COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

SUMMARY OF DECISION OF INVESTIGATION COMMITTEE "B"

Re: Dr. David Soussou

Investigation Committee "B" concluded its investigation into matters arising from a complaint concerning Dr. Soussou's prescribing practices. The following is a summary of the Committee's decision dated January 26, 2017.

BACKGROUND:

Dr. David Soussou is a family physician, previously licensed to practise medicine in Nova Scotia. He closed his family practice in December, 2014 and commenced an ER practice in January, 2015. He advised the College he was intending to leave the province. He nonetheless applied for renewal of his licence for 2016 but made an error respecting submission of CME credits. He was away for the month of January, 2016 and upon his return, corrected the error, but was unable to find a new sponsor. He currently does not hold a licence to practice in Nova Scotia.

Dr. Soussou's prescribing practice underwent a routine review by the Practice Review Committee (PRC) of the Nova Scotia Prescription Monitoring Program (PMP), based on his overall prescribing patterns.

On September 19, 2014, a letter of inquiry was sent to Dr. Soussou by the PRC, asking specific questions concerning his prescribing patterns. No response was received.

In February 2015, the PMP contacted the College to assist them in obtaining a response from Dr. Soussou.

In March 2015, the PMP was informed by the College that Dr. Soussou had left the province. At that time, the PMP determined it would no longer continue to seek a response from Dr. Soussou.

In June 2015, Dr. Soussou's prescribing activities indicated he had provided 87 patients with part-fill prescriptions, 4 of which received part-fills for large quantities. The PMP considered this to be a risk to patient safety and contacted the College. A complaint was initiated by Dr. Grant.

In response to the complaint, Dr. Soussou advised he was not aware of the letter from the PMP until October 2014. Once a copy was resent to him, he provided a response on November 3, 2014. He was unaware that this letter was not received. He assumed the PMP was satisfied with his response because he did not hear from them again. Further, when the PRC did a follow up review, they made no attempt to contact him. If he had been contacted, Dr. Soussou states he would have provided the required explanation.

In December 2014, Dr. Soussou changed the focus of his work to emergency medicine. He closed his family practice and instead worked out of three ER departments. Dr. Soussou states he was unable to find a replacement for himself when he closed his practice, leaving patients that would need prescriptions. He felt that providing larger prescriptions to these patients was

the best way to deal with the problem. By doing so, he felt he was complying with the College guidelines regarding practice closure.

Dr. Soussou admits that he did tell College staff that he planned to leave the Province, but he did not say when. Dr. Soussou believes this complaint arose due to miscommunication.

PROCESS OF INVESTIGATION COMMITTEE:

The Investigation Committee reviewed four specific patient charts identified in the complaint. In addition, the Investigation Committee conducted an audit of Dr. Soussou's patient charts, and interviewed Dr. Soussou.

DISCUSSION:

The Committee reviewed the four specific patient charts identified in the complaint. These charts indicated Dr. Soussou prescribed large amounts of opioids without using an opioid risk tool, and prescribed short-acting opioids for prolonged periods. When Dr. Soussou closed his practice, he extended prescriptions for large amounts of opioids to patients for whom no follow-up care had been arranged. Some of these patients were prescribed both benzodiazepines and opioids. In some cases, these prescriptions were provided to patients with documented issues of opioid misuse. In these cases, the patients had only been seen approximately every 2 or 3 months. These prescribing practices are a risk to public safety and fall below the standard expected of the profession.

During his interview with the Committee, Dr. Soussou did not have a good explanation as to how he would follow patients on opioids for chronic non-cancer pain, nor did he have a satisfactory answer as to how he would manage patients who had broken an opioid contract. Dr. Soussou made only vague reference to guidelines on the College's website during his discussion with the Committee. When asked about what he would have done differently in relation to the closing of his practice, Dr. Soussou simply responded that he would communicate with the College more.

The investigation of Dr. Soussou's prescribing practices was initially hampered by the fact he does not currently hold a licence, and his records were either in storage or had been transferred to other physicians. In order to determine if the concerns raised were isolated to the files already reviewed, or indicative of a more global issue, a selection of Dr. Soussou's electronic charts was obtained from the facility where Dr. Soussou stores his patient files. These files were audited by a College appointed auditor. Part of the audit process included a discussion between the auditor and Dr. Soussou regarding specific patients.

The auditor found Dr. Soussou's most recent patient encounters to have good histories, but were lacking in the documentation of physical examinations. Her review of older patient encounters indicated Dr. Soussou's documentation was "very detailed and written beautifully".

The auditor shared the Committee's concern regarding the high amount of opioids prescribed when the practice was closed. Dr. Soussou told the auditor that he notified the local pharmacists to only dispense the medication monthly, however this was not documented on the patient charts. The auditor was able to determine that the high prescribing was not Dr. Soussou's common practice, and appeared to be isolated to the time of the closure of his practice.

The auditor also identified a concern with Dr. Soussou's use of templates in the Practimax system, which did not fit the presenting problem.

The Committee questioned Dr. Soussou about his use of templates during the interview. He indicated that he had listened to the heart and lungs of all the patients who had that template on their chart, and that he does it at the time of taking their blood pressure. The Committee did not accept Dr. Soussou's explanation. The Committee reviewed some of the audit files and found that particular template utilized in visits that did not have relevant presenting complaints. Nor was there documentation of blood pressure in those cases.

DECISION:

Dr. Soussou failed to adhere to the following College Standards (formerly Policies):

- Prescribing in the Absence of Direct Patient Contact; and
- Review or Monitoring of Drug History Before Prescribing.

In accordance with section 99(5)(f)(i)(A) of the Medical Practitioners Regulations, the Committee has determined there is sufficient evidence that, if proven, would constitute professional misconduct, and warrants a licensing sanction.

Rather than refer the matter to a Hearing, the Committee has determined that the matter can be resolved with the consent of Dr. Soussou to the following, pursuant to section 99(7)(a)(i) and (ii):

1. Dr. Soussou is reprimanded for prescribing large amounts of opioids without any on-going follow up.

2. Dr. Soussou must attend the next available sitting of the prescribing course – "Safe Opioid Prescribing for Chronic Non-Cancer Pain".

3. Dr. Soussou must attend the next available sitting of a medical record keeping course in Ontario.

4. Dr. Soussou will undergo a re-audit of his prescribing practice at his own expense, after being in practice for six months.

5. Dr. Soussou will pay a contribution towards the costs of the investigation.

The Committee believes that the disposition outlined above reflects its serious concerns with Dr. Soussou's prescribing practices.