizk had told Mr. Stanowich that the hemoglobin A1C measurement greater than 19% was caused by DS consuming a meal the night before the test and that her blood sugar was 23 mmol/L in his office, and this is a known interfering factor. Mr. Stanowich explained that hemoglobin A1C measurements represent a 3-month average and do not require the patient to fast before taking the test. This was confirmed by Dr. Burton. Mr. Stanowich also noted that DS's hemoglobin A1C was tested at greater than 19% twice while she was under Dr. Rizk's care, on January 3, 2018 and April 18, 2018. These tests therefore showed a critical lack of glucose control while Dr. Rizk was supervising DS's diabetes care. Despite these test results, Dr. Rizk's response to the complaint asserted that DS's diabetes was "perfectly controlled" under his care, except when she engaged in "drinking sugary beverages".

[370] Dr. Burton and Dr. Mayo both confirmed that the evidence showed that DS suffered sustained hyperglycemia while under Dr. Rizk's care. DS's diabetes had been under control in March 2017 with her hemoglobin A1C measured at 6.6%. Dr. Rizk prescribed fludrocortisone and dexamethasone in July 2017 and DS's blood sugar became poorly controlled. By April 2018, DS's hemoglobin A1C was no longer readable at greater than 19% and this continued for several months. Dr. Burton opined that this may have caused DS long-term damage such as kidney damage, retinopathies and neuropathies. It also put DS at risk of ketoacidosis or hyperosmolar hyperglycemia, both of which can lead to hospitalization.

[371] Dr. Rizk's response to Dr. [LB's] concerns, his comments to DS in the recorded telephone conversations and his response to the complaint demonstrate that he lacked insight into the role of his treatment decisions in the deterioration of DS's condition. Dr. Rizk clearly failed to self-reflect and consider that DS's best interests would require him to collaborate with Dr. [LB] adjust the therapies he was prescribing and ensure appropriate monitoring, assessment and follow-up for DS Instead, Dr. Rizk proceeded as if only he knew what was best for the patient and it was unnecessary for him to consider others' concerns. Dr. Burton and Dr. Mayo's evidence confirmed that Dr. Rizk failed to exercise the judgment expected of a qualified Alberta clinical pharmacist and he exposed DS to serious risks of harm.

[372] Dr. Rizk demonstrated a dangerous lack of clinical judgment in his conduct as described above. This lack of judgment placed Dr. Rizk's interests in prescribing complex therapies and managing complex conditions above DS's health and this was unprofessional.

Complaint 6785: Allegation 3

[373] Allegation 3 in Complaint 6785 alleged that Dr. Rizk failed to treat other healthcare professionals with respect, including when he chose to approach criticisms of his practice by calling Dr. [LB] a "liar", "negligent", "incompetent" and by questioning her competency.

[374] The Hearing Tribunal found this allegation to be factually proven and that Dr. Rizk's conduct was unprofessional.

[375] Dr. [LB's] complaint was a factual narrative of her telephone call from Dr. Rizk and her subsequent efforts to determine what Dr. Rizk had prescribed for DS. The complaint was critical of Dr. Rizk's care but Dr. [LB] did not impugn Dr. Rizk's character or question his competence or credentials.

[376] Dr. Rizk did not just respond to the complaint, he also included express criticisms of Dr. [LB] He accused Dr. [LB] of incompetence, of not caring for DS and of leaving DS untreated for several serious conditions. He suggested that Dr. [LB] was negligent for leaving her patient to suffer. Dr. Rizk also accused Dr. [LB] of lying in her complaint, though he chose not to attend the hearing to cross-examine her or testify under oath himself. None of these express criticisms were necessary for Dr. Rizk to thoroughly respond to the complaint.

[377] Principle 10(10) of the College's Code of Ethics requires pharmacists to respond honestly, openly and courteously to complaints and criticism. Dr. Rizk failed to do this. His response to this complaint demonstrated a lack of courtesy and respect. As described earlier in this decision, civility, humility and courtesy are essential for pharmacists as members of a profession. Without them pharmacists would be unable to place their patients' interests above all else. In addition, the Hearing Tribunal considered that Dr. Rizk's responses would tend to harm the integrity of the pharmacy profession in the eyes of the public. The public should be entitled to expect that pharmacists respond frankly and courteously to any questions or concerns about the care they provide.

Complaint 6785: Allegation 4

[378] Allegation 4 in Complaint 6785 alleged that Dr. Rizk attempted to mislead and failed to cooperate with an investigator appointed by the Complaints Director when he falsely claimed that he:

a. Faxed approximately 57 documents to Dr. B when she only received two documents from you on December 18, 2017 and January 23, 2018;
b. Did not keep fax transmission logs before April 2018 when you had fax transmission logs for December 18, 2017 and January 23, 2018; and
c. Did not personally fax documents before April 2018.

[379] The Hearing Tribunal found this allegation factually proven and that Dr. Rizk's conduct was unprofessional.

[380] Dr. [LB] testified that other than two faxes dated December 18, 2017 and January 22, 2018, she received no correspondence from Dr. Rizk about DS. The faxes she had received were about alterations to prescriptions she had written, and she had no concerns with them, nor was there any need to write back to Dr. Rizk. Dr. [LB] testified that she uses an EMR in her practice. She and her staff had checked the chart and with the EMR provider, but they did not receive any of the 54 other faxes from Dr. Rizk about DS, as he suggested he sent in his response to the complaint.

[381] Mr. Stanowich testified that Dr. Rizk's response to the complaint suggested that he had faxed documents to Dr. [LB] but she never replied. Dr. Rizk's response included copies of two letters he sent to Dr. [LB] about prescription alterations, one dated December 18, 2017 and another dated January 22, 2018. These copies of the letters included fax transmission logs. The first letter was actually faxed on December 17, 2017 at 23:43 hours. The second was faxed on January 22, 2018 at 21:56 hours. There were also fax transmission logs for correspondence Dr. Rizk had sent to Alberta Blue Cross in January 2018.

[382] Dr. Rizk's response to the complaint asserted that he had notified Dr. [LB] of his prescribing activities. His response included a number of "Prescribing Notification/Managing Ongoing Therapy" documents dated between March 21, 2017 and April 16, 2018. These documents had handwritten notations including they were faxed to Dr. [LB] with a handwritten fax number, but Dr. Rizk provided no fax transmission log for any of them. There was no fax header or other indication of the date they were faxed, the number they were faxed to or any notation that the transmission was successful. There were also a number of "Renewal Notification of Rx Medications" with dates between June 10, 2017 and April 4, 2018 but these were similarly lacking in any confirmation that they were sent.

[383] When Mr. Stanowich interviewed Dr. Rizk about this, Dr. Rizk said that his fax procedures were not standardized before April 2018 and fax transmission logs were not being kept. This was despite the few fax transmission logs that were included with his own response. Dr. Rizk added that his assistant, Ms. [S] may have missed sending some of the faxes before that time. Dr. Rizk denied that he sent any faxes himself prior to April 2018.

[384] Mr. Stanowich also interviewed Ms. [S]. Mr. Stanowich testified that she said that she began working at the pharmacy in approximately mid-2017, but they had just begun sending faxes in April or May of 2018. Prior to that she had not sent any faxes and had no idea what was being sent. If anything was sent prior to April 2018 it would have been sent by Dr. Rizk himself. Ms. [S] began keeping a fax transmission log in April or May of 2018.

[385] The Hearing Tribunal was satisfied that Dr. Rizk falsely claimed to Mr. Stanowich that he sent the prescribing and renewal notification documents in his response to the complaint to Dr. [LB] Dr. Rizk did fax two letters to Dr. [LB] but he did not send the prescribing or renewal notifications as he had claimed during the investigation.

[386] The Tribunal was also satisfied that Dr. Rizk falsely claimed to Mr. Stanowich that he was not keeping fax transmission logs before April 2018. He clearly was keeping fax transmission logs, as the documents in his response that he actually faxed to Dr. [LB] before April 2018 were accompanied by fax transmission logs. There were also fax transmission logs for documents he had faxed to Alberta Blue Cross in January 2018.

[387] Finally, the Tribunal was satisfied that Dr. Rizk falsely claimed to Mr. Stanowich that he did not personally fax documents before April 2018. The evidence demonstrated that Dr. Rizk sent correspondence to Dr. [LB] and to Alberta Blue Cross by fax prior to April 2018. Mr. Stanowich testified that Ms. [S] said she hadn't been sending any faxes before April 2018 and any faxes sent before that time would have been sent by Dr. Rizk. Dr. Rizk did not identify anyone else who could have sent the faxes.

[388] Attempting to mislead and failing to cooperate with an investigator is defined as unprofessional conduct by the HPA, as described above. The College's ability to regulate the pharmacy profession depends upon pharmacists and pharmacy technicians cooperating with lawful investigations, such as the investigation Mr. Stanowich was conducting into the complaints here. Failing to cooperate and attempting to mislead an investigator also tends to harm the integrity of the pharmacy profession in the public's eye. It frustrates and undermines investigations intended to protect the public interest. The public should be able to expect

regulated members of the College to diligently cooperate with any College investigation into a complaint.

Complaint 6940: Allegation 1

[389] Allegation 1 in complaint 6940 alleged that the practice inspection ordered by the Registrar resulted in a review of seven patient files and demonstrated that Dr. Rizk failed to notify other healthcare professionals involved with the care of his patients of his prescribing activities in cases one through seven. Allegation 1 alleged in particular that:

a. There was a consistent pattern of failing to notify other health professionals involved in the care of his patients of his prescribing activities;
b. There was little to no evidence that even one-way communication or notification had occurred.

[390] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[391] In their inspection report, Mr. Munchua and Ms. Patel explained that they attempted to contact the other healthcare professionals identified in the seven patient files they reviewed. Of the seven professionals they contacted, they were able to communicate with two. Each of these physicians confirmed they had received no prescribing or adaptation notifications from Dr. Rizk. They also confirmed they had no recollection of any verbal communications from Dr. Rizk about their mutual patients.

[392] Mr. Munchua and Ms. Patel concluded that Dr. Rizk consistently demonstrated a lack of appropriately involving other healthcare professionals in his care of patients. In one case, they noted that there was no documentation of any collaboration or notification of Dr. Rizk's prescribing activities to other professionals. In the other six cases Dr. Rizk's records included prescribing notification forms but they only found one fax confirmation. There were no other documented interactions with other healthcare professionals, such as fax responses or documentation of verbal communications. Dr. Rizk was unable to provide specific examples of any clinically significant interactions with other healthcare professionals for any of the seven cases when Mr. Munchua and Ms. Patel visited the pharmacy on July 25, 2018. They concluded it was extremely unlikely he had collaborated sufficiently, given the complexity of the cases, the number of patient interactions he had, and the scope of the care he provided.

[393] Mr. Stanowich spoke to Dr. Rizk's response to this allegation. Dr. Rizk asserted that the notifications were faxed, but he indicated that fax confirmations were not retained. Dr. Rizk also acknowledged that there were times that he couldn't reach some physicians.

[394] Mr. Stanowich investigated Dr. Rizk's claims to have sent faxes to his patients' other healthcare providers in respect of patient files 1 through 7. Mr. Stanowich wrote to each of the patients' physicians with lists and copies of the documentation that Dr. Rizk's patient charts suggested he had faxed to the physicians. He received responses from six of them. Dr. [Q] had never seen Dr. Rizk's patient, nor had he received any of the documents Dr. Rizk suggested he had faxed. Dr. [R2] had not seen Dr. Rizk's patient since 2016, prior to the date of the first fax Dr. Rizk suggested he had sent. Dr. [R2] had not received any of the 15 documents

Dr. Rizk's file suggested had been sent in any event. Dr. [D] had seen Dr. Rizk's patient during the relevant time frame, but she only received one of the sixteen documents Dr. Rizk's file suggested he had faxed to her. Dr. [S] had also seen Dr. Rizk's patient during the relevant time frame but only received five of the 26 documents that Dr. Rizk suggested he had sent. Dr. [E] confirmed that Dr. Rizk's patient was also his patient and recalled one telephone call with Dr. Rizk about the patient. Dr. [E] had not received any of the documents that Dr. Rizk's file suggested he had faxed. Dr. [Z] had not received any of the twenty documents that Dr. Rizk's file suggested he had faxed on the dates that they were suggested to have been faxed. Dr. [Z] received a fax with 21 pages and a telephone consultation call from Dr. Rizk on June 5, 2018, but this was after the inspection of the pharmacy was ordered. Dr. [Z] had also received one fax refill request from Dr. Rizk on August 21, 2018.

[395] Mr. Stanowich also spoke to his interviews with Dr. Rizk's assistant Ms. [S] and with Dr. Rizk on January 8, 2019. As described earlier, Dr. Rizk said that his assistant may have missed sending some faxes prior to April of 2018. He said he didn't send any faxes himself. Ms. [S] advised Mr. Stanowich that she only began working at the pharmacy in approximately mid-2017. They had only begun sending faxes to physician in April or May of 2018. They also began keeping a transmission log in April or May of 2018 every time a fax was sent. Before that she was not sending any faxes and she had no idea what was being sent. Anything faxed before April 2018 would have been sent by Dr. Rizk himself.

[396] The Tribunal was satisfied that the evidence demonstrated a consistent pattern of Dr. Rizk's failure to notify his patients' other healthcare professionals of his prescribing activities. There was little to no evidence of even one-way communications with his patients' care providers about significant prescribing decisions.

[397] The Standards of Practice requiring prescribing pharmacists to notify other healthcare professionals involved in the patients' care of their prescribing decisions and the importance of those standards have been described earlier in this decision. The Hearing Tribunal considered that Dr. Rizk contravened at least Standards of Practice 1.4, 11.9, 14.4 and 14.5(b). The Hearing Tribunal was also satisfied that Dr. Rizk's conduct demonstrated a lack of knowledge, skill and judgment in the provision of pharmacy services. As described earlier, clinical pharmacists are an important part of patient's overall health care team, but they are just one part. Pharmacists must understand the limitations of their knowledge and clinical skills. By notifying and collaborating with other healthcare professionals such as physicians involved in patient's care of their clinical decisions, they ensure the patient's best interests are being monitored. Dr. Rizk's conduct also tends to harm the integrity of the pharmacy profession in the public's eye. The public should be able to expect pharmacists to diligently comply with Standards of Practice and to exercise evidence-based knowledge, skill and judgment.

Complaint 6940: Allegation 2

[398] Allegation 2 in complaint 6940 alleged that Dr. Rizk failed to collaborate or appropriately refer to other healthcare professionals, the particulars of which were alleged to be as follows:

a. there was no evidence in any of the 7 cases of the level of reciprocal communication required for patients with complex medical issues;

b. you could not provide any specific examples of clinically significant interactions with other healthcare professionals;
c. the absence of collaboration and communication with other health care professionals created situations where patient safety was placed at risk;
d. you placed no value on the professional knowledge or contributions of other health care professionals;
e. particulars of this failure to collaborate with or appropriately refer to other health care professionals include:
    i. In Case 1 when you diagnosed your patient with tonsillitis and did not consider referral to other healthcare professionals;
    ii. In Case 2 when you
        1. did not collaborate with your patient's psychiatrist while treating the patient's depression disorder and migraines; and
        2. did not refer or consider referring your patient to a physician to manage their chronic migraines.
    iii. In Case 3 when you independently treated your patient for erectile dysfunction for approximately six months without referring the patient to a physician or other healthcare professional.
    iv. In Case 6 when you
        a. prescribed a second round of Maxitrol eyelid gel and did not consider alternative therapy or referral to another healthcare professional;
        b. prescribed a compounded prescription to treat actinic keratosis and did not consider the value of obtaining assessment from other healthcare professionals with dermatological experience; and
        c. failed to document obtaining or considering information from other healthcare professionals.

[399] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[400] In Mr. Munchua and Ms. Patel's inspection report, which was the subject of their testimony at the hearing, they concluded that Dr. Rizk consistently failed to involve other health professionals in the care of his patients, either by referring his patients for assessment by appropriately trained professionals or to determine mutual goals of therapy for his patients. They noted that Dr. Rizk could not provide specific examples of any clinically significant interactions with other health professionals for any of the seven cases they reviewed during their inspection. They concluded that Dr. Rizk's lack of awareness of his own limitations rendered his practice ineffective and unsafe.

[401] This was also evident to the Hearing Tribunal. The Tribunal carefully reviewed Dr. Rizk's responses to the 6940 complaint. It is clear that Dr. Rizk believed that only he knew how to assess, diagnose and treat his patients and he placed no value on the professional knowledge or contributions of other healthcare professionals. This was very dangerous for the members of the public who went to Dr. Rizk for care for serious, complex health conditions. Dr. Rizk's lack of insight and his cavalier attitude towards his patient's health and safety were clearly demonstrated in his response to this complaint. Mr. Munchua and Ms. Patel's inspection report

commented that given the complexity of the patients, the number of patient interactions and the scope of the care Dr. Rizk was providing, they found it extremely unlikely that he collaborated sufficiently. Dr. Rizk responded to this saying "This is denigrating because of their lack of experience, they find these cases very complex which I don't and they also show inferiority complex because their qualifications are not commensurate with mine."

[402] Mr. Munchua and Ms. Patel's inspection report included several examples of Dr. Rizk's failure to collaborate or appropriately refer to other healthcare professionals. On June 12, 2017 Dr. Rizk assessed Patient 1, a 41-year-old female and diagnosed her with tonsillitis. They noted that his file contained no indication that Dr. Rizk considered any other possible diagnoses or that he considered referring his patient to a physician.

[403] Mr. Munchua and Ms. Patel also noted that Dr. Rizk's documentation did not reflect sufficient or timely collaboration with Patient 2's psychiatrist for the management of the patient's major depressive disorder. Dr. Rizk also purported to treat Patient 2 for complaints of chronic migraine headaches, but there was no documented evidence of a referral to a physician to assess or manage the chronic migraines.

[404] In Case 3, Mr. Munchua and Ms. Patel noted that Dr. Rizk treated a 36-year-old male patient for erectile dysfunction and smoking cessation over a period of 6 months. There was no documented evidence of any attempts to collaborate or communicate with other health professionals. The patient did not have a primary care physician but there was no evidence that Dr. Rizk attempted to assist the patient to find a physician to share management of the patient's condition. The inspectors also noted that erectile dysfunction can be a complex condition with psychological factors potentially contributing. Dr. Rizk's file documentation reflected insufficient consideration of the possibility of psychological factors.

[405] Mr. Munchua and Ms. Patel also pointed out Case 6. In this case, Dr. Rizk diagnosed his patient with "make-up contact dermatitis/bacterial skin infection" on her eyelid. On October 12, 2017 Dr. Rizk documented that the patient was to resume using Maxitrol eyelid gel that he had previously prescribed. The inspectors noted that Dr. Rizk had not considered other appropriate management options such as alternative therapies or a referral to a health professional better suited to assess and treat eye conditions. On November 8, 2017 Dr. Rizk provided Patient 6 with a compounded prescription of lactic acid and TCA to treat her stated actinic keratosis. There was no indication that Dr. Rizk considered referring his patient to a physician with greater expertise in dermatological conditions for assessment, particularly as related to cancerous vs. non-cancerous lesions. Further, Dr. Rizk failed to document obtaining or considering information from other healthcare professionals. As an example, Mr. Munchua and Ms. Patel's report explained that on September 7, 2017 Dr. Rizk documented that he would communicate with Patient 6's physician regarding her thyroid condition. Despite this note, there was no documentation in the entire patient file of obtaining or considering any relevant information obtained from the patient's physician, or from anyone.

[406] The Tribunal considered that Dr. Rizk Contravened at least Standards of Practice 1.4, 11.9, 14.4 and 14.5. While there is overlap with the standards breached above in Allegation 1, the Tribunal considered the conduct to be different. This allegation is about Dr. Rizk's failure not just to notify other healthcare professionals of his clinical decisions and prescribing, but to collaborate with them or refer his patient appropriately. As above, pharmacists must

understand the limitations of their knowledge and clinical skills. The Standards of Practice require collaboration among pharmacists and other members of the healthcare team because pharmacists' training and skills complement those of those other members. They do not supersede them.

[407] By notifying other healthcare professionals of their clinical decisions, such as physicians involved in a patient's care, they ensure the patient's best interests are being monitored. Dr. Rizk's conduct also tends to harm the integrity of the pharmacy profession in the public's eye. The public should be able to expect pharmacists to diligently comply with Standards of Practice and to exercise evidence-based knowledge, skill and judgment.

Complaint 6940: Allegation 3

[408] Allegation 3 in complaint 6940 alleged that Dr. Rizk ordered unnecessary or clinically inappropriate lab tests and then failed to appropriately consider or interpret those tests or to document the rationale or results of the tests, including:

> a. In Case 1 when on or around May 19, 2017 you ordered 27 lab tests for your patient for routine screening without providing patient or condition specific rationale.
> b. In Case 4 when you ordered laboratory tests for C-reactive protein, FSH, LH and parathyroid hormone when your patient was seeking your assistance for weight loss.

[409] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[410] Mr. Munchua and Ms. Patel's inspection report described that on or about May 19, 2017 Dr. Rizk assessed Patient 1, a 41-year-old female, for complaints of fatigue. He assessed the patient to be clinically obese, but he did not document any goal for therapy. During the inspection Dr. Rizk advised Mr. Munchua and Ms. Patel that the patient did not want to lose weight. Despite this, he proceeded to order lab testing without documentation of a rationale. He ordered tests including ECG, homocysteine, PTH and C-reactive protein.

[411] Similarly, in Case 4, Dr. Rizk saw a 37-year-old female patient seeking assistance with weight loss. Dr. Rizk ordered lab work on this patient including C-reactive protein, FSH, LH, and parathyroid hormone. These tests were unnecessary and Dr. Rizk failed to demonstrate sufficient consideration of appropriate information.

[412] The Hearing Tribunal found that Dr. Rizk's ordering of unnecessary and clinically inappropriate testing Contravened Standard of Practice 3.7. This standard requires that pharmacists only order lab tests that they are personally competent to order and interpret, and that they only order a lab test if it is indicated to assist with the management of drug therapy for a patient. Standard 3.8 is also relevant. It provides that a pharmacist who makes a decision based on the interpretation of laboratory data must document the decision and the rationale for it in the patient record. Inspectors Munchua and Patel noted that Dr. Rizk had failed to document any rationale for ordering the lab tests.

[413] The Tribunal also considered that Dr. Rizk's conduct demonstrated a lack of skill and judgment in the practice of pharmacy and tended to harm the integrity of the pharmacy profession. The public should be entitled to expect that pharmacists understand the indications for any lab tests that they order and only to order tests when the information would be clinically significant. To do otherwise represents an abuse of the provincial healthcare system.

Complaint 6940: Allegation 4

[414] Allegation 4 in complaint 6940 alleged that Dr. Rizk failed to consider appropriate information when assessing patients. The particulars of this were alleged to include:

a. In Case 1 when he
    i. Diagnosed his patient with tonsillitis without considering differential diagnoses;
    ii. Provided 10 cyanocobalamin (vitamin B12) injections to his patient between May 25 – June 7, 2017 despite recorded levels being within the normal range on May 25, 2017;
b. In Case 3 when he failed to consider psychological factors contributing to his patient's erectile dysfunction.
c. In Case 5 when he did not consider alternative diagnoses for the patient's premature ejaculation.
d. In Case 7 when he did not appropriately prioritize his patient's drug problems.

[415] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[416] The Hearing Tribunal was satisfied that Dr. Rizk had disregarded and failed to consider appropriate information when he was assessing his patients. Mr. Munchua's and Ms. Patel's inspection report confirmed that in Case 1 there was no documented evidence that Dr. Rizk considered other differential diagnoses before diagnosing Patient 1 with tonsillitis. The inspection report also noted that Dr. Rizk prescribed and administered ten cyanocobalamin injections for Patient 1 between May 25 and June 7, 2017 even though the patient's levels were recorded to be within the normal ranges on May 25, 2017. There was no indication that Dr. Rizk considered oral vitamin therapy instead of injections either.
In Case 3, as described above, the Inspectors noted that Dr. Rizk's documentation did not reflect appropriate action was taken to address psychological factors potentially contributing to the patient's erectile dysfunction. Similarly, in Case 5, Mr. Munchua and Ms. Patel noted that there was no documentation that Dr. Rizk had considered any potential alternatives to drug therapy for the patient's premature ejaculation, such as referral, behavioural therapy, topical products or other selective serotonin reuptake inhibitors.

[417] Further, in Case 7 Inspectors Munchua and Patel noted that the patient described bloating as one of his chief complaints but there was no documentation that Dr. Rizk did anything to address it. There was no action plan or any documentation of a patient-specific goal of therapy. The Inspectors noted that Dr. Rizk also failed to effectively prioritize smoking cessation therapy and weight management therapy. On April 21, 2017 he documented that weight loss was the next priority, but there was no comprehensive or clinically meaningful plan for the patient.

[418] The Hearing Tribunal considered these examples and found that Dr. Rizk made a number of significant clinical decisions for these patients but without seeking out or considering very relevant information that was readily available to him. Perhaps the most obvious example was Dr. Rizk's prescription and administration of vitamin injections for Patient 1 when her recorded levels were normal. All medical procedures involve risks. Injections are no different. If there is no vitamin deficiency, or at least no need to administer vitamins by injection because oral administration would work just as well, then the injections are unnecessary and there is no justification for the patient to assume those risks. Dr Rizk apparently disregarded the available information about the patient's vitamin levels and proceeded with injections anyway. The other examples described above are similar.

[419] Dr. Rizk had an express obligation to consider appropriate information. This is set out in Standard of Practice 3.1. It states that a pharmacist must consider appropriate information to assess the patient and the patient's health history and history of drug therapy each time the pharmacist prescribes a schedule 1 drug, reviews the patient's drug utilization or provides advice about a drug, blood product or drug therapy. Dr. Rizk failed to meet this obligation and this was unprofessional. The Hearing Tribunal also considered Dr. Rizk's conduct to represent a lack of skill or judgment in the practice of pharmacy and that it tends to harm the integrity of the pharmacy profession. Being able to identify and rely on clinically significant information is essential for pharmacists, particularly those who have prescribing authority and intend to use it. In this case Dr. Rizk apparently disregarded clinically significant information and the Tribunal concluded these were lapses in skill and judgment. The Tribunal also considered that the public should be able to expect prescribing pharmacists to prescribe only after obtaining and considering all relevant clinical information. Dr. Rizk's decisions to proceed in these cases tended to undermine the public's confidence in the integrity of the pharmacy profession.

Complaint 6940: Allegation 5

[420] Allegation 5 in complaint 6940 alleged that Dr. Rizk provided patients with information that was inadequate or inaccurate, including:

a. In Case 4 when he provided unrealistic expectations for drug therapy and weight loss to his patient.
b. In Case 6 when he failed to explain how the established goal of therapy, blood pressure of 115/75 mmHg, was determined or how meeting this goal would be of clinical value in resolving the patient's tiredness.

[421] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[422] Inspectors Munchua and Patel noted in their report that in Case 4, Dr. Rizk saw a 37-year-old female patient seeking assistance with weight loss. He documented an initial goal for the patient to lose 48 pounds, but he didn't document any expected timeframe to accomplish this goal or any recommendations for an exercise regime to help accomplish it. Instead, Dr. Rizk prescribed liraglutide and a caloric intake of 1000 calories per day, which is well below safe intake levels set by Health Canada. Dr. Rizk documented that he expected the patient's appetite to decrease by 30-40% on liraglutide, but this is not supported by the product monograph produced by the drug's manufacturer. Inspectors Munchua and Patel noted that

inaccurate or incomplete information may have been provided to the patient regarding reasonable expectations for weight loss therapy. Without that information Patient 4 would not have had sufficient information to make an informed choice to proceed with the therapy.

[423] In Case 6, Inspectors Munchua and Patel noted that the 40-year-old female patient sought Dr. Rizk's assistance with fatigue. Dr. Rizk assessed the patient as hypotensive and documented a goal to get her blood pressure up to approximately 115/75 mmHg. There was no documentation of how Dr. Rizk selected this blood pressure or how he thought raising her blood pressure could resolve her complaints of feeling tired. Inspectors Munchua and Patel noted that Dr. Rizk did not sufficiently consider the patient's concurrent iron anemia deficiency and hypothyroidism as differential causes of fatigue. Dr. Rizk may have provided inaccurate or incomplete information to the patient about reasonable expectations for the fludrocortisone he prescribed for hypotension. Without that information the patient would not have been able to make an informed choice to proceed with drug therapy.

[424] The Tribunal concluded that it was more likely that not that Dr. Rizk provided these patients with inaccurate or inadequate information to make informed choices about the therapies he prescribed. Dr. Rizk prescribed Patient 4 with a drug intended for weight loss and recommended that she limit her caloric intake to levels below what Health Canada has determined to be safe. Dr. Rizk also failed to document any discussion with Patient 4 about the importance that lifestyle changes, such as an exercise regime play in achieving reasonable weight loss goals. Dr. Rizk just documented that Patient 4 could expect her appetite to decrease by 30-40% and she could expect to lose 48 pounds. This was inadequate and irresponsible. Dr. Rizk also recommended drug therapy to raise Patient 6's blood pressure, but there was no documentation that Dr. Rizk discussed with Patient 6, or even that he considered how this was going to help her. This was also inaccurate and irresponsible.

[425] The College's Code of Ethics, Principle 2 requires that pharmacists respect each patient's autonomy and dignity. Subparagraphs 3 and 4 of Principle 2 require pharmacists to provide each patient with any information they need to make informed decisions about the patient's health and health care and to discuss that information with the patient. Pharmacists are also specifically required to properly inform each patient about drug therapy and reasonable alternatives. The Tribunal found that Dr. Rizk failed to meet these requirements. Based on what Dr. Rizk documented for Patients 4 and 6, they were not properly informed about the treatments Dr. Rizk was suggesting as well as reasonable alternatives.

[426] The Tribunal also considered Dr. Rizk's conduct to represent a lack of skill or judgment in the practice of pharmacy and that his conduct tended to harm the integrity of the pharmacy profession. Being able to identify and then document the provision of accurate and complete information about drug therapies and alternatives is an expectation for clinical pharmacists. Dr. Rizk's failure to do so represents a lack of the expected skills or judgment. Further, the public should be able to expect to provide their fully informed consent to any drug therapy. Dr. Rizk could have collaborated with a physician to care for each of patients 4 and 6, but he elected not to. Dr. Rizk therefore took the obligation to ensure his patients were fully informed of the benefits as well as risks and alternatives to treatment upon himself. Dr. Rizk's documentation demonstrates that he failed in this obligation and this would undermine public confidence in the pharmacy profession.

Complaint 6940: Allegation 6

[427] Allegation 6 in Complaint 6940 alleged that Dr. Rizk engaged in prescribing practices that were not rooted in sound evidence, best practice or even common practice and differed from decisions made by other pharmacists or healthcare professionals including:

a. routinely prescribing for indications that were not approved by Health Canada without using critical appraisal skills for evaluating evidence and without being able to provide adequate evidence or to support your decision, including;
    i. In Case 4 when you
        (a) prescribed bupropion 100Mg SR for weight loss and your patient was not on caloric restriction and an exercise regimen;
        (b) prescribed metformin as an appetite suppressant up to a maximum dosing of 2.5g/day;
        (c) prescribed topiramate 12.5Mg HS for appetite suppression and weight loss.

    ii. In Case 5 when you prescribed duloxetine for premature ejaculation based on a single study of 20 patients.
    iii. In Case 6 when you prescribed fludrocortisone for orthostatic hypotension and fatigue.
    iv. In Case 7 when you prescribed topiramate for weight loss and did so without any comprehensive exercise or diet plan.

b. prescribing treatments or medications in unsafe combinations, at unsafe doses or at doses that were not evidence-based in a manner contrary to best practices including;
    i. In Case 1 when you
        (a) prescribed four medications concurrently to treat shoulder pain, including rectal diclofenac and injectable ketorolac; and
        (b) diagnosed sinusitis and then after prescribing clarithromycin and beclomethasone and your patient developed systemic symptoms, you prescribed injectable dexamethasone followed by oral prednisone.

    ii. In Case 2 when you prescribed multiple dose changes and new agents at the same time without allowing sufficient time to assess the effectiveness or safety.
    iii. In Case 3 when you "prescribed" multiple herbal products (maca, Korean ginseng, and tribulus terrestris) to treat your patient's erectile dysfunction that were either at subtherapeutic doses or lacked evidence of effectiveness.
    iv. In Case 4 when you
        (a) recommended a caloric intake well below safe levels as determined by Health Canada;
        (b) prescribed liraglutide without recommending it be used in combination with a calorie restricted diet and exercise regimen; and

(c) prescribed chitosan and injectable B vitamins despite no evidence or poor evidence of their effectiveness.

v. In Case 5 when you prescribed injectable tramadol, injectable ketorolac, oral baclofen and rectal diclofenac for joint pain.

vi. In Case 6 when you

(a) prescribed spironolactone for acne despite your patient being on medication to raise her blood pressure; and

(b) prescribed diclofenac at a dose that doubled the maximum dose recommended by Health Canada based on a proprietary NSAID dosing chart published by MagellanRx Management, a non-Canadian pharmacy benefit manager.

vii. In Case 7 when you

(a) did not consider drug therapy other than vitamin B12 for your patient's diabetic neuropathy;

(b) prescribed levofloxacin and budesonide/formoterol for your patient's bacterial bronchitis and pneumonia and added prednisone when your patient did not respond to the other drugs;

(c) diagnosed candida balanid on your patient's penis and instructed your patient to rub the area for 3-4 minutes four times daily;

(d) prescribed a combination of diclofenac, tramadol, injectable ketorolac and injectable dexamethasone concurrently with injectable lidocaine and did not use step therapy.

[428] The Hearing Tribunal found allegation 6(a) and (b) proven and that Dr. Rizk's conduct was unprofessional.

[429] Clinical pharmacists are not always required to agree and make the same decisions that other pharmacists and healthcare professionals would make, but the Standards of Practice do require pharmacists to practice responsibly. Standard 3.1 requires pharmacists to consider appropriate information to assess the patient and the patient's health history and history of drug therapy before prescribing a Schedule 1 drug. Standard 11.6 provides that pharmacists must not prescribe a drug or blood product unless the intended use is an indication approved by Health Canada, considered a best practice or accepted clinical practice in peer-reviewed clinical literature, or part of an approved research protocol.

Inspector Munchua's and Patel's inspection report revealed a number of very problematic prescribing decisions by Dr. Rizk. For example, the Inspectors noted that in Case 4, Dr Rizk was treating his patient for weight loss and he prescribed bupropion 100Mg SR on March 21, 2017. Bupropion is not indicated for weight loss by Health Canada. While there is some literature showing that bupropion can be effective at inducing weight loss, that literature confirms that the patients in the studies were on caloric restrictions and exercise regimes. Dr. Rizk did not document a recommendation for an exercise regime for Patient 4. Dr. Rizk's approach was therefore not an accepted clinical practice in peer-reviewed literature. Dr. Rizk also prescribed metformin and topiramate for Patient 4 for appetite suppression and weight loss. Neither drug is indicated for these purposes by Health Canada.

[430] In Case 5, Dr. Rizk treated Patient 5 his patient for premature ejaculation with duloxetine. This drug is not indicated by Health Canada for this condition and Mr. Munchua and Ms. Patel noted the available evidence does not suggest duloxetine would be effective in treating this condition.

[431] In Case 6 Dr. Rizk assessed the patient as hypotensive and prescribed fludrocortisone in an attempt to raise her blood pressure. This drug has an off-label indication for hypotension and is not indicated for fatigue in Canada. The literature does not support the use of fludrocortisone for fatigue nor does the literature suggest it can be effective to treat those concerns. Dr. Rizk provided a suboptimal assessment for his diagnosis of orthostatic hypotension without considering other differential diagnosis, and his care plan was insufficient to manage, monitor, and follow-up on this condition, particularly for an off-label indication for a medication.

[432] In Case 7 Dr. Rizk also prescribed topiramate off-label, as it is not indicated for weight loss use in Canada. Mr. Munchua and Ms. Patel also noted that Dr. Rizk had prescribed topiramate for weight loss without a foundational diet and exercise plan and this was unsupported and inappropriate.

[433] The Tribunal was satisfied that allegation 6(a) was proven. Mr. Munchua's and Ms. Patel's report noted several instances in which Dr. Rizk prescribed drugs off-label, when not indicated for the conditions he was treatment by Health Canada. While there are circumstances in which drugs can be prescribed off-label, and prescribing pharmacists can prescribe off-label in these circumstances, none of those circumstances existed here. Dr. Rizk did not demonstrate that his prescribing decision were best practices or supported by peer-reviewed clinical literature. He did not suggest that he was participating in any approved research protocols. Dr. Rizk failed to meet Standards of Practice 3.1 and 11.6 and his conduct was dangerous and unprofessional.

[434] The Tribunal also considered Dr. Rizk's conduct to represent a lack of skill or judgment in the practice of pharmacy and that his conduct tended to harm the integrity of the pharmacy profession. A pharmacist intending to prescribe a drug to treat a patient's conditions must know the indications for the drug he intends to prescribe. A pharmacist intending to prescribe a drug off-label, for a use not indicated by Health Canada must be still more cautious and ensure its use is a known best practice or accepted by peer-reviewed clinical literature. Dr. Rizk did not meet these expectations. The public are entitled to expect that clinical pharmacists with prescribing authority are aware of the indications and of the literature for drugs they intend to use. Dr. Rizk's decisions to proceed in the circumstances that he did would tend to undermine public confidence in the integrity of the pharmacy profession.

[435] Allegation 6(b) alleged that Dr. Rizk prescribed treatments or medications in unsafe combinations, at unsafe doses or at doses that were not evidence-based in a manner contrary to best practices.

[436] Inspectors Munchua and Patel noted that in Case 1, Dr. Rizk prescribed four different drugs concurrently to treat Patient 1's complaint of acute shoulder pain. This included rectal diclofenac and injectable ketorolac. They noted that this combination was potentially unsafe. Dr. Rizk also assessed Patient 1 on January 4, 2018 and diagnosed her to have an acute bacterial sinusitis. He prescribed a course of clarithromycin and beclomethasone. Twelve days later, on

January 16, 2018 Dr. Rizk reassessed the patient as having developed a systemic infection and he administered what he documented as a "loading dose" of injectable dexamethasone, followed by oral prednisone. Inspectors Munchua and Patel noted that although Dr. Rizk had taken steps to prevent potential adverse gastrointestinal side effects, there was no indication that he was monitoring for possible adverse renal effects of the concurrent NSAID therapy, or for possible adverse endocrine effects from the corticosteroid therapy.

[437] In Case 2, on July 10, 2017 Dr. Rizk increased Patient's 2's doses of venlafaxine and zopiclone and started the patient on bupropion at the same time. On July 31, 2017 Dr. Rizk documented that the patient had discontinued the venlafaxine therapy because he "started to feel irritable and weird". Dr. Rizk's documentation does not reflect that he considered that his July 10 prescribing decisions may have been responsible for his patient's adverse symptoms.

[438] In Case 3 Dr. Rizk was treating his patient for erectile dysfunction. Dr. Rizk prescribed or advised his patient to take maca, Korean ginseng and tadalafil. He prescribed maca to increase libido, despite Dr. Rizk having documented that the patient's libido was normal. Inspectors Munchua and Patel also noted that there was insufficient reliable evidence to recommend the efficacy of maca in increasing libido. Further, the doses of maca and Korean ginseng that Dr. Rizk prescribed or recommended were inadequate compared to the dosing suggested in the literature that was available. Dr. Rizk also prescribed tribulus terrestris for Patient 3, but there was similarly insufficient reliable evidence of its efficacy for libido and the dose Dr. Rizk prescribed was inadequate compared to the dosing in the literature that did exist.

[439] In Case 4, Dr. Rizk was treating his patient for weight loss. As described above, Inspectors Munchua and Patel noted that Dr. Rizk recommended a 1000 calorie per day intake, which was well below safe levels determined by Health Canada. In Dr. Rizk's response to the complaint he asserted that he didn't have to follow Health Canada recommendations for caloric intake. His recommendation for his patient to limit herself to 1000 calories per day was based on his assessment of her metabolic rate and her "unwillingness to exercise". Dr. Rizk also prescribed liraglutide without recommending that Patient 4 use it in combination with an exercise regime. liraglutide is only indicated as an adjunct to a calorie reduced diet and increased physical activity. He also prescribed chitosan with a goal to "decrease fat mass absorption" but Inspectors Munchua and Patel noted that the evidence did not suggest the effects of chitosan on weight loss would be clinically significant. Finally, Dr. Rizk prescribed injectable B vitamins in order to "increase metabolism of carbs, proteins, lipids" but the Inspectors found insufficient evidence that the B vitamins would have a clinically significant effect.

[440] In Case 5, Inspectors Munchua and Patel noted that Dr. Rizk treated his patient for joint pain and on July 14, 2017 he prescribed a combination of four drugs: injectable tramadol, injectable ketorolac, oral baclofen and rectal diclofenac. Three days later, on July 17, 2017 Dr. Rizk supplemented this with oral tramadol in order to "decrease pain until the AI" and documented that "his pain still not 0/10 on most days".

[441] In Case 6, Dr. Rizk was treating Patient 6 for hypotension with fludrocortisone when he assessed and diagnosed her with acne vulgaris Type 3. Dr. Rizk omitted to consider or document that the patient's acne symptoms may have been caused or exacerbated by the fludrocortisone therapy he prescribed on August 16, 2017. Rather than withdraw or taper the fludrocortisone, or address the other potential causes of the acne, Dr. Rizk prescribed a

compound of clindamycin and adapalene/benzoyl peroxide on September 29, 2017, azithromycin on December 21, 2017, spirolactone on January 18, 2018 and trimethoprim/sulfamethoxazole on February 14, 2018. The prescription for spirolactone was concerning because at the dose Dr. Rizk was using, spirolactone is indicated to treat hypertension. It would counteract the fludrocortisone that Dr. Rizk was simultaneously using to treat hypotension. Inspectors Munchua and Patel noted that Dr. Rizk had not sufficiently considered this medication conflict. During their attendance at the pharmacy to interview Dr. Rizk he said he believed the spirolactone's effect on the patient's blood pressure would be minimal, but this ignored the fact that the drug is indicated at that dose to lower blood pressure. Finally, the Inspectors noted that Dr. Rizk prescribed diclofenac Na 100Mg SR once with breakfast and once with dinner on the start of Patients 6's menses. This dosing is contrary to Health Canada's recommendation not to exceed 100Mg daily, due to the increased risk of vascular events.

[442] In Case 7, Dr. Rizk was treating his patient including for diabetic neuropathy. On November 9, 2016 Dr. Rizk documented that he prescribed injectable B vitamins daily for ten days. Inspectors Munchua and Patel noted that there was no indication that Dr. Rizk had considered alternatives to injectable vitamins to treat this condition, such as indicated drug therapy. On January 11, 2017, Dr. Rizk assessed and diagnosed Patient 7 with acute bacterial bronchitis and pneumonia, which are serious conditions. Despite the patient's severity, Dr. Rizk purported to manage the patient's condition himself and he prescribed levofloxacin and budesonide/formoterol. Three days later on January 14, 2017, when Dr. Rizk assessed that the patient was not responding to the therapy he again decided that he could manage the patient on his own and he prescribed prednisone as an additional therapy. Dr. Rizk also purported to diagnose candida balanitis on Patient 7 and he prescribed both oral fluconazole and topical lotriderm. Inspectors Munchua and Patel noted that there was insufficient evidence to support the use of two anti-fungal drugs at the same time, given that the patient was no immunocompromised and Dr. Rizk's documentation did not reflect widespread cutaneous involvement. When the patient returned for a follow-up appointment on December 12, 2016, Dr. Rizk instructed the patient to rub the topical medication against the glans and the shaft of his penis for 3-4 minutes, four times per day. The Inspectors noted that this application duration and frequency was not aligned with best practices and that it could be potentially unsafe. Finally, the Inspectors noted that on June 21, 2018, Dr. Rizk treated Patient 7 for mild osteoarthritis of his foot by prescribing a combination of diclofenac SR 100Mg, tramadol 50Mg, injectable ketorolac, injectable dexamethasone and injectable lidocaine. This combination demonstrated that Dr. Rizk failed to consider other, or stepwise treatment options. More significantly, the Inspectors noted that Dr. Rizk's decision to prescribe these drugs concurrently demonstrated a lack of judgment, considering that the combination included concurrent NSAIDs and steroids. This creates a known risk of gastrointestinal bleeding.

[443] The Tribunal also considered Allegation 6(b) to be proven. These examples described above demonstrate that Dr. Rizk purported to treat serious conditions on his own and he thereby assumed full responsibility for his patients' health and safety. He prescribed combinations of drugs and added drugs to therapy regimes with little regard for the efficacy of the drugs or the safety of his patients. He prescribed more drugs than were necessary to address the patients concerns, and this led in some cases to patients being exposed to unsafe drug interactions. He prescribed drugs at dosages that were beyond the safe levels determined by Health Canada and he failed to consider adding drug therapies in a stepwise manner rather than all at once. Dr.

Rizk also adjusted dosages and drugs without determining the actual causes of adverse drug effects his patients were suffering. He used drugs without sufficient evidence of their efficacy and thereby exposed his patients to unwarranted and unacceptable risks. Dr. Rizk's prescribing decisions represented a lack of skill and judgment in the practice of pharmacy, they were dangerous and unprofessional.

[444] The Tribunal also considered that Dr. Rizk's conduct tended to harm the integrity of the pharmacy profession. Pharmacists should be expected to practice in an evidence-based manner. Prescribing pharmacist are drug experts. They should be expected to recognize and anticipate medication risks, side-effects and potential drug interactions and caution the patient about how to avoid them. Dr. Rizk disregarded this and his conduct would undermine the integrity of the profession in the eyes of the public. This too was unprofessional.

Complaint 6940: Allegation 7

[445] Allegation 7 in Complaint 6940 alleged that Dr. Rizk failed to adequately consider the over-the-counter or non-pharmacologic options for patient care, including:

a. including lifestyle changes such as dietary modifications to address your patient's obesity in Case 1; and
b. including lifestyle changes such as exercise, diet or referral to another healthcare professional in Case 4.

[446] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[447] Inspectors Munchua and Patel noted that in Case 1, Dr. Rizk diagnosed his patient, who was complaining of fatigue, as clinically obese. While he told the Inspectors during their visit to his pharmacy that the patient did not want to lose weight, Dr. Rizk did not provide the patient with lifestyle modification information related to diet or exercise. Such lifestyle modifications would have been part of a comprehensive action plan to address the patient's concerns. Dr. Rizk's response to the complaint acknowledged he didn't advise the patient about lifestyle modifications. He wrote that he believed if he was to impose lifestyle modifications on his patient then he would be committing professional misconduct. It was apparent that Dr. Rizk believed he should continue to offer the drug therapy to his patient regardless of what she was prepared to do to improve her own health.

[448] In Case 4, the patient was seeking assistance with weight loss. Dr. Rizk set a goal for the patient to lose 48 pounds but this was based on severely restricting her caloric intake combined with drug therapy. Dr. Rizk omitted to document any recommended exercise regime or timeframe for the patient to be able to meet this goal.

[449] Diet and exercise are obviously essential elements of any plan to address a patient's desire to increase their energy levels, lose weight or both. Dr. Rizk omitted to consider or document any plan to include these non-pharmacologic lifestyle modifications in his patients' care plans. Pharmacists have an obligation to consider appropriate information before prescribing Schedule 1 drugs, conducting a review of the patient's drug utilization or providing advice about a drug. This is prescribed in Standard of Practice 3.1. Appropriate information is further defined in Standard 3.4(h) and (j) to include other health care products, aids and devices and

any other information that a reasonable pharmacist would require to provide the pharmacy service. Standard 3.5(g) further provides that this includes lifestyle information. Dr. Rizk failed to consider the importance of lifestyle modifications in the examples set out above and this was contrary to the standards. He seemed to prefer to emphasize the value of drug therapy that he prescribed over exercise or increased physical activity, and this was unprofessional.

[450] The Hearing Tribunal also considered Dr. Rizk's approach to these cases to represent a lack of skill and judgment in the practice of pharmacy, and that his conduct tended to undermine public confidence in the integrity of the pharmacy profession. Pharmacists are expected to recognize that drug therapy is only one part of an effective plan to address weight loss, or energy levels for obese patients. The public should be able to expect pharmacists to recommend complementary therapies such as dietary and activity level changes under the supervision of qualified health practitioners. The failure to do so was insular and unprofessional.

Complaint 6940: Allegation 8

[451] Allegation 8 alleged that Dr. Rizk responded inappropriately to drug therapy problems, including:

a. In Case 2
    i. when he responded to a complaint of grogginess by concurrently lowering zopiclone and raising amitriptyline and then at a later date by concurrently raising zopiclone and lowering amitriptyline;
    ii. when you continued to treat a patient's migraines with naproxen despite noting that it appeared ineffective.
b. In Case 3 when you identified finasteride as a contributing factor to your patient's erectile dysfunction but did not consider stopping this medication.

[452] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[453] In Case 2, Inspectors Munchua and Patel noted that on May 8, 2017 Dr. Rizk responded to his patient's complaint of grogginess in the morning by lowering the dose of zopiclone the patient was taking but simultaneously increasing the dose of amitriptyline. When the patient complained about the same thing on July 10, 2017 Dr. Rizk responded by reversing the dosages, lowering the amitriptyline and raising the zopiclone. The inspectors also noted that Dr. Rizk continued to prescribe naproxen and Schedule 2 acetaminophen/caffeine/codeine to treat Patient 2's migraine headaches, but on August 25, 2017 Dr. Rizk had documented that "the patient has bouts of headaches that are not responsive to high dose naproxen". They also noted that Dr. Rizk had omitted to document sufficient ongoing symptoms to support these prescriptions. There was no documentation that Dr. Rizk had considered adjusting the treatment to try alternatives.

[454] In Case 3, Inspectors Munchua and Patel noted that Dr. Rizk was treating the patient for erectile dysfunction. The documentation demonstrated that Dr. Rizk identified the patient's finasteride therapy as a potential cause or contributor to his erectile dysfunction, but there was no indication that Dr. Rizk considered stopping the finasteride. Dr. Rizk chose to prescribe

instead. There was no apparent consideration of a stepped treatment approach to manage side effects and effectively measure treatment response.

[455] The Hearing Tribunal concluded that Dr. Rizk's conduct demonstrated a lack of skill and judgment in the practice of pharmacy. Lowering the dose of one medication to address a side effect is not useful if the pharmacist simultaneously raises the dose of another medication that can have the same side effect. Reversing the process later in response to the same complaint is equally unhelpful. It suggests a desire to experiment rather than any serious concern for his patient's health. Dr. Rizk's decision to prescribe additional therapies to manage a possible side-effect of Patient 3's finasteride therapy similarly demonstrated Dr. Rizk's own desire to experiment and a flippant attitude towards his patient's health. Further, the Tribunal considered that Dr. Rizk's tinkering with his patient's medications, rather than taking an evidence-based, stepped approach to treatment fell short of what the public should be able to expect clinical pharmacists to do. Dr. Rizk's approach was seemingly more about fulfilling his own interests than taking care of his patients and this would tend to harm the integrity of the pharmacy profession in the public's eye.

Complaint 6940: Allegation 9

[456] Allegation 9 was that Dr. Rizk used inappropriate timeframes to assess efficacy of current therapy before making changes or adding additional therapy, including:

a. In Case 4 when you rapidly added, discontinued or changed medications and doses for various conditions without sufficient time to assess the effectiveness and safety of these medications.

[457] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[458] Inspectors Munchua and Patel noted that Dr. Rizk treated Patient 4 for weight loss. Dr. Rizk prescribed bupropion on March 21, 2017, even though weight loss is not an indicated use for this drug by Health Canada. Dr. Rizk added metformin as an appetite suppressant one week later, even though metformin again wasn't indicated for this use. He then added chitosan on April 25, 2017 to "decrease fat mass absorption". Less than one month later, on May 16, 2017 Dr. Rizk discontinued the bupropion, metformin and chitosan regimen and prescribed liraglutide for weight loss. Only two months later, on July 18, 2017 he added topiramate, even though topiramate was again not indicated for weight loss by Health Canada. The Inspectors noted that Dr. Rizk omitted to plan any expected timeframe for the weight loss treatment. Rather than monitor the patient's progress over a reasonable timeframe, he varied the medication regimen without allowing sufficient time to monitor the efficacy of the regimen he had prescribed.

[459] The Hearing Tribunal found Dr. Rizk's conduct to have Contravened Standard of Practice 14.8. This standard requires pharmacists who prescribe at initial access or to manage ongoing therapy to develop a follow-up plan with the patient, including parameters that will be monitored, expected outcomes and time frames. Dr. Rizk omitted to develop an appropriate follow-up plan with reasonable timeframes that the therapy should take to show results. Instead Dr. Rizk varied the therapies seemingly without regard for time frames. This was

unprofessional. It led to Dr. Rizk's use of multiple drugs over a relatively short period of time, rather than selecting one appropriate treatment regimen and monitoring its efficacy over an appropriate time frame.

[460] The Tribunal was also satisfied that Dr. Rizk's conduct demonstrated a lack of skill and judgment in the practice of pharmacy. Pharmacists are expected to practice in an evidence-based manner, using the expected degree of clinical knowledge and in the best interests of the patient. Dr. Rizk's additions and withdrawals of various drugs was not consistent with the expected application of clinical knowledge. Further, it tended to harm the integrity of the pharmacy profession. The public should be able to expect clinical pharmacists to know what to prescribe, or to refer them to someone who does. The public would lose confidence in the integrity of the pharmacy profession if prescribing pharmacists are seen to be experimenting on their patients with various drugs, especially when some of those drugs are used off-label.

Complaint 6940: Allegation 10

[461] Allegation 10 alleged that Dr. Rizk failed to appropriately monitor his patients, including:

a. In Case 1 when he did not monitor his patient for renal adverse effects from concurrent NSAID therapy or for adverse endocrine effects from concurrent corticosteroid therapy.
b. In Case 6 when you
    i. prescribed fludrocortisone to treat hypotension and by extension drowsiness and did not appropriately monitor his patient for adverse effects, including potassium levels;
    ii. did not monitor his patient's potassium levels despite her being on fludrocortisone and spirolactone concurrently.
c. In Case 7 when he did not address his patient's triglycerides in a timely manner and then once addressed, inappropriately monitored his patient for drug interactions and adverse effects.

[462] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[463] In Case 1, Inspectors Munchua and Patel noted that Dr. Rizk had prescribed diclofenac and ketorolac, which are non-steroidal anti-inflammatory drugs, along with other concurrent drugs to treat the patient's shoulder pain, and that he later prescribed the corticosteroids beclomethasone and then dexamethasone and prednisone for a systemic bacterial sinusitis. The Inspectors noted there was no documentation that Dr. Rizk was monitoring for renal effects from the concurrent NSAID therapy, or that he was monitoring for adverse endocrine effects from the concurrent corticosteroid therapy.

[464] In Case 6, the Inspectors noted that Dr. Rizk was treating his patient for tiredness that he attributed to hypotension. He prescribed fludrocortisone to raise the patient's blood pressure and subsequently increased the dosage several times. While Dr. Rizk documented that he monitored for some side effects of this therapy, such as pedal edema and headache, he did not document monitoring for other adverse effects such as serum potassium. Dr. Rizk didn't document giving his patient a lab work requisition until after he had increased her dose of

fludrocortisone three times. There was no indication that Dr. Rizk had monitored the patient's serum potassium for four months after initiating spirolactone therapy concurrently with the fludrocortisone either.

[465] In Case 7, Inspectors Munchua and Patel noted that Dr. Rizk was treating Patient 7 when in November 2016 he became aware that the patient's triglyceride level was high. Dr. Rizk did not document any response to this clinical finding until April 28, 2017, when he prescribed fenofibrate. Dr. Rizk stated rationale for waiting that long to address the triglycerides was "compliance issues", but the Inspectors founds Dr. Rizk had prescribed other drug therapies in the interim. The Inspectors also noted that Dr. Rizk had no documented plan to monitor for hepatic or myotoxicity despite that the patient was also taking a statin medication.

[466] The College's Standards of Practice make very clear that prescribing pharmacists have an obligation to develop appropriate follow-up and monitoring plans. Standard 14.8(a) requires pharmacists who prescribe to develop a follow-up plan with the patient including parameters that will be monitored, expected outcomes and timeframes. Standards 14.8(b) and 14.10 require that pharmacists must also be satisfied that the patient's usual prescriber is aware of the drug therapy and that there is ongoing monitoring by a regulated health professional acting within the scope of their profession.

[467] Based on the examples described above the Hearing Tribunal was satisfied that Dr. Rizk failed to appropriately monitor his patients and that he breached these Standards of Practice. This was unprofessional. The standards exist to ensure that drug therapy is safe and effective. Dr. Rizk's failure to ensure his patients were monitored appropriately reflected his flippant attitude to patient safety. It was also surprising given his insistence that he was more qualified than most everyone else he encountered.

[468] The Tribunal was also satisfied that Dr. Rizk's conduct represented a lack of skill and judgment in the practice of pharmacy and that it tended to harm the integrity of the pharmacy profession. As described earlier, pharmacists are drug experts and the public should be entitled to expect them to practice as such. Monitoring for adverse effects and interactions is an expectation of pharmacists, particularly those who prescribe drug therapies themselves. The failure to properly implement that monitoring and respond to issues that are identified is unprofessional conduct for a pharmacist.

Complaint 6940: Allegation 11

[469] Allegation 11 in Complaint 6940 alleged that Dr. Rizk failed to adequately document treatment progress, outcomes, rationales, assessment and notification to other healthcare professionals, including:

a. In Case 1 when the patient complained of fatigue and you did not document specific treatment outcomes.
b. In Case 4 when you added, discontinued or changed medications or doses for various conditions without providing a rationale for doing so.
c. In Case 5 when you

i. prescribed zopiclone to treat the symptom of difficulty sleeping and subsequently raised the dose without documentation that your patient showed a positive response to the treatment;
ii. failed to document specific outcomes for your patient's premature ejaculation.

d. In Case 7 when you
i. Failed to sufficiently document your patient's plan or progress with his diabetes and smoking cessation.

[470] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[471] In Case 1 Inspectors Munchua and Patel noted that while the patient presented to Dr. Rizk complaining of fatigue and he diagnosed her with clinical obesity, there were no documented goals for therapy. They wrote that the patient complained of fatigue, but the goals of therapy were not addressed in a patient-specific, comprehensive manner regarding specific treatment outcomes such as quantity/quality of sleep, or modification of lifestyle factors contributing to fatigue.

[472] In Case 4, the Inspectors noted that Dr. Rizk initiated, discontinued and changed drug regimens and dosages to treat Patient 4 for migraine headaches and for weight loss. He did not document his rationale for the drugs he was using or the changes he was making.

[473] In Case 5, the Inspectors noted that Dr. Rizk had prescribed zopiclone to assist his patient with sleep, but Dr. Rizk increased the dose from 5Mg to 7.5 Mg on March 22, 2018 when the lower dose proved ineffective. Dr. Rizk did not document whether the drug was effective, but in his interview with Inspectors Munchua and Patel he told them that the drug had a positive effect on the duration of the patient's sleep, increasing it from 5 to 6 hours. The Inspectors also noted that Dr. Rizk had prescribed duloxetine to treat the patient's premature ejaculation, but there was no documentation of specific outcomes for the duloxetine therapy, or any documentation that Dr. Rizk had considered alternative treatments or a referral.

[474] In Case 7, the Inspectors noted that Dr. Rizk prescribed bupropion to assist Patient 7 with smoking cessation on November 2, 2016, but there was no documented care plan nor sufficient documentation to monitor the patient's progress or facilitate monitoring care. This reoccurred when Dr. Rizk adapted the patient's bupropion prescription on February 23, 2017. The Inspectors noted there was insufficient documentation of the patient's progress and treatment plan, particularly considering that Dr. Rizk had recently documented that the patient had resumed smoking due to stress. The Inspectors also found that Dr. Rizk had failed to adequately document Patient 7's diabetes status and blood glucose values to effectively facilitate monitoring. On November 7, 2016 Dr. Rizk documented that the patient's blood sugar "has gone down to around 8 mmol/L so far (sometimes with higher numbers)". The Inspectors concluded that Dr. Rizk's documentation had been inadequate to facilitate accurate monitoring of the patient's progress since his initial intake interview with the patient.

[475] Dr. Rizk's response to the complaint provided a record of bupropion care plan that he said had been was missed when Inspectors Munchua and Patel copied the file. This did not change the

Hearing Tribunal's analysis as the Tribunal found the allegation proven based on the other examples, in Cases 1, 4 and 5.

[476] Pharmacists are required to create and maintain patient records. Standards of Practice 18.4 provides that patient records must meet the requirements of Appendix A to Standard 18. Appendix A requires that when pharmacists prescribe, they must document the circumstances under which the drug was prescribed, the rationale for prescribing, a summary of their assessment of the patient and include follow up plans that are sufficiently detailed to monitor the patient's progress and ensure continuity of care by other regulated health professionals or caregivers. Dr. Rizk did not meet these obligations. He failed to create an adequate plan that could be monitored for Patient 1's therapy for fatigue and for Patient 7's smoking cessation and diabetes management. Dr. Rizk's prescribing decisions for Patient 4 lacked any stated rationale for the drugs he was initiating, discontinuing and varying. His documentation for prescribing duloxetine for Patient 5 was also lacking. Patient records are intended to facilitate continuity of care for the patients' best interests. Dr. Rizk's documentation failures made it difficult for any successor healthcare professionals to provide continuity of care, not to mention the difficulties they posed for Dr. Rizk in providing safe and effective therapy to his own patients. His conduct was unprofessional.

[477] Dr. Rizk's conduct also demonstrated a lack of skill and judgment in the practice of pharmacy. Pharmacists are regulated healthcare professionals and clinicians like Dr. Rizk can have additional prescribing authority. With the privilege to practice pharmacy comes the responsibility to document care thoroughly and accurately, so that someone else could pick up where Dr. Rizk left off or assess the patient and collaborate effectively. Dr. Rizk failed to meet this responsibility.

Complaint 6940: Allegation 12

[478] Allegation 12 alleged that Dr. Rizk failed to demonstrate self-awareness to determine the limitations of his practice and the need for communication and collaboration with other health care professionals or to reflect on the decisions that he made.

[479] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[480] In their inspection report, Inspectors Munchua and Patel concluded that Dr. Rizk did not demonstrate sufficient self-awareness about the limitations of his practice. They expressed their concern that "an awareness of what we do not know as health professionals is as important in the care of our patients as what we do know."

[481] The College's Code of Ethics at Principle 5, Subparagraph 6 requires pharmacists to recognize their limitations and when indicated, refer their patients to other health professionals whose expertise can address the patient's needs. Dr. Rizk failed to meet this expectation. The Hearing Tribunal has also considered the knowledge, skills and judgment required of a regulated pharmacist in Alberta. Pharmacists have to understand and be aware of their own limitations, and their role within the larger healthcare team that may be involved in a particular patient's care.

[482] The Hearing Tribunal carefully reviewed the inspection report and noted examples of Dr. Rizk failing to demonstrate the requisite knowledge, skills and judgment. His many prescriptions of indicated and off-label drugs for weight loss and appetite suppression without adequate provision for lifestyle counselling exemplified this. Dr. Rizk seemingly lacked the insight necessary to understand that drug therapy alone was sometimes not in his patients' best interests. Other examples were even more alarming. Dr. Rizk purported to assess and diagnose medical conditions for patients who came to see him. These included candida balanitis and actinic keratosis even though Dr. Rizk could have suggested the patients seek advice from a physician trained in dermatological conditions. He diagnosed other very serious conditions as well. As an example, Dr. Rizk purported to diagnose Patient 7 with acute bacterial bronchitis and pneumonia, but he did not consider referring his patient or collaborating in the management of his condition. This was insular, dangerous and unprofessional.

Complaint 6940: Allegation 13

[483] Allegation 13 alleged that Dr. Rizk administered drugs by injection in an unsafe manner, including by administering multiple injectable medications in quantities that exceed the best practice maximum of 1-2ml per deltoid muscle and with the addition of lidocaine for pain relief, as:

> a. In Case 5 when you injected up to 8ml of six different injectable medications into your patient's deltoid muscles on February 22-23, 2018 and March 22-24, 2018 and prescribed and administered lidocaine to minimize pain without evidence to support this decision as being safe or effective.
> b. In Case 6 when you
> i. administered injectable lidocaine to manage injection pain; and
> ii. injected up to 3 ml into the deltoid muscle.
> c. In Case 7 when you injected ranitidine to prevent GI dyspepsia despite no clear rationale for administration by this route.

[484] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[485] Inspectors Munchua and Patel noted in their report that they were very concerned with Dr. Rizk's injection administration practices. They noted consistent examples across the cases they reviewed in which Dr. Rizk administered multiple medications concurrently, in injection volumes of up to 4 ml to the deltoid muscle. They also noted that on multiple occasions Dr. Rizk prescribed and administered lidocaine into the patient's deltoid to minimize pain from subsequent injections he administered.

[486] In Case 5, the Inspectors noted that Dr. Rizk's injection administration records for the patient documented that he administered up to 8 ml daily, meaning at least 4 ml per deltoid muscle, of six different injectable medications on February 22-23 and March 22-24, 2018. The Inspectors noted that this exceeded best practices for intramuscular injection volumes of 1-2 ml, depending on the reference source. They also noted that Dr. Rizk include lidocaine within these injections to minimize injection pain, but he did not provide sufficient good quality evidence that this treatment was safe and effective.

[487] In Case 6, the Inspectors noted that Dr. Rizk prescribed and administered injectable lidocaine to manage pain from other intramuscular injections. The Inspectors noted they did not find sufficient evidence supporting the use of lidocaine in this manner, including in the literature Dr. Rizk himself provided. They also noted that Dr. Rizk's injection administration record for the patient documented that he injected up to 3 ml into the patient's deltoid.

[488] In Case 7, the Inspectors noted that on July 5, 2018 Dr Rizk prescribed and administered injectable ranitidine to prevent "GI dyspepsia" related to a prescribed anti-inflammatory therapy. The Inspectors concluded that they did not find any good evidence to support this treatment route. Further, they noted that the injection administration record documented that Dr. Rizk injected volumes of medications in excess of acceptable limits.

[489] The Hearing Tribunal accepted Mr. Munchua's and Ms. Patel's evidence that best practices are to limit the volumes of medications that can be injected intramuscularly into the deltoid. Current evidence and best practice suggest a maximum of 2 ml for injection volume into the deltoid muscle. There is good reason for this since the deltoid muscle is comparatively small and generally cannot absorb the same volume of fluid as other, larger muscles. Injecting greater than 2ml of volume into the deltoid muscle places the patient at a significantly higher risk of experiencing ongoing injection site pain, abscess formation, nerve injury, and other serious complications, creating unnecessary risk to the patient. Dr. Rizk prescribed and administered large volumes by injection into the patients' deltoids, but he also added lidocaine to manage injection site pain in several cases. This was very concerning as it suggests that Dr. Rizk was aware that his injection therapy was causing pain serious enough to require an additional drug to manage it. Dr. Rizk failed to consider alternatives to administering drugs by injection and proceeded despite best practices to the contrary. He used lidocaine when its use was not supportable by evidence, and risked masking pain that could have been important to signal that something was wrong. He also injected ranitidine for Patient 7 but the evidence accessed by the Inspectors did not suggest this was an appropriate route of administration.

[490] The Hearing Tribunal found that Dr. Rizk's intramuscular injection practice was unsafe and represented a lack of skill and judgment in the practice of clinical pharmacy. It was unprofessional for the reasons described above.

Complaint 6940: Allegation 14

[491] Allegation 14 alleged that Dr. Rizk failed to respond honestly, openly and courteously to complaints and criticisms of his practice, including when in his responses:

a. you were unable to accept any review or criticism from any source;
b. you failed to acknowledge or take any responsibility for your conduct;
c. you attacked the integrity and competence of anyone who raised concerns about your actions;
d. you stated that the inspectors' opinion regarding the potential for patient harm was irrelevant because there had been no instances of patient harm; and
e. you stated that lidocaine is very safe and "instead of being offensive and ignorant", the inspectors should have looked at your results.

[492] The Hearing Tribunal reviewed Dr. Rizk's response to the 6940 complaint. Dr. Rizk's response was similar in tone to his responses to the other complaints about his conduct addressed earlier in this decision. Dr. Rizk refused to accept that there were any issues with his care. He responded to criticisms of his patient care and his files by impugning the credentials and the competence of the Inspectors. He also demonstrated his ignorance of the risks he created when he asserted that the Inspectors' opinions were irrelevant because there had been no instances of patient harm. This was very concerning to the Hearing Tribunal because pharmacists must strive to care for patients without unwarranted risks of harm. It is not sufficient to expose patients to risks and hope that those risks don't materialize. It was also untrue that no patients suffered harm. The many examples described above include patients suffering side effects for which Dr. Rizk prescribed additional drug therapies and thereby increased the risk of adverse effects and drug interactions. Perhaps the most obvious example is Dr. Rizk's intramuscular injection practice. Dr. Rizk prescribed lidocaine to manage pain that his patients were experiencing due to the treatments he was providing.

[493] Pharmacists are required by Principle 9, subparagraph 5 of the College's Code of Ethics to respond constructively to competence assessment, practice visits and other appraisals and reviews of their professional performance. Principle 10, subparagraph 10 requires pharmacists to respond honestly, openly and courteously to complaints and criticism. Dr. Rizk failed to meet these obligations. His response to the practice inspection demonstrated that he is unable, or unwilling, to accept constructive feedback and criticism to improve his practice. Health professionals who are unwilling to accept that they may be wrong and unwilling to learn from their mistakes are dangerous liabilities for the public. Dr. Rizk's response was unprofessional conduct. It would also tend to harm the integrity of the pharmacy profession. The public should expect regulated health professionals to accept constructive criticism, adopt it and improve. Pharmacists who respond in the same manner as Dr. Rizk would cause the public to lose trust in the profession.

Complaint 6940: Allegation 15

[494] Allegation 15 alleged that Dr. Rizk failed to treat his colleagues with respect when in his responses to the inspection and the complaint he suggested that Mr. Munchua and Ms. Patel were not qualified to assess his practice and described them as "lying", incompetent, having a "lack of experience", "lack of skills and knowledge" and suggesting that they could not read.

[495] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[496] While Allegation 14 addressed the overall tone and substance of Dr. Rizk's response to the 6940 complaint, Allegation 15 was about his accusations about Mr. Munchua and Ms. Patel in particular. As above, Dr. Rizk was subject to the College's Code of Ethics. Principle 10, subparagraph 10 provides that pharmacists are required to respond honestly, openly and courteously to complaints and criticism. Dr. Rizk failed to meet this obligation. His response directed many statements at Mr. Munchua and Ms. Patel, including the following:

- They were "targeting Dr. Rizk's practice even though he was using evidence for his prescribing."

- "Munchua and Patel are not in a position to challenge or criticize someone like me who has the following: Doctor of Pharmacy (6-year curriculum)…"
- "Both Munchua and Patel have poor skills in searching the literature…"
- They demonstrated "complete disrespect and lack of competence"
- "Their interpretation of the medical literature is below mediocre…"
- "…they have breached their code of ethics by disrespecting me and showing prejudice and inferiority complex. They can't say these words especially that don't hold a Doctor of Pharmacy Degree and no clinical experience."
- "Both Munchua and Patel didn't even prove any evidence of patient harm. As indicated in each case below, they kept on assuming "may have", which is irrelevant and offensive."
- "They don't have clinical experience in direct patient care like ordering lab tests and managing drug therapy and most importantly the medical knowledge."
- "Again, the 2 inspectors are lying because they haven't done inspections pursuant to the operations of Supreme Health Drug Therapy Management clinic & pharmacy…"
- "This is denigrating because of their lack of experience, they find these cases very complex which I don't and they also show inferiority complex because their qualifications are not commensurate with mine."
- "…they don't know what they are doing and are incompetent."
- "Apparently, they don't know how to read patient records because all of the requirements have been met."

[497] Dr. Rizk's statements about the Inspectors were discourteous and contrary to the Code of Ethics. Rather than respond openly and honestly, recognizing that he may have made mistakes, Dr. Rizk attacked and disparaged the Inspectors' personal integrity and competence. His response demonstrated his unwillingness to accept constructive criticism and to learn from his mistakes. As above, this was dangerous and unprofessional.

Complaint 6940: Allegation 16

[498] Allegation 16 in Complaint 6940 alleged that Dr. Rizk attempted to mislead and failed to cooperate with an investigator appointed by the Complaints Director of the Alberta College of Pharmacy when he:

a. falsely claimed that you sent approximately 12 documents to Dr. Q;
b. falsely claims that you sent approximately 15 documents to Dr. R[2];
c. falsely claimed that you sent approximately 5 documents to Dr. E;
d. falsely claimed that you sent approximately 15 documents to Dr. D when she received only one document from you;
e. falsely claimed that you sent approximately 26 documents to Dr. S when he received only five documents from you;
f. falsely claimed that you sent approximately 21 documents to Dr. Z during your treatment of your mutual patient M.S., when in fact you sent 13 of the 21

documents to Dr. Z's office on June 5, 2018, after the inspection was ordered; and

g. falsely claimed that you did not personally fax documents before April 2018.

[499] The Hearing Tribunal found this allegation proven and that Dr. Rizk's conduct was unprofessional.

[500] Dr. Rizk's response to Complaint 6940 asserted that he had collaborated and corresponded with each of his patients' physicians throughout his care.

[501] Mr. Stanowich testified that he reviewed each of the seven patient files and wrote to each of the patients' physician with summaries and copies of all of the documentation that Dr. Rizk's files suggested he had sent to them. Of the six physicians who Mr. Stanowich was able to contact, Dr. [Q], Dr. [R2], and Dr. [E] all confirmed that they had not received any of the documents. Dr. [D] had only received one out of sixteen documents that Dr Rizk's file suggested he had faxed to her. Dr. [S] had received just five out of twenty-six documents that Dr. Rizk maintained he had faxed. Dr. [Z] had not received any documents other than one faxed refill request, until June 5, 2018 which was after Dr. Rizk was notified of the practice inspection. On June 5, 2018 Dr. Rizk sent 21 pages by fax and initiated a telephone consultation with Dr. [Z] about their mutual patient.

[502] Mr. Stanowich's investigative records included a summary of his January 17, 2019 interviews with Dr. Rizk and his assistant Ms. [S]. Dr. Rizk had advised Mr. Stanowich that his pharmacy's fax procedures were not consistent prior to April 2018 and fax transmission logs were not being saved before that time. Prior to April 2018 they may have missed sending some faxes. He said he was not the person sending the faxes. It was his assistant Ms. [S] but he cannot say with 100% certainty that all of the faxes were sent. He asserted that there had been no mistakes with faxes since April 2018. Dr. Rizk's statement was inconsistent with Ms. [S's]. She advised Mr. Stanowich that she only began working at the pharmacy in mid-2017 and she only began sending faxes in April or May of 2018. Before April 2018 she was not sending any faxes and she had no idea what was being sent. Anything that was sent before then would have been sent by Dr. Rizk himself.

[503] The Hearing Tribunal concluded that Dr. Rizk's response to Complaint 6940 attempted to mislead and failed to cooperate with Mr. Stanowich when he falsely asserted that he had communicated and collaborated with his patients' physicians throughout his care. Mr. Stanowich was appointed an investigator by Mr. Krempien and Dr. Rizk had a regulatory obligation to comply with the investigation. Dr. Rizk's misleading statements to Mr. Stanowich and his failure to cooperate and respond in a forthright, honest manner was unprofessional conduct as defined by section 1(1)(pp)(vii)(B) of the HPA. The Hearing Tribunal considers pharmacists' obligation to comply with the lawful regulatory investigations to be very important. Pharmacists who refuse to cooperate undermine the College's ability to regulate the pharmacy profession in the public interest and this places the public at risk.

VI. CONCLUSION

[504] The Hearing Tribunal has found all of the allegations proven in the Notices of Hearing for the Complaint 6463, Complaint 6774, Complaint 6785 and Complaint 6940.

[505] The Hearing Tribunal will now receive submissions on sanctions. If the parties wish to have an oral hearing on sanctions, they may request this by writing to the Hearings Director, Ms. Morley, proposing possible hearing dates. Alternatively, if the parties wish to proceed with written submissions on sanctions, they may propose a process to exchange written submissions and to provide them to the Tribunal for consideration.

Signed on behalf of the hearing tribunal by its Chair on September 2, 2020.

Brad Willsey (Sep 2, 2020 09:28 MDT)

Brad Willsey

Appendix A

Exhibit List

1. NOTICE OF HEARING - COMPLAINT 6463
2. NOTICE OF HEARING - COMPLAINT 6785
3. NOTICE OF HEARING - COMPLAINT 6774
4. AFFIDAVIT OF MARGARET MORLEY
5. LETTER DATED MAY 15TH, 2019, FROM THE ALBERTA COLLEGE OF PHARMACY AND LETTER DATED MAY 16TH, 2019, FROM BROWNLEE LLP
6. LETTER DATED DECEMBER 17TH, 2019, DECISION OF SECTION 65 COMMITTEE
7. LETTER DATED APRIL 18TH, 2019, FROM THE SECTION 65 COMMITTEE
8. LETTERS DATED APRIL 17TH, 2019, FROM RICHARD HAJDUK
9. LETTER DATED APRIL 18TH, 2019, ACP, LINDA HAGEN
10. COPY OF AN E-MAIL FROM MS. HAGEN DATED APRIL 24TH, 2019, THAT ATTACHES AN E-MAIL FROM DR. RIZK DATED APRIL 23RD, 2019
11. BUNDLE OF E-MAILS
12. LETTER DATED APRIL 29TH, 2019, FROM BROWNLEE LLP, MR. CHIVERS
13. INFORMATION MANAGER AGREEMENT DATED MAY 18TH, 2019
14. E-MAIL AND TWO PHOTOGRAPHS
15. LETTER FROM BROWNLEE LLP FROM MR. CHIVERS DATED MAY 27TH TO MS. MORAN
16. LETTER FROM MS. MORAN TO DR. RIZK DATED JUNE 17TH, 2019
17. RECORD OF DECISION
18. INVESTIGATION REPORT
19. INVESTIGATION RECORDS
20. ADDITIONAL CORRESPONDENCE
21. INVESTIGATION REPORT, COMPLAINT 6785
22. RECORD OF DECISION, COMPLAINT 6785, DATED APRIL 9TH, 2019
23. INVESTIGATION REPORT, COMPLAINT 6774, DATED FEBRUARY 22ND, 2019
24. RECORD OF DECISION, COMPLAINT 6774, DATED APRIL 9TH, 2019
    A: EXPERT REPORT - DR. DANIEL BURTON
    B: EXPERT REPORT - DR. PATRICK MAYO
25. INVESTIGATION RECORDS, COMPLAINT 6785
26. MEMO RE: 6940, JAMES KREMPIEN FROM MONTY STANOWICH
27. EXPERT REPORT - DANIEL BURTON
28. INVESTIGATION RECORDS, VOLUMES 1 AND 2, ACP COMPLAINT FILE 6774
29. EXPERT REPORT - DR. PATRICK MAYO

30. NOTICE OF HEARING – COMPLAINT 6940
31. RECORD OF DECISION DATED APRIL 16TH, 2019
32. INVESTIGATION REPORT – COMPLAINT 6940
33. INVESTIGATION RECORDS - COMPLAINT 6940

END