COLLEGE OF PHYSICIANS AND SURGEONS OF NOVA SCOTIA

DECISION OF INVESTIGATION COMMITTEE B

PHYSICIAN: Dr. Janice MacGregor

PROCESS

This matter was initiated by a letter from the complainant received on February 5, 2018. A response from Dr. Janice MacGregor was received on March 16, 2018.

Investigation Committee B, formed in accordance with the *Medical Act* of Nova Scotia, 2011, was responsible for the investigation of this complaint.

In addition to correspondence from the complainant and respondent, the Committee considered the following:

- an interview with the complainant on August 28, 2018;
- an interview with Dr. Janice MacGregor on August 28, 2018;
- an interview with Dr. Janice MacGregor on December 11, 2018;
- a Prescription Monitoring (NSPMP) Prescriber Report for Dr. MacGregor from August 28, 2017 to August 30, 2018;
- a DIS (Drug Information System) report for Patient X;
- a copy of a prescription issued by Dr. MacGregor to Patient X and dated August 22, 2017; and
- a prescribing assessment ordered by the Committee.

PARTIES

Dr. Janice MacGregor is a family physician licensed to practice medicine in Nova Scotia.

Patient X was a 39-year-old man who resided in Halifax, Nova Scotia.

The complainant is Patient X's mother. She resides outside of Nova Scotia.

SUMMARY

Key points as reported by the Complainant

The complainant was Patient X's Substitute Decision Maker (SDM) at the time of his death. Dr. MacGregor was Patient X's long-term family doctor. The complainant is concerned about two prescriptions for hydromorphone written by Dr. MacGregor for Patient X, one in August 2017 and one in September 2017.

Patient X was found dead in his home on September 14, 2017. The autopsy report stated cause of death as combined hydromorphone, tramadol, clonazepam, and clozapine intoxication.

Patient X had recently been discharged after lengthy admission to the Abbey Lane Hospital. Patient X was placed on a Community Treatment Order (CTO) with a supervising psychiatrist, case management by Connections Halifax Clinical Team, and the complainant as his SDM. Patient X has had mental health problems since the age of 17, initially treated in numerous institutions in another province. He moved to Nova Scotia at age 20, and was diagnosed with paranoid schizophrenia. His disease was severe, and he spent many years as an inpatient.

The complainant has been directly involved in Patient X's care, has always had Patient X's permission to discuss his care with his physicians, and has acted as his SDM on many occasions. It was recommended Patient X stay in Nova Scotia to access the level of care he required, both in hospital in the community.

The complainant states she has had reservations about prescribing of opioids to Patient X by Dr. MacGregor, and spoke to her about this seven years previously. Dr. MacGregor continued to prescribe opioids to Patient X. The complainant alleges that Patient X's care workers attempted to engage Dr. MacGregor in a team approach to his care, but Dr. MacGregor chose not to participate in this.

In the past, it was found clozapine provided the best reduction in Patient X's psychiatric symptoms, however he developed bowel obstructions and an ileostomy and had to be monitored carefully for the constipating effects of the clozapine. He also suffered from seizures and had bilateral ankle fractures from a seizure, and developed renal failure from his ileostomy, which had to be reversed. He then developed a drop in his white cell count secondary to the clozapine, which was therefore discontinued. This resulted in a deterioration in his mental health symptoms, requiring repeated hospitalizations for the next five years, searching for an effective alternative anti-psychotic medication.

In the winter of 2017, another physician treating Patient X began a trial of clozapine again, as this was the only medication that was effective for Patient X's schizophrenia. Clozapine was started with close monitoring of Patient X's bowel health, to minimize the possibility of side effects. The clozapine trial resulted in significant reduction of Patient X's schizophrenia symptoms. Patient X was able to leave hospital and visited his home province in July 2017, accompanied by the complainant. Patient X was eventually discharged from the hospital under the requirement of the CTO.

According to the complaint letter, Patient X phoned the complainant on July 29, 2017, to ask her to cover the cost of Tramacet prescribed by QEII pain management upon his discharge, as Nova Scotia Social Services did not cover the medication.

Dr. MacGregor prescribed Patient X hydromorphone on August 22, 2017 and again on September 12, 2017. Neither the complainant nor Connections Halifax Clinical Team were informed of these prescriptions.

Police informed the complainant on September 14, 2017 Patient X was dead. The Connections Halifax Clinical Team had gone to Patient X's home concerned for his well-being after he missed a meeting. The initial autopsy did not reveal a cause of death, and a neurological cause was suspected.

On September 27, 2017, hydromorphone and Tramacet were found in Patient X's home. The complainant discussed this with Dr. MacGregor and asked her why she had prescribed the hydromorphone instead of the recommended Tramacet, and she informed her it was because the Tramacet was not covered by Social Services, and Dr. MacGregor did not want him to be in pain. The complainant also informed the medical examiner about the hydromorphone being in Patient X's home.

The final autopsy conclusion was accidental overdose due to combined hydromorphone, tramadol, clonazepam, and clozapine intoxication.

The complainant states opioids were not recommended for Patient X for many reasons in his past medical history:

- a 20 year history of self-medication;
- a history of self-research into which medications would help him, and requesting these from his physicians;
- previous hydromorphone abuse;
- several overdoses requiring Naloxone;
- opioid abuse increased his psychosis symptoms;
- opioids could cause constipation, worsening his bowel problems;
- the Pain Management team at QE2 recommended switching to Tramacet for pain control rather than Fentanyl patch;
- opioids could exacerbate the sedating effects of his other medications; and
- a history of non-compliance with his medications due to schizophrenia.

As part of his CTO, clozapine was to be delivered and consumption witnessed.

Key points reported by the Respondent

In response to this complaint, Dr. MacGregor states she first attended Patient X in November 2007. He had a past medical history of:

- schizophrenia with numerous hospital admissions;
- scoliosis;
- epilepsy;
- ileocecal intussusception; and
- bilateral ankle injuries and subsequent acute renal injury, thought to be due to a seizure.

Dr. MacGregor saw Patient X on August 22, 2017 after his discharge from hospital on July 28, 2017. At that time, she only had a report from his psychiatrist from a clinic appointment of

August 2, 2017, and a request for refill of his non-psychiatric mediations. The psychiatrist's note mentioned the CTO, but she did not yet have a copy of it. The medication list on the letter included Tramacet.

Dr. MacGregor, at that appointment, was under the impression Patient X was not taking the Tramacet due to its cost, and was aware it was not covered under Social Assistance or Pharmacare. In her experience, she had not had a successful application for Pharmacare to cover Tramacet or Tramadol. She prescribed a low dose of hydromorphone to help control his back and foot pain. She requested a back x-ray, and physiotherapy. She believed Patient X was reluctant to attend physiotherapy.

On August 31, 2017, she received a clinic note from his psychiatrist dated August 25, 2017.

She saw Patient X again on September 12, 2017. Patient X had not had the x-ray of his back. He was not sedated, and appeared similar to his previous visit. He was still having pain, and had discomfort on clinical exam. She increased his dose of hydromorphone as a short-term plan until she could get the x-ray, confirm the source of the pain, get him to physiotherapy, and develop a more definitive plan for managing his pain. She was aware of his potential for abuse. She continued to feel he was not using his Tramacet.

Dr. MacGregor states in the future, she will make more effort to obtain needed medical information, especially in complicated patients, and she will endeavour to document more fully.

Further points as reported by the Complainant

In comments to Dr. MacGregor's response to her complaint, the complainant would like to know if there will be measures in place to ensure Dr. MacGregor will act upon the changes in her patient care she has suggested.

She states she had asked Dr. MacGregor many years ago not to prescribe hydromorphone to Patient X due to his history of drug abuse and bowel problems. She does not believe Dr. MacGregor demonstrated vigilance in monitoring Patient X's bowel issues.

The complainant would like to know why Dr. MacGregor did not request the hydromorphone be added to his daily medication delivery. She would like to know why Dr. MacGregor did not consult the NSPMP before prescribing the hydromorphone. She believes Dr. MacGregor did not exercise due diligence in the care of Patient X.

Further points as reported by the Respondent

In response to the complainant's comments, Dr. MacGregor notes Patient X had a history of misusing multiple medications in the past. He had chronic pain, and Patient X was prescribed an opiate (Tramadol) while in hospital, despite his history of addiction. Patient X denied taking the Tramadol, and Dr. MacGregor could not check NSPMP, as Tramadol is not a monitored drug in Nova Scotia.

She notes Patient X did not fill his prescription for Tramadol until August 29, 2017, and did not fill it at his regular pharmacy. As she had no reason to believe Patient X had filled his Tramadol prescription, and she would not have been able to verify it if she suspected he did, and he continued to have complaints and physical evidence of pain, she felt the hydromorphone prescription was indicated to allow him to function until she could develop a more concrete treatment plan for pain control.

She believes, as Patient X was not having complaints of constipation, it would be better for him to have a potential constipating medication for its other benefits, and to treat constipation as it occurred. She notes Patient X was on many other medications that could cause constipation.

She believes she was being vigilant when she was treating Patient X. She believes she prescribed hydromorphone for sound medical reasons.

Preliminary Investigation

Pursuant to Section 88(1) of the Medical Practitioners Regulations, an investigator was appointed to conduct a preliminary investigation of this complaint.

CONCERNS/ALLEGATIONS OF COMPLAINANT

The complainant alleges:

- Dr. MacGregor prescribed hydromorphone to Patient X despite his high risk for abuse and side effects, documented thoroughly in the past;
- Dr. MacGregor should have been aware of the Patient X's substance abuse and drug seeking behaviour;
- Dr. MacGregor did not cooperate with the Patient X's psychiatric team; and
- Dr. MacGregor was aware of the CTO but did not access it or follow its recommendations.

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.

In this instance, the Committee noted the following additional areas of concern arising from the investigation of this complaint beyond those expressed by the complainant:

- Dr. MacGregor issued prescriptions for both Tramacet and hydromorphone to Patient X at his appointment of August 22, 2017, and did not document the Tramacet prescription in his medical record;

- Dr. MacGregor did not recall writing this prescription but when she saw a copy of it, she acknowledged it was her hand writing; and

- Dr. MacGregor does not follow the recommendations of the *Canadian Guideline for Opioids for Chronic Non-Cancer Pain.*

DISCUSSION

This complaint alleges Dr. MacGregor's prescribing practices contributed to the death of Patient X. To further investigate these allegations the Committee considered the written submissions of the complainant and Dr. MacGregor, as well as its interviews with the complainant and Dr. MacGregor. The Committee also considered an assessment report of Dr. MacGregor's general prescribing practices.

In her interview, the complainant made note of documentation on his chart regarding his history of opioid dependence and his history of abusing psychiatric medications. She informed the Committee she had told Dr. MacGregor part of Patient X's delusion was he was able to prescribe medications to himself, to the extent he had acquired a copy of the Canadian Compendium of Pharmaceuticals and Specialties (CPS) and had studied it for this purpose. He ordered medications online and she believed his seizure, which caused his fractured ankles, resulted from medications he had ordered from internet- based sources.

The complainant believed Dr. MacGregor was aware of all this information, and yet kept prescribing Dilaudid and Fentanyl to Patient X.

In her interview with the Committee Dr. MacGregor confirmed she was well aware of Patient X's history, but was convinced he was much healthier looking than he had been for years when she saw him on August 22, 2017. She stated she reviewed a letter from Patient X's psychiatrist from his most recent clinic appointment, but did not have a copy of the CTO or his discharge summary from his last admission. She reviewed his medications and noted he had been prescribed Tramadol.

She confirmed to the Committee it was her duty to prescribe another opioid in an effort to help him with his significant pain symptoms as she felt Patient X was unable and had not accessed his prescription for Tramacet. She stated in retrospect, she should have contacted Patient X's psychiatrist, and faxed the opioid prescriptions to Patient X's pharmacy, instead of giving him a written prescription.

The Committee had significant concerns with Dr. MacGregor's treatment of Patient X, and her approach to prescribing opioid medications for chronic non-cancer pain. The Committee ordered a Drug Information System Record (DIS) for Patient X. This indicated Patient X had filled a

prescription for Tramadol at a pharmacy that was not his usual pharmacy on August 29, 2017. Dr. MacGregor issued the prescription. The Committee also requested a copy of this prescription from the pharmacy, which confirmed Dr. MacGregor had issued it. The report indicated Patient X had not filled a prescription for Tramadol or Tramacet from any other prescriber.

Based on its concerns raised by this case, and the results of Dr. MacGregor's NSPMP report, the Committee ordered a prescribing assessment to evaluate Dr. MacGregor's opioid prescription practices. The Committee noted a number of concerns about Dr. MacGregor's opioid prescribing practice. The report noted a number of deficiencies in medical record-keeping including no Cumulative Patient Profiles, no chronic disease flowcharts, and limited documentation of history and physical examinations, especially acute presentations of back pain, knee injuries, and new rashes. The dose and amount of medication dispensed was not always noted on the chart.

The assessor noted Dr. MacGregor appeared to be tapering opioid doses starting in 2018, but still had many patients on greater than 90 morphine milligram equivalents. The assessor noted Dr. MacGregor had inconsistent monitoring for opioid diversion. She noted Dr. MacGregor was not using NSPMP e-access. She noted Dr. MacGregor was making increased use of urine drug screens, but was still using them less often than necessary. She noted more of Dr. MacGregor's patients had opioid agreements, but some high-risk patients still did not have opioid agreements. She noted a number of patients were being prescribed opioids and benzodiazepines concurrently, and a number of patients were still on two different benzodiazepines.

In her response to the audit, Dr. MacGregor states she had made a number of changes in her opioid prescribing. She had arranged for a computer so she can access the NSPMP e-access site in her examination room. She had registered for the Safer Opioid Prescribing Program in Toronto. She was planning to contact Dr. John Fraser, a chronic pain management specialist who has offered to meet with her regularly to discuss challenging pain cases.

As a result of these findings, the Committee requested another interview with Dr. MacGregor. At this interview, Dr. MacGregor states she had no recollection of writing a prescription for Tramacet for Patient X, either at the time she responded to her complaint, or at the first interview with the Committee.

At the interview, Dr. MacGregor confirmed she had made a number of other changes to her practice. She confirmed she has a computer that will allow access to the NSPMP e-access site in her examination room. She has instituted a policy of obtaining an opioid contract for all her opioid patients, and will be making use of urine drug screens on all patients being prescribed opioid medications. She has started to wean a number of her opioid patients, and has been able to stop opioids in some patients.

Dr. MacGregor stated she is a member of the Atlantic Mentorship for Pain and Addiction and will be meeting with this group regularly. She had recently attended the Safer Opioid Prescribing Program in Toronto.

The Committee identified a number of concerns with Dr. MacGregor's assessment and treatment of Patient X. The Committee acknowledges the difficulties some patients can have in accessing

medications when they are out of hospital, however believes Dr. MacGregor failed to access a number of resources available to her which would have enabled Patient X to obtain the medications he needed in a safe manner.

The Committee noted Dr. MacGregor has much experience in treating psychiatric patients both in and out of hospital. Dr. MacGregor admitted to the Committee she was well aware of Patient X's complicated medical history and history of addiction and drug abuse. Her actions, however, did not reduce the risk of misuse of the medications she prescribed. Dr. MacGregor did not use her knowledge and experience to access a number of resources available to her to assist in Patient X's safe care, including consulting directly with Patient X's outpatient psychiatrist to confirm the management plan upon Patient X's discharge from hospital. The Committee was very concerned Dr. MacGregor had prescribed two different opioid medications for Patient X at the same appointment, and did not recall prescribing one of them until the Committee itself discovered the second prescription.

The Committee is concerned with Dr. MacGregor's opioid prescribing patterns in general, as identified by her practice audit. The Committee finds Dr. MacGregor is not following the recommendations included in the *Canadian Guideline for Opioids for Chronic Non-Cancer Pain*, as endorsed by the College.

The Committee would like to extend its condolences to the complainant on the death of her son, and to thank her for bringing this issue to the Committee's attention

DECISION

In accordance with clause 99(5)(f) of the *Medical Practitioners Regulations,* the Committee has determined there is sufficient evidence that, if proven, would constitute professional misconduct incompetence or conduct unbecoming, warranting a licensing sanction.

Pursuant to clause 99(7)(a)(i) of the *Medical Practitioners Regulations*, and with Dr. MacGregor's consent, Dr. MacGregor is ***Reprimanded*** for:

- prescribing opioids to a patient at high risk for abuse without appropriate assessment and safeguards;
- failing to document a prescription for opioids, such that she could not recall doing so when consulting her medical record;
- failing to collaborate with psychiatric colleagues in the management of a high risk, complex patient; and
- failing to follow *Canadian Guideline for Opioids for Chronic Non-Cancer Pain,* as endorsed by the College of Physicians and Surgeons of Nova Scotia.

In addition to the Reprimand, pursuant to clause 99(5)(e) of the *Medical Practitioners Regulations,* the Committee has referred Dr. MacGregor to the Registrar for a competence assessment and recommends to the Registrar that the competence assessment include the following elements, with the costs to be borne by Dr. MacGregor:

1. Dr. MacGregor will attend the next available offering of a Safe Opioid Prescribing Course for Chronic Non-Cancer Pain at her own expense, and will provide the College with a certificate of attendance. If Dr. MacGregor has already attended a safe prescribing course, she will provide the College with a certificate of attendance;

2. Dr. MacGregor will establish contact with Dr. John Fraser and arrange regular meetings with Dr. Fraser to evaluate and assist in her management of complex chronic pain patients. Dr. MacGregor will arrange for Dr. Fraser to issue a report to the College on the results of these meetings to the College after 6 months; and

3. Dr. MacGregor will undergo a re-audit of her practice in approximately 6 months, with a focus on her prescribing opioids for chronic non-cancer pain. This re-audit will be performed by a College approved assessor as chosen by the College's Compliance Officer.