COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

DECISION OF INVESTIGATION COMMITTEE "A"

IN THE MATTER OF:

COMPLAINANT: **Mr. Kevin Lynch, Manager, PMP** [redacted]

PHYSICIAN: **Dr. Philip Davis**

PROCESS:

This matter was initiated by a letter from the complainant, Mr. Kevin Lynch, received on August 28, 2013. A response from Dr. Philip Davis was received on September 12, 2013.

Investigation Committee "A", formed in accordance with the *Medical Act* of Nova Scotia, 1995-6, was responsible for the investigation of this complaint.

In addition to the complaint and response, the Committee considered the following:

a) Dr. Davis' complete chart for [redacted];
b) a PMP prescriber profile and opioid comparison report for Dr. Davis;
c) an independent expert review from a family physician in Lunenburg, NS;
d) comments from Dr. Davis, dated November 15, 2013
e) an interview with Dr. Davis on December 10, 2013;
f) a prescribing audit of Dr. Davis' practice on October 1 and 2, 2013;
g) comments from Dr. Davis regarding the prescribing audit report, dated October 30, 2013.
h) a general audit of Dr. Davis' practice on February 13, 2014
i) comments from Dr. Davis regarding the audit report, dated March 25, 2014;
j) an updated PMP prescriber profile for Dr. Davis;
k) an onsite assessment of Dr. Davis' practice on April 30, 2014; and
l) comments from Dr. Davis regarding the assessment report.

SUMMARY OF COMPLAINT AND RESPONSE

Dr. Philip Davis is a family physician, licensed to practise medicine in Nova Scotia since 1971.

Mr. Kevin Lynch is the Manager of the Nova Scotia Prescription Monitoring Program (PMP). In this role, Mr. Lynch forwarded concerns regarding the prescribing practices of Dr. Davis in relation to a specific patient, [redacted], to the College Registrar, Dr. Gus Grant.

[redacted] is a long- time patient of Dr. Davis and has several health issues such as hepatitis C, depression, low testosterone, and genital herpes. [redacted] also has a long history of drug and alcohol abuse, previous admissions to detox programs and participation in a methadone treatment program.

On February 13, 2012, Dr. Davis began prescribing hydromorphone to [redacted] after being told that he had left the methadone treatment program due to weight gain and decreased libido. Dr. Davis provided the prescription to address [redacted] withdrawal symptoms. Dr. Davis believed the medication would maintain stability in [redacted] life, and that he would not use it to get high.

[redacted] was prescribed 8mg four times daily with the intention of gradually decreasing the amount over the next 4 to 6 months. In fact, the dosage increased over this time.

On February 22, 2012, a letter was sent to Dr. Davis from the methadone treatment program. The letter informed Dr. Davis that [redacted] had been discharged from the methadone treatment program for non-compliance, in part for receiving a prescription from Dr. Davis for hydromorphone on February 13, 2012.

On August 15, 2013, the PMP received a call from a pharmacy indicating they were not comfortable filling a prescription written by Dr. Davis for [redacted]. [redacted] had been provided with a prescription from Dr. Davis for 2360 Dilaudid 8mg tablets, to be dispensed in amounts of 118 tablets every 14 days. The prescription also allowed for part-fills for a total of 280 days. Based on this information, the matter was referred to the PMP Medical Consultant.

On August 27, 2013, the Medical Consultant contacted Dr. Davis to discuss the concerns of the PMP. At that time, Dr. Davis admitted knowledge that [redacted] had been enrolled in a methadone treatment program, and that he had been discharged for non-compliance. Dr. Davis also acknowledged that he was aware that [redacted] had a history of injecting hydromorphone. Further, Dr. Davis stated that [redacted] had no indication of pain, and that he believed he continued to inject hydromorphone.

The Medical Consultant advised Dr. Davis that [redacted] required treatment for addiction and recommended that the prescription he wrote him be cancelled. Dr. Davis felt it would be more beneficial for [redacted] to continue to receive his medication through his prescription, than to acquire the drugs on the street. Dr. Davis went on to explain that he believed he was providing support to [redacted], which would enable him to maintain employment as [redacted]. The Medical Consultant believed this to be a public safety issue and subsequently referred the matter to the College.

CONCERNS/ALLEGATIONS OF COMPLAINANT:

Mr. Lynch has the following concerns regarding Dr. Davis' prescribing practice:

1. Dr. Davis' knowledge of [redacted] continued abuse of monitored drugs and subsequent continued prescribing promotes and supports addiction for this patient;

2. Dr. Davis is not concerned that [redacted] addiction issues and current employment as an [redacted] represent an issue of public safety;

3. a prescription providing a total of nine months of part-fills to a patient with addiction issues, with no formalized plan for re-assessment or monitoring is, in PMP's opinion, an inappropriate approach to the prescribing of monitored drugs; and

4. Dr. Davis does not implement monitoring strategies such as continued re-assessment, short dispensing intervals and/or smaller quantities in situations involving potential abuse/misuse or diversion, PMP monitored contracts, urine drug screening, or active use of PMP eAccess for patient profile review.

CONCERNS OF COMMITTEE:

As with all complaints, the Investigation Committee is not limited to investigating only the concerns set out in the complaint. The Committee has the responsibility to look into all aspects of a physician's conduct, capacity or fitness to practise medicine that arise in the course of the investigation.

Although this investigation concentrated on the management of one patient, the Committee has concerns about Dr. Davis' overall management of his pain patients. Dr. Davis is a high volume prescriber with inadequate charting in support of his prescribing decisions. The Committee is concerned the deficiencies in Dr. Davis' prescribing, clearly evident in the review of this particular patient, might be present in the management of other patients in his practice.

DISCUSSION:

Both audits of Dr. Davis' practice indicate deficiencies in his medical records. The auditors found Dr. Davis' records to be brief, lacking in physical findings, and the assessment and treatment plan was often unclear.

There was very limited documentation in [redacted] medical record regarding opioid prescriptions, and no indication that the opioids were prescribed for the treatment of pain.

Most significantly, Dr. Davis was aware that [redacted] was injecting the hydromorphone, yet continued to prescribe the medication to prevent [redacted] from obtaining it on the street.

The Committee was very concerned that even with his knowledge of [redacted] medication abuse, Dr. Davis did not use any monitoring strategies such as continued re-assessment, short dispensing intervals, prescribing smaller quantities, PMP monitored contracts, urine drug screening, or active use of PMP eAccess for patient profile review.

Overall, the Committee was concerned that Dr. Davis' lack of insight has prevented him from understanding that his prescribing to [redacted] has created a potential risk to the public and to his patient.

DECISION:

1. The Committee **reprimands** Dr. Davis for the following:

    a. prescribing opioids to a patient where there is no clinical indication such medication was needed for pain;

    b. prescribing opioids to a patient who is known to abuse his narcotics prescriptions. This practice is contrary to the College's Guidelines For The Use of Controlled Substances in the Treatment of Pain; and the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain;

    c. failing to use any monitoring strategies with respect to a patient receiving large quantities of opioids.

2. It is imperative that Dr. Davis understand the risks associated with his prescribing practices. He is **counselled** to review and to apply the following enclosed College Guidelines and Policies:

    - Policy Regarding the Review of Monitored Drug History Before Prescribing;
    - Guidelines For The Use of Controlled Substances in the Treatment of Pain; and
    - Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain

3. In addition, the Committee is concerned that Dr. Davis failed to appropriately and fully document clinical encounters. As a result, Dr. Davis is **cautioned** that he must improve his record keeping.

4. The Committee also imposes the following **conditions** on Dr. Davis' licence to practise medicine:

    a. Dr. Davis is required to take the next available College of Physicians and Surgeons of Ontario Medical Record Keeping Course at his expense. In the event that Dr. Davis does not register for the next

offering of this course or successfully complete it, his licence to practice medicine will be suspended pending successful completion of the course;

b. Dr. Davis will have his practice subject to an audit within 6 months from the date of this decision to determine if his record keeping and prescribing meet the required standards of practice. Part of this audit will include a review of Dr. Davis' prescribing profile. This audit will be conducted through the College's Physician Performance Department, and will be at Dr. Davis' cost.

5. Finally, Dr. Davis is required to pay **costs** to the College in the amount of $5000.00, as a contribution toward the College's costs in the investigation and resolution of this matter. These costs shall be paid in two equal instalments, with the first instalment due by December 31, 2014, and the second instalment due no later than December 31, 2015. Failure to make payment in accordance with this paragraph will result in the immediate suspension of Dr. Davis' licence to practice medicine.

The Committee believes that the disposition outlined above reflects the serious concerns of the Committee with regard to Dr. Davis' prescribing practices and deficiencies in record keeping, both of which require significant improvement in order for Dr. Davis to practice competently and safely.

Pursuant to the *Medical Act* of Nova Scotia, 1995-6, there is no appeal of this decision.

Dated this 2nd day of October, 2014.

[redacted], Acting Chair
Investigation Committee "A"

[redacted]

Enclosure(s) Guidelines and Policies

Distribution: [redacted]