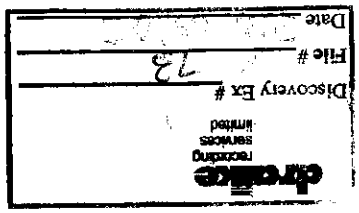

PROVINCE OF NOVA SCOTIA)
COUNTY OF HALIFAX)

IN THE MATTER OF: The ***Canada Evidence Act***

- and –

IN THE MATTER OF: The ***Medical Act***, R.S.N.S. 1995-96, c.10

- and –

IN THE MATTER OF: Dr. William Hunter Blair

SETTLEMENT AGREEMENT

Dr. William Hunter Blair, a medical practitioner in the Province of Nova Scotia, and a member of the College of Physicians and Surgeons of the Province of Nova Scotia (the "College") hereby agrees with and consents to the following in accordance with the provisions of the *Medical Act,* R.S.N.S. 1995-96, c.10.

I. STATEMENT OF FACTS

1. Dr. William Hunter Blair is a 65 year old physician, who has practiced medicine for over 40 years, the last 23 of which have been as a family practitioner in Barrington Passage, Nova Scotia.

2. Commencing in or about 1981, upon his arrival in Barrington Passage, Dr. Blair began seeing Patient A as his patient. Patient A had a long and complex medical history, involving several surgeries and chronic illnesses, including chronic back pain.

3. Between 1981 and 2002, Dr. Blair prescribed many oral and intra-muscular doses of Demerol for Patient A. In this same time period, Patient A was hospitalized on several occasions and was seen by physicians other than Dr. Blair. Several of Patient A's treating physicians provided Demerol for Patient A to assist in post-operative recovery. Patient A had approximately twelve surgical procedures to treat her back problems, including spinal fusion.

4. Commencing in 1997, Dr. Blair's office notes show repeated references to Patient A having "shaky spells", being "jerky", being "off balance", being "very wobbly", being "rubber legged", and having repeated falls. As the notes progress

from 2000 to 2002, the notes describe "shakiness getting worse"; and "falling lots".

5. From July, 2000 to July, 2001, Dr. Blair did not engage in the practice of medicine. During Dr. Blair's absence from practice, other physicians prescribed Patient A medications, including oral doses of Demerol.

6. On February 6, 2002, Dr. Blair's progress notes for Patient A indicate "falling down all over the place ? due to overindulgence in Demerol". The patient was given IM Demerol.

7. In addition to Demerol, Dr. Blair also regularly prescribed benzodiazepines to Patient A.

8. On at least two occasions following visits by Patient A to the Emergency Room, Emergency Room physicians warned Dr. Blair about Patient A's use of opioids. The prescriptions for opioids continued unchanged.

9. On at least two occasions a relative of Patient A called Dr. Blair's office to advise of concerns concerning the quantity of drugs she was taking. Despite this, the prescriptions for opioids continued unchanged.

10. Between 1998 and 2002, Dr. Blair provided the following Demerol to Patient A:

Time Frame	**# of Tablets**	**# of IM Injections**
January to December 1998	3120	21
January to December 1999	3395	21
January to July, 2000	2000	14
July 2001to December 2001	2400	5
January to June 2002	2070	6

11. Patient A died on June 23, 2002 from a cerebrovascular accident.

12. Family members of Patient A filed a complaint with the College of Physicians and Surgeons of Nova Scotia, regarding Dr. Blair's over-prescribing of Demerol to Patient A. In his response to the letter of complaint, Dr. Blair admits that Patient A was taking more Demerol than he would have liked, but it was an amount that the patient felt was required to give her some relief from her chronic pain.

13. Following receipt of the complaint at the College, the Investigation Committee of the College ordered an audit of Dr. Blair's practice by two physicians. One audit focused on Dr. Blair's general/family practice (the "practice audit") and the second audit (the "prescribing audit") focused on Dr. Blair's prescription of narcotics and other controlled substances.

14. The audits resulted in a detailed review of the patient chart for Patient A, together with detailed chart reviews for a number of randomly selected patients.

15. With respect to Patient A, the prescribing audit concluded that Dr. Blair had no explanation as to why he did not consult the Pain Clinic. The audit further commented on many side effects exhibited by Patient A, including recurrent falls, feeling shaky, headaches, constipation and weakness. Despite these side effects, Dr. Blair continued to treat Patient A with Demerol. The prescribing audit concluded that Patient A "demonstrated signs of opioid toxicity and abuse through her treatment, but these signs were either avoided by Dr. Blair or not recognized." The prescribing auditor also concluded that Dr. Blair used opioids inappropriately in this case "using short acting agents and intramuscular agents which were not indicated, and combining these with benzodiazepines which was potentially dangerous."

16. In addition to Patient A, both auditors concluded that over a prolonged period of time Dr. Blair over-prescribed or inappropriately prescribed opioids for several of his patients, including excessive amounts of "office use" injectable opioids. The auditors concluded that treating chronic headache patients with Demerol likely caused more headaches from the use of this medication. The auditors further concluded that Dr. Blair had over-prescribed benzodiazepines for patients with chronic pain, who were concurrently prescribed opioids.

17. The prescribing auditor found that the use of consultant assistance was limited, and specifically, pain management consultants were under-utilized. He further found that information regarding patients' opioids use was not adequately relayed to consultants in referral letters, and that documentation of opioids prescriptions was inadequate.

18. Pending the resolution of this matter by a Hearing Committee of the College, Dr. Blair voluntarily ceased prescribing narcotics.

II. COMPLAINT

19. In the Notice of Hearing dated May 16, 2005, the College of Physicians and Surgeons charged Dr. William Hunter Blair with the following:

> THAT being registered under the *Medical Act*, R.S.N.S., 1995-96, c.10, and being a medical practitioner in the Province of Nova Scotia during the periods listed below, it is alleged that:
>
> 1. At various times between 1981 and 2002 Dr. Blair over-prescribed and inappropriately prescribed opioids to Patient A;
>
> 2. Between 1999 and 2002, Dr. Blair inappropriately combined prescriptions for benzodiazepines with prescriptions for opioids for Patient A;
>
> 3. Over the course of his treatment of Patient A, Dr. Blair failed to provide the appropriate care in view of Patient A's signs and symptoms of opioids toxicity and over use;
>
> 4. In addition to Patient A, Dr. Blair over-prescribed or inappropriately prescribed opioids, including excessive amounts of "office use" injectable opioids for several of his patients;
>
> 5. With respect to several of his patients between the period 1981 and 2002 Dr. Blair either did not conduct or did not record assessments and evaluation of pain management therapies;
>
> 6. At various times between 1981 and 2002, Dr. Blair over-prescribed benzodiazepines for patients with chronic pain who were concurrently receiving opioids; and
>
> 7. During the period 1981 to 2002, Dr. Blair failed to maintain appropriate entries on patients' charts with respect to the management of chronic pain and provision of opioids.

AND in relation to any or all of the above Dr. Blair is alleged to be guilty of professional misconduct and therefore is guilty of a disciplinary matter within the meaning of the *Medical Act*.

III. ADMISSION

20. Dr. William Hunter Blair admits the allegations outlined in the Notice of Hearing and admits that he is guilty of professional misconduct.

IV. CONSENT TO PENALTY

21. Dr. William Hunter Blair hereby consents to the following:

    (a) Dr. William Hunter Blair shall be suspended from the practice of medicine commencing June 18, 2005 and continuing for a period of six (6) months.

    (b) Upon the lifting of the suspension of his license, Dr. Blair's license to practice medicine shall be restricted, in that he shall no longer have prescription privileges for narcotics and other controlled substances. The appropriate documentation to reflect this restriction shall be filed with Health Canada by the College of Physicians and Surgeons of Nova Scotia.

    (c) Upon the lifting of the suspension of his license, Dr. Blair shall not sponsor defined licensees with the College of Physicians and Surgeons of Nova Scotia.

V. COSTS

22. Dr. Blair agrees to pay $4,000.00 as a contribution toward the costs of the College in its investigation and resolution of this matter. Such amount shall be paid by Dr. Blair prior to the lifting of the suspension of his license to practice medicine.

VI. EFFECTIVE DATE

23. This Settlement Agreement shall only become effective and binding when it has been recommended for acceptance by the Investigation Committee of the College, and accepted by the Hearing Committee appointed to hear this matter.

DATED at [illegible], Province of Nova Scotia, this 5 day of May, 2005.

WITNESS

DR. WILLIAM HUNTER BLAIR

DATED at Halifax, Province of Nova Scotia, this 17th day of May, 2005.

WITNESS

MARJORIE A. HICKEY
COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

CHAIR,
The Investigation Committee
of the College of Physicians and Surgeons
of Nova Scotia

This 17 day of May, 2005.

CHAIR,
The Hearing Committee
of the College of Physicians and Surgeons
of Nova Scotia

This 8 day of June, 2005.