IN THE MATTER OF: The *Medical Act*, S.N.S. 2011, c. 38

and

IN THE MATTER OF: A Settlement Agreement

BETWEEN:

The College of Physicians and Surgeons of Nova Scotia

("the College")

-and-

Dr. Sarah Jones

("Dr. Jones")

HEARING COMMITTEE DECISION

Date Heard: June 26, 2019

Location: Halifax, Nova Scotia

Hearing Committee: Mr. Raymond F. Larkin, Q.C.
Dr. Michael Teehan
Dr. Erin Awalt
Dr. Zachary Fraser
Ms. Mary Hamblin

Counsel: Ms. Marjorie Hickey, Q.C., Counsel for the College of Physicians and Surgeons of Nova Scotia

Mr. Colin Clarke, Q.C., Counsel for Dr. Sarah Jones

1. On June 26, 2019, the Hearing Committee considered a proposed Settlement Agreement between the College and Dr. Sarah Jones which had been recommended by the Investigation Committee.

2. Dr. Jones, over a period of years, prescribed a shockingly excessive amount of Oxycodone or similar drugs to one particular patient, lied to the Prescription Monitoring Program and community pharmacists to justify these prescriptions, and failed to provide the College with any satisfactory explanation for why she prescribed excessive amounts of this drug, or explain what happened to the large quantities of the drug that the patient himself could not have ingested.

3. The Settlement Agreement includes a three year time-served suspension of her licence to practice medicine, strict conditions to be met before her return to practice and extensive conditions and restrictions on her practice when she does return.

4. At the hearing, the Hearing Committee indicated that it accepted this Settlement Agreement as recommended by the Investigation Committee, with an amendment agreed to by the Registrar and Dr. Jones, with reasons to follow.

5. These are the reasons for the Hearing Committee's decision to accept the Settlement Agreement.

Partial Publication ban

6. Since the hearing, counsel for the College and Dr. Jones have requested the Hearing Committee to order a partial publication ban on aspects of the Settlement Agreement that included Dr. Jones' personal medical information and to order a number of redactions to the Settlement Agreement that are made necessary by the partial publication ban.

7. The Hearing Committee is authorized by Section 53(5) of the Medical Act and Section 109(4) of the Medical Practitioners' Regulations to order a publication ban for proper reasons as the Committee deems necessary. In our opinion, it is unnecessary to publish the personal medical information of Dr. Jones to meet the objective of a clear and transparent account of her conduct in this case. We agree that the proposed redactions are necessary and appropriate to protect her personal privacy.

8. Accordingly, we order that the paragraphs in the Settlement Agreement which disclose certain personal medical information of Dr. Jones be redacted in any publication of the Settlement Agreement in the manner set out in the Redacted Settlement Agreement which is attached to these reasons for decision as Appendix 1.

9. The full Settlement Agreement without redactions is attached to the original approval by the Hearing Committee signed on June 26, 2019 and is incorporated into these reasons and is attached as Appendix 3. Any publication of the Settlement Agreement shall be in the form of the Redacted Settlement Agreement.

Facts

10. The facts which have been agreed to by the College and Dr. Jones are set out extensively in the Redacted Settlement Agreement. It is unnecessary to review all of those facts, but certain key facts must be kept in mind.

11. Dr. Jones began practice in 2009. In the previous decade there was widespread recognition of problems with the use of prescription opioids, both by patients themselves and by others who obtained prescribed drugs from them.

12. In Nova Scotia, the *Prescription Monitoring Act* was enacted in 2004 to establish a prescription monitoring program to promote the appropriate use of monitored drugs such as OxyContin and the reduction of abuse or misuse of monitored drugs. Regulations under the *Act* dealt with the prescription and dispensing of monitored drugs, and authorized the Administrator of the program to obtain detailed information about the prescriber, the recipient, and the dispensers of the monitored drugs.

13. The system under the *Prescription Monitoring Act* was well in place by the time that Dr. Jones obtained her certification in the College of Family Physicians and began medical practice as a family physician in 2009. Shortly after, the 2010 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-cancer Pain established guidelines for opioid prescribing practices aimed at limiting inappropriate or excessive use of opioids.

14. In January 2010 Dr. Jones took on Patient X as a patient. He was a gentleman in his 60s who had chronic pain in his right hip, knee and foot stemming from multiple sources. Based on her initial assessment, Dr. Jones concluded that Patient X's pain was not well controlled, and she prescribed increasing amounts of opioids between then and August 2015, when Patient X was hospitalized and Dr. Jones' prescribing practices to Patient X came under scrutiny.

15. During this four year period, Dr. Jones made frequent strength switches and dosage adjustments in the prescribed drugs which resulted in the dispensing of significant excess amounts of drugs, mainly Oxycodone, beyond what Patient X could ever consume himself. The quantities of drugs prescribed were astonishing in comparison to the 2010 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-cancer Pain. For example, Dr. Jones prescribed Patient X 33,282 tablets of Oxycodone from August 7, 2014 to August 12, 2015, totalling 584,220 mg. of Oxycodone. In the month before Patient X's admission to hospital in August 2015, Dr. Jones prescribed him a total of 47,770

mg. of Oxycodone. These amounts of Oxycodone could not have been safely ingested by one patient.

16. In July 2010, Dr. Jones began picking up Patient X's prescriptions at the pharmacy and making house calls bringing them to Patient X at his home. Within a few months, the Prescription Monitoring Program called her and, as a result, Dr. Jones stopped picking up Patient X's prescriptions as of October 23, 2010. However, in January 2012 she started picking up his prescriptions again, doing so without advising the Prescription Monitoring Program.

17. Over the period of time that Dr. Jones treated Patient X, and as early as 2011, there was evidence that his use of opioids was harmful to him. Dr. Jones continued to prescribe high doses of opioids after there was demonstrable harm such as choking, falling, and confusion with dosing.

18. The amount of opioids prescribed to Patient X while under Dr. Jones' care was excessive, dangerous and inappropriate. Given the quantities of opioids prescribed to Patient X, it is likely there were pills left over, missing, not accounted for, diverted or consumed in excess or inappropriately by Patient X or others, which presented a real danger to Patient X and the public.

19. Dr. Jones let Patient X take over the direction of his care. For example the Seniors' Community Health Team recommended a visit from their Pharmacist to discuss his medication. Patient X refused to undergo the medication review but Dr. Jones did not insist. He refused to follow her advice including her referrals to specialists.

20. Dr. Jones did not properly document Patient X's medication use. Nor did she monitor his actual consumption of opioids or monitor safe storage of the pills.

21. The extent of Patient X's use of opioids drew the attention of others in the health care system but Dr. Jones misled them with false explanations. She gave false and misleading responses to inquiries from the Prescription Monitoring Program and the pharmacists who dispensed the prescriptions and continued to prescribe excessive amounts of opioids to Patient X. She later gave false or misleading information to the Registrar of the College and to her practice colleagues respecting her health.

22. The Investigation Committee ordered two audits of Dr. Jones' practice. Neither audit identified concerns with her clinical care of the patients whose charts were identified. The second assessor concluded that she provided very good clinical care and had excellent medical records. Except for her dealings with Patient X, no issues have arisen about her clinical care of patients.

23. Dr. Jones' treatment of Patient X and her misleading others about it cries out for an explanation. In the Settlement Agreement she admits her many failures to meet the standards of practice. Her explanation for why she engaged in this behavior is that she was a young, naïve physician who got in over her head with a single patient whose pain she was not able to control. There is some suggestion that her deception of the Registrar of the College and her colleagues in October 2015 was the result of severe stress and reactions to sleeping medications. Dr. Jones provided an expert report which concluded that she was a relatively inexperienced physician who found herself clinically over her head but tried her best but ultimately failed in her care of Patient X.

24. These rationales for Dr. Jones' conduct do not come close to explaining the amount of oxycodone ordered for Patient X and her home visits to deliver the medications over a long period of time. There is no real explanation for what happened to the excess drugs prescribed for Patient X. There is no explanation for her repeated misleading explanations of her treatment of Patient X to others in the health system and the

authorities who questioned her conduct. There is no explanation, in particular, for her extensive false statements to the Prescription Monitoring Program.

25. There is no evidence that Dr. Jones used the opioids herself or provided them to anyone but Patient X. There is no evidence that Patient X provided excess medication to others.

26. Dr. Jones was charged criminally for aspects of her dealings with Patient X but was acquitted of all charges.

Allegations of Professional Misconduct, Incompetence and Incapacity

27. The Investigation Committee has referred the following matters to the Hearing Committee:

> 1. With respect to the care provided to the Patient from January 2010 to August 2015, Dr. Jones failed to meet the accepted standards of practice of medicine respecting the prescription of opioids, by engaging in practices including the following:
>
> a. prescribing amounts of opioid medication to the Patient that were excessive, unsafe or otherwise inappropriate;
>
> b. failing to properly monitor Patient's use of opioids;
>
> c. failing to monitor the system for safe storage of opioids in the Patient's home;
>
> d. continuing to prescribe high doses of opioids after there was demonstrable harm to the patient, such as choking, falling and confusion with dosing;
>
> e. failing to properly and safely dispose of opioid medication;
>
> f. failing to properly document the Patient's opioids during an alleged weaning period in July and August, 2015; and/or

g. continuing to prescribe large quantities of opioids during an alleged weaning period in July and August, 2015; and/or

h. failing to obtain and/or retain a written prescribing agreement with the Patient.

2. With respect to the care provided to the Patient from January 2010 to August 2015, Dr. Jones failed to maintain the appropriate physician/patient boundaries by engaging in practices including the following:

a. frequently picking up and delivering the Patient's opioid medication and removing the Patient's unused opioid medication from his residence;

b. ignoring and/or failing to act on indications that the Patient was not using the opioid medication properly or safely;

c. ignoring and/or failing to act on indications that the patient was not storing opioid medication properly or safely and/or

d. permitting the Patient to direct his own care.

3. In Dr. Jones' June 14, 2012 and February 25, 2014 letters to the Prescription Monitoring Program, she violated the accepted standards of practice and *Code of Ethics* by doing one or more of the following:

a. Providing false, misleading and/or incomplete information respecting:

i. the Patient's medical history and quality of life;

ii. the Patient's level of compliance;

iii. the existence of a signed narcotics contract;

iv. the filling of prescriptions;

v. the disposition of excess medication;

vi. her level of consultation with pharmacists and her colleagues about the Patient; and/or

vii. the weaning of the Patient;

b. Failing to advise that she had resumed the pick-up and delivery of medication to the Patient.

4. During Dr. Jones' October 27, 2015 meeting with Dr. D.A. Gus Grant, Registrar of the College, she violated the standards of the profession, the Canadian Medical Association's *Code of Ethics* and the duty to cooperate under the *Medical Act* by providing false, misleading and/or incomplete information (redacted in part by the partial publication ban).

5. Dr. Jones violated accepted standards of practice and the Canadian Medical Association's Code of Ethics by providing false, misleading and/or incomplete information to pharmacists, including information that she was working with a pain specialist regarding prescriptions for the Patient when that was not the case.

6. Between August and October 2015, Dr. Jones violated accepted standards of practice and the Canadian Medical Association's *Code of Ethics* by providing false, misleading and/or incomplete information, [redacted], to her physician colleagues (redacted in part by the partial publication ban).

7. Dr. Jones failed to meet accepted documentation standards by engaging in practices including the following:

a. Failing to retain an alleged written prescribing agreement with the Patient;

b. Failing to properly document the Patient's prescriptions and treatment; and/or

c. Making a number of excessively late entries into the Patient's record.

8. Dr. Jones practiced medicine while suspended by editing a large number of patient encounters on the Patient's electronic record while her license to practice medicine was suspended by the College.

28. In the Settlement Agreement Dr. Jones admits the particulars of above allegations and acknowledges that collectively they constitute professional misconduct,

incompetence and incapacity. The Hearing Committee agrees with the Investigation Committee that the facts support these admissions.

Disposition

29. In the Settlement Agreement Dr. Jones and the College have agreed to the following disposition of the complaint against Dr. Jones:

126. Dr. Jones agrees to the following:

a. Dr. Jones' license to practice medicine is suspended for a period of 36 months. She will receive credit for her time suspended on an interim basis and, accordingly, her suspension is considered fully served.

b. Dr. Jones will provide no medical care to Patient X at any time in the future if she holds a medical license.

c. As Dr. Jones has been out of practice for a period greater than 3 years, she is required to meet the provisions of section 16 of the regulations under the *Medical Act* prior to return to practice. This regulation requires physicians who have been out of practice for 3 years or more to complete a competence assessment prior to returning to practice. For purposes of the competence assessment Dr. Jones will be issued a Clinical Assessment licence, whereby Dr. Jones will not be considered the most responsible physician, and will not bill for her services. With successful completion of the competence assessment (as determined by the Registration Committee), she can then apply for a Restricted License to practice medicine as the most responsible physician, as set out in subparagraph 126(g). The terms of the competence assessment for Dr. Jones are set out in the document attached as Schedule "B" to this Settlement Agreement. The costs of this competence assessment shall be paid by Dr. Jones as set out in Schedule "B".

d. While engaged in the competence assessment outline in Schedule "B", Dr. Jones must commence counselling with a therapist who will be provided by the College with a copy of this Settlement Agreement in order to understand the context in which the counselling is required. Counselling sessions must occur on a monthly basis or such other more frequent basis as recommended by the therapist. Prior to Dr. Jones applying for a Restricted License upon completion of the competence assessment outlined in Schedule "B", the therapist is required to provide a report to the College's Professional Conduct

Compliance Office either confirming Dr. Jones' fitness to return to practice or identifying any concerns for follow up with the Hearing Committee.

e. While engaged in the competence assessment outlined in Schedule "B", Dr. Jones must maintain contact with her family physician who will be provided by the College with a copy of this Settlement Agreement. Dr. Jones agrees to see her family physician on at least a monthly basis or more frequent basis as recommended by her physician while participating in the competence assessment. Prior to Dr. Jones apply for a Restricted License upon completion of the competence assessment outlined in Schedule "B", the physician is required to provide a report to the College's Professional Conduct Compliance Office either confirming Dr. Jones' fitness to return to practice or identifying any concerns for follow up with the Hearing Committee.

f. Prior to commencing the competence assessment outlined in Schedule "B", Dr. Jones must supply a hair sample to a testing agency selected by the College, in such manner as determined by the College and must test negative for any of the Prohibited Substances set out in subparagraph 126 (g)(vii). The cost of this test shall be initially paid for by the College and then reimbursed by Dr. Jones in the same manner as ongoing tests described in subparagraph 126(g) viii).

g. When the Professional Conduct Compliance Office determines that Dr. Jones has met the criteria set out in subparagraphs (a) to (f) above, she may apply to the College's Registration Committee for a Restricted License. If she is issued a Restricted Licence, she may return to practice under a Restricted Licence, with the following conditions and restrictions, and such other conditions as the Registration Committee may determine are necessary based on the recommendations coming out of the competence assessment set out in Schedule "B" and based on the requirements set out in the *Medical Act* for a restricted licence:

i. Dr. Jones must complete the following remedial education, at her cost, at the first available opportunity following her return to practice in accordance with Schedule "B":

A. The *Understanding Boundaries and Managing Risks Inherent in the Doctor Patient Relationship* course provided by Western University;

B. Ethics education as determined by the Physician Performance Department.

ii. Dr. Jones will have a permanent restriction on her medical licence preventing her from prescribing Narcotics (under the *Controlled Drugs and Substances Act* Schedule I) and cannabis (under the *Controlled Drugs and Substances Act* Schedule II). Dr. Jones will prominently place a College approved sign to that effect in her clinic waiting room and examination room.

iii. Dr. Jones will have a restriction on her licence preventing her from prescribing benzodiazepines, and zoplicone, zaleplon or additional members of this class of drugs that may emerge (collectively the "Z-drugs") for a minimum period of 2 years following her return to practice. Dr. Jones will prominently place a College approved sign to that effect in her clinic waiting room and examination room. Upon completion of the 2-year period she may apply to the Hearing Committee of the day for a variation of this restriction and the Hearing Committee will consider whether it is in the public interest at that time to vary or remove this restriction.

iv. Dr. Jones will be required to notify Health Canada that she has relinquished her privileges for the drugs identified in subparagraph (ii). The Registrar will provide Dr. Jones with a letter template she agrees to sign and return to the College for forwarding to Health Canada with an explanatory letter from the College.

v. Dr. Jones' practice will be subject to the supervision requirements set out in Schedule "C" to this Settlement Agreement for a period of two years following return to practice. The costs of the supervision shall be paid by Dr. Jones as set out in Schedule "C" at the time supervision is provided.

vi. Dr. Jones will not practice as a sole practitioner (in an office with no other practising physicians) for a minimum period of two years following her return to practice. The Physician Performance Department must approve of the location of Dr. Jones' practice for the first two-year period. If, following the two year period, Dr. Jones wishes to practice by herself, she will be required to apply to the Hearing Committee for approval.

vii. Dr. Jones shall abstain from taking any opioids, benzodiazepines, cannabis and Z-Drugs unless expressly prescribed by a physician (the "Prohibited Substances"). Dr. Jones must notify the College of any prescriptions for the Prohibited Substances within 24 hours of such prescription.

viii. For a period of five years, Dr. Jones shall participate in a program of monitoring (the "Monitoring Program") to be conducted by such testing agency as may be approved by the College. The Monitoring Program shall test for the presence of any Prohibited Substances at such times and in such manner as will be specified in a protocol provided by the College, which will, to the extent possible utilize hair testing as the means to test for Prohibited Substances. Testing shall not occur more than four times per year for the first two years, and no more than six times in total for the remaining three years. Reasonable accommodation shall be given to Dr. Jones' work and travel schedules. The College shall pay the invoice received from the testing agency and shall then remit each invoice for reimbursement from Dr. Jones, who shall remit such reimbursement within 30 days of receipt of the invoice from the College.

ix. Dr. Jones shall continue in monthly counselling with a therapist for a minimum period of two years, or such greater frequency as recommended by her therapist, at her cost. At the end of the two year period, if the therapist determines additional therapy is needed, Dr. Jones agrees to abide by the recommendations of her therapist. Dr. Jones consents to her therapist immediately reporting to the College at any time any breach of this settlement agreement or any concerns respecting Dr. Jones' fitness to practice. For clarity, the therapist will not be required to provide the College with any portion of Dr. Jones' patient chart or any notes made during the counselling sessions. Dr. Jones agrees to notify the Professional Conduct Compliance Office of the name and contact information of her therapist during the period of time when she is required to see a therapist, and agrees the College may provide a copy of this Settlement Agreement to her current therapist.

x. Dr. Jones shall continue with regular visits to her family physician at such frequency as recommended by her physician for the first two years following return to practice. Dr. Jones agrees the frequency of her visits will be no less than quarterly, and hereby consents to her family physician providing quarterly reports to the College respecting her fitness to practice during this two year period.

xi. Dr. Jones further consents to attending visits with her family physician at such intervals as recommended by her family physician for a period of 10 years following return to practice, and hereby provides her consent for her family physician to report to the College any breach of this settlement agreement or any concerns respecting Dr. Jones' fitness to practice during this ten year period. She agrees to notify the Professional Conduct

Compliance Office during this ten year period of the name and contact information of her family physician and agrees the College may provide a copy of this Settlement Agreement to the family physician of the day for this ten year period.

Settlement Agreements Generally

30. In its previous decisions, the Hearing Committee has accepted the principle of deference to a recommendation of the Investigation Committee for approval of a settlement agreement reached between the Registrar and a practitioner. There are good reasons for this.

31. In most cases, the Investigation Committee will have a much more detailed knowledge of the facts than a hearing committee because of their involvement in investigating a complaint over an extended period of time. Furthermore, the Investigation Committee makes a recommendation of a settlement agreement within a legislative framework in Section 102 of the Medical Practitioners' Regulations which ensures a rigorous and exacting approach to whether a complaint should be settled.

32. In our view, settlement agreements should be encouraged because they permit the Registrar and the Investigation Committee to negotiate the resolution of complaints without the delay and expenses of a formal hearing. As in this case, there may be significant issues of proof that make the outcome of a formal adjudicated hearing uncertain. Likewise for the practitioner subject to a complaint, the prospect of success in a hearing may be uncertain, and the possibility of a significant costs award provide an incentive to make appropriate admissions and consent to a disposition they can accept. Some agreed dispositions are possible in a settlement agreement that may not be possible in a formal hearing.

33. It is true that the settlement agreement process is not as transparent to the public as a formal hearing but to be acceptable settlement agreements have to include detailed statements of the facts. The decision of a hearing committee to accept a settlement agreement requires the reasons for accepting it. These are made public.

The Limits of Deference

34. This particular case has tested the limits of the Hearing Committee's willingness to defer to the judgment of the Investigation Committee. In the absence of any satisfactory explanation from Dr. Jones for prescribing excessive quantities of opioids for her patient and any adequate explanation for what happened to the Oxycodone that her patient did not use, we have to consider whether the Settlement Agreement assures us that the public is protected by permitting Dr. Jones to return to practice on the one hand and, on the other hand, whether a 3-year time served suspension is an appropriate disposition.

35. The absence of any acceptable explanation for Dr. Jones' conduct creates doubt that she can safely be returned to practice. Her answer that she got in over her head as a young naïve physician, leaves so many questions unanswered that it is really no explanation at all. The fact that she has now admitted her many departures from the accepted standards of practice does not inspire confidence in the face of her persistent dishonesty over several years.

36. The Hearing Committee does not just rubber-stamp a settlement agreement recommended by the Investigation Committee. We not only assess the criteria for the recommendation of a Settlement Agreement by the Investigative Committee set out in Section 102 of the Medical Practitioners Regulations, but we examine the settlement agreement closely for its consistency with the purposes of the College, as set out in Section 5 of the *Medical Act* which provides as follows:

Purpose and duties of College

5 In order to

(a) serve and protect the public interest in the practice of medicine; And

(b) subject to clause (a), preserve the integrity of the medical profession and maintain the confidence of the public and the profession in the ability of the College to regulate the practice of medicine, the College shall

(c) regulate the practice of medicine and govern its members Through

(i) the registration, licensing, professional conduct and other processes set out in this Act and the regulations,

(ii) the approval and promotion of a code of ethics,

(iii) the establishment and promotion of standards for the practice of medicine, and

(iv) the establishment and promotion of a continuing professional
development program; and

(d) do such other lawful acts and things as are incidental to the attainment of the purpose and objects of the College. 2011, c. 38, s. 5.

37. In our opinion, the public interest in the practice of medicine is first and foremost the protection of the public. Members of the public as patients depend fundamentally on the assessment, diagnosis and treatment of illness or injury by medical practitioners for life, health and happiness. The public depends on medical practitioners working in accordance with the accepted standards of the practise of medicine, including high standards of integrity and ethics. The College strives to ensure the protection of the

public by regulating the practice of medicine and governing the conduct of its members to the high standards that the public expects.

38. Serving and protecting the public interest in the regulation of professional conduct under the *Medical Act* also requires fair treatment of medical practitioners who are subject to complaints. There is a strong public interest in ensuring that the process for the investigation and adjudication of complaints, and the substance of decisions made in that process, are fair to the medical practitioners.

39. There is an important public interest in finding appropriate dispositions that keep medical practitioners in practice so they can serve the public in accordance with the standards of the medical profession. There continues to be a shortage of physicians in Nova Scotia. If possible, medical practitioners who engage in professional misconduct should be returned to practice with appropriate conditions and restrictions.

40. There is also a public interest in maintaining the credibility of the College as a regulator of the practice of medicine. It is important that the public is assured that genuine complaints are not swept under the rug, and that the College is effective in protecting the public and in maintaining high standards among medical practitioners.

41. In our view, in considering whether to accept this Settlement Agreement, the Hearing Committee has to balance all of these aspects of the public interest so that the approval of this Settlement Agreement serves to protect the public, treats Dr. Jones fairly, and maintains the confidence of the public and profession in the College.

42. We recognize that there can often be more than one reasonable conclusion about how to balance these aspects of the public interest in assessing a particular settlement

agreement. If the Investigation Committee recommends a disposition that falls within a reasonable range of alternative conclusions we will defer to their judgement.

43. In assessing whether the dispositions in a settlement agreement fall within a reasonable range of alternatives the Hearing Committee keeps in mind its statutory mandate where it has found professional misconduct, conduct unbecoming, and competence or incapacity after a formal hearing.

Remedial not punitive dispositions

44. Neither the *Medical Act* or the Medical Practitioners Regulations aim primarily at penalizing or punishing medical practitioners who engage in professional misconduct. Section 54 of the Act authorizes a hearing committee to "dispose of the matter in accordance with the Regulations." Section 115 of the Medical Practitioners Regulations sets out the possible dispositions when a hearing committee finds professional misconduct, conduct unbecoming, incompetence or incapacity as follows:

> 115 A hearing committee that finds professional misconduct, conduct unbecoming, incompetence or incapacity on the part of a respondent may dispose of the matter in any manner it considers appropriate, including doing 1 or more of the following, and must include orders for the action in the committee's disposition of the matter:
>
> a. revoke the respondent's registration or licence;
>
> b. for a respondent who held a temporary licence at the time of the incident giving rise to the complaint, revoke the respondent's ability to obtain registration or require the respondent to comply with any conditions or restrictions imposed by the committee if registration is granted;
>
> c. authorize the respondent to resign their registration;

d. suspend the respondent's licence for a specified period of time;

e. suspend the respondent's ability to obtain a licence for a specified period of time;

f. suspend the respondent's licence pending the satisfaction and completion of any conditions a hearing committee orders;

g. impose any restrictions or conditions, or both, on the respondent's licence for a specified period of time;

h. reprimand the respondent and direct that the reprimand be recorded in the records of the College;

i. direct the respondent to pass a particular course of study or satisfy a hearing committee or any other committee established under the Act of the respondent's general competence to practise or competence in a particular field of practice;

j. refer the respondent to for a competence assessment as determined by the Registrar, and require the respondent to pay for any costs associated with the assessment;

k. direct the respondent to pay a fine in an amount determined by the hearing committee for findings that involve

i. practising while not holding a valid licence to practise, or

ii. professional misconduct or conduct unbecoming the profession;

l. direct the respondent to pay any costs arising from compliance with an order under clause (g), (i) or (j);

m. publish or disclose its findings in accordance with the Act and these regulations.

45. In our view, these provisions in the Medical *Act* and the Medical Practitioners Regulations require orders that are remedial in nature, not punitive. In our opinion, the

Medical Act and the Medical Practitioners' Regulations require a hearing committee to dispose of a matter by adopting orders that promote the public interest in the circumstances of the matter. Most often this will be best accomplished by conditions or restrictions that provide an assurance of public protection and demonstrate to the public and the medical profession that there are effective means of maintaining the standards of the profession.

46. There is a role for including sanctions in a set of dispositions that together reflect the public interest. The purpose of a suspending a medical practitioner's license should be correction of the medical practitioner who has engaged in professional misconduct and to send a message to the profession that certain conduct will not be tolerated. In our opinion revocation of a licence should only be ordered as a last resort.

47. We would not be inclined to defer to a recommendation from the Investigation Committee which included a proposed disposition that put excessive emphasis on punishment of the medical practitioner for professional misconduct or conduct unbecoming.

Is the Agreed Disposition in the Public Interest?

48. The Settlement Agreement permits Dr. Jones to return to practice. As a Hearing Committee we could only approve her return to practice if we were satisfied that the conditions and restrictions in the Settlement Agreement protect the public both by assuring that her patients will receive an acceptable standard of care and by assuring both the public and the profession that the College can effectively maintain high standards of competence and professional integrity among medical practitioners.

49. The Settlement Agreement requires Dr. Jones not to provide care to Patient X. It imposes a permanent restriction on her prescribing narcotics and a temporary restriction on prescribing benzodiazepines and Z-type drugs.

50. In a narrow sense, those restrictions will prevent a repetition of the conduct involved in the care of Patient X by Dr. Jones. However, the Settlement Agreement goes much further. Before Dr. Jones can return to practice she must meet the requirements of a Competency Assessment. She must engage in counselling with a therapist who will report whether she is fit to return to practice. She must maintain contact with her family physician who also must confirm her fitness to return to practice. She has to pass a specified drug test.

51. We are satisfied that Dr. Jones will not repeat the conduct that occurred with Patient X if she is permitted to return to practice after her completion of the Competency Assessment and certification of her fitness to return to practice by her therapist and her family physician.

52. For a two year period following her return to work, Dr. Jones may only practice under an onerous supervision requirement and she may not practice as a sole practitioner. She must continue counselling with a therapist and regular visits to her family doctor. For five years, Dr. Jones will be subject to a mandatory Drug Test Monitoring Program. For ten years she will continue with visits to her family practitioner who will be authorized to report any breach of the Settlement Agreement to the College.

53. The depth of this combination of conditions and restrictions provide an assurance not only that Dr. Jones will not repeat the conduct involved in her excessive prescribing of opioids to Patient X but provide a level of supervision and support which should generate any red flags for the College and permit the College to intervene if there are problems.

54. These conditions and restrictions satisfy concerns arising from Dr. Jones' failure to provide any acceptable explanation for prescribing excess amounts of opioids to Patient X and her inability to explain what happened to opioids that he did not ingest. However, they do not address her misconduct in providing false and misleading information in response to legitimate concerns from regulators, her colleagues and others in the healthcare system. The answer for that in the Settlement Agreement is the suspension of 36 months from practice on a time served basis.

36-month Time Served Suspension

55. Counsel for the College has provided the Hearing Committee with a comprehensive review of cases decided in Nova Scotia and in other provinces that involve inappropriate opioid prescribing practices and cases dealing with dishonesty by physicians in their dealings with the College or more generally in the course of their professional activities. A copy of Ms. Hickey's review dated June 24, 2019 is attached as Appendix "2" to this decision.

56. The cases provided to us dealing with misconduct in opioid prescribing tend to be different than this case. Dr. Jones engaged in professional misconduct in opioid prescribing for a single patient. Many of the cases involved multiple patients. Not all of the cases involved conduct similar to the false and misleading explanations that Dr. Jones provided when faced with inquiries about her prescribing practices. However, the cases are helpful in showing that in similar cases a lengthy suspension rather than license revocation is often the appropriate sanction.

57. The following cases illustrate the range of suspensions that have been found appropriate:

- *Ontario (College of Physicians and Surgeons of Ontario) v. Arnold*, 1999 ONCPSD 2 – 12 month suspension for excessive prescription of narcotics.

- *College of Physicians and Surgeons of Ontario v. Pontarini*, 2000 ONCPSD 21 – Nine month suspension for prescribing oxycodone without proper therapeutic purpose.

- *Ontario College of Physicians and Surgeons v. Adams,* 2000 ONCPSD 23 – Suspension until successful completion of Competence Assessment and long-term supervision.

- *College of Physicians and Surgeons of Ontario v. Gale*, 2002 ONCPSD 3 – Revocation for administering excessively high doses of opioids to multiple patients. This decision was overturned by the Ontario Divisional Court in *Gale v. College of Physicians and Surgeons of Ontario,* 2003, CanLII 30486 when some of the charges against Dr. Gale were overturned stating in part "…even if Dr. Gale had been guilty of all of the offences of which he was convicted, the penalty of revocation, the capital punishment of a profession, was excessive to the point of being unduly harsh."

- *Hlynka (Re),* 2010 CanLII 21054 (MB CPSDC) – Prescribing narcotic drugs to multiple patients in a reckless manner, one of the purposes of which was to obtain a supply of narcotic drugs for his own use, providing false and misleading information to the College – Revocation with readmission six months later subject to restrictions.

- *College of Physicians and Surgeons of Ontario v. Redekopp,* 2011 ONCPSD 43 – Over prescribing of narcotics – Reprimand.

- *Coyle, Re* 2013 CarswellMan 810 – Inappropriate prescribing of narcotics and benzodiazepines, creating false records to permit him to divert narcotics and benzodiazepines for his own use. Inappropriately prescribing of narcotics and benzodiazepines to multiple patients, boundary violation and misrepresentations to the College – 18 months with multiple conditions.

- *Datar (Re)*, 2016 CanLII 74173 (AB CSPDC) – Prescribing opioids inappropriately to a single patient – three month suspension.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Proulx*, 2018 ONCPSD 16 – Prescribing large amounts of opioids to a neighbour, diverting narcotics to himself, untruthful responses to the College – Revocation.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Cameron*, 2018 ONCPSD 25 – Prescribing narcotics inappropriately to multiple patients – Agreement to surrender licence.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Aly,* 2018 ONCPSD 33 – Inappropriate prescribing of narcotics to multiple patients – Four month suspension.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Garcia,* 2018 ONCPSD 35 – Inappropriate and excessive prescribing of controlled substances to multiple patients recklessly – Eight month suspension

- *Ontario (College of Physicians and Surgeons of Ontario) v. Pasternak* 2018 ONCPSD 49 - Over prescribing of opioid and benzodiazepine to a single patient – Reprimand, clinical supervision and conditions and restrictions.

- *Ontario (College of Physicians and Surgeons of Ontario) v. LeDuc,* 2018 ONCPSD 59 – Unsafe prescribing of narcotics and benzodiazepines to a single patient with boundary violations – Six month suspension.

- *Ontario (College of Physicians and Surgeons of Ontario) v. Roy,* 2018 ONCPSD 66 – Over prescribing of narcotics and breach of undertaking to the College – Three month suspension.

58. The decisions in all of these cases emphasize that the appropriate disposition, apart from conditions and restrictions to protect the public, should be one that meets the objectives of denunciation of the conduct of the medical practitioner, specific deterrence of the physician personally and general deterrence to send a message that certain conduct will not be accepted. Applying those principles, generally, the cases have limited revocation of license to circumstances where there has been an agreement to do so between the physician and the College. They generally accept that suspensions of varying lengths, depending on the seriousness of the conduct involved, combined with conditions and restrictions, are the disposition of choice.

59. It should be noted that the cases in Ontario and in Manitoba have legislative frameworks that emphasize the use of a penalty where there is professional misconduct. The statutory framework adopts a structure of "charges". A practitioner is "found guilty". Based on that framework, the decisions in those jurisdictions tend to import the principles of sentencing under the *Criminal Code* i.e. denunciation, specific deterrence, general deterrence and rehabilitation. Applying sentencing principles in applying the *Medical Act* and the Medical Practitioners Regulations remedial approach requires some caution.

60. Considering both the cases cited above and the remedial framework in the *Medical Act* and Medical Practitioners' Regulations, we agree that a period of suspension from practice and the conditions and restrictions discussed above is an appropriate disposition. Dr. Jones' misconduct in providing false and misleading information in response to legitimate concerns from regulators, her colleagues and others in the healthcare system and the absence of a satisfactory explanation for overprescribing opioids for Patient X, is serious misconduct which justify a period of suspension from practice.

61. However with a remedial approach, it would be difficult to recognize a 36 month suspension as an appropriate disposition. Generally speaking, it is hard to see how a 36 month suspension on a go forward basis would ever be an appropriate disposition. It would never likely be fair to a medical practitioner. A three year suspension would not be more effective as a denunciation of a medical practitioner's conduct or as a deterrent as, for example, a one year suspension. A one year suspension would demonstrate clearly to the member and the public that the misconduct involved will not be tolerated.

62. It is noteworthy that in the cases from other jurisdictions which are listed above the range of suspensions are generally between three months and 18 months.

63. Nevertheless, the Settlement Agreement provides for a 36 month suspension to be considered fully served. The reason for considering the suspension fully served is that Dr. Jones has been suspended on an interim basis since October 29, 2015. Ordinarily, once an interim suspension is imposed, the Investigation Committee carries on its investigation in as timely a manner as possible. The length of Dr. Jones' interim suspension is very unusual. It resulted from a delay in the investigation as a result of the criminal charges against Dr. Jones. When she was acquitted on October 13, 2017 the investigation proceeded and this matter was referred to hearing on October 30, 2018. The combination of the ordinary delay in completing a proper investigation, the complexity of scheduling a hearing involving several days of evidence and the delay resulting from the criminal charges have combined to extend the interim suspension to three years and nine months.

64. While a 36 month suspension going forward would not be appropriate, the recognition of 36 months of Dr. Jones' suspension as time fully served is fair to her and consistent with the objective of a strong statement of disapproval for her conduct.

65. The ultimate question here is whether the combination of the 36 month time served suspension, strict conditions for permitting Dr. Jones to return to practice and extensive conditions and restrictions on her practice once she does return falls within the range of reasonable alternatives to protect and promote the public interest in this case. We think they do.

66. As set out earlier in these reasons, we are satisfied that the conditions and restrictions in this Settlement Agreement will ensure that Dr. Jones does not repeat the excessive prescribing of opioids. She will not be caring for Patient X. The College's audit indicates that she can meet the standards of the medical profession. She has suffered an interim suspension of three years and nine months and the conditions on her return to practice will extend that time further.

67. Finally, we recognize that Dr. Jones is a young medical practitioner who has a lot to contribute. As a Committee, we think she should have a chance to do that.

68. Accordingly, for all the reasons that are set out above, the Hearing Committee has approved the recommendation of the Investigation Committee and accepts the Settlement Agreement reached between the Registrar and Dr. Jones.

Decision issued this 19th day of August, 2019

Raymond F. Larkin, Q.C., Chair

Dr. Michael Teehan

Dr. Erin Awalt

Dr. Zachary Fraser

Ms. Mary Hamblin

TAB 1

PROVINCE OF NOVA SCOTIA)

COUNTY OF HALIFAX)

IN THE MATTER OF: The ***Medical Act***, S.N.S. 2011, c. 38

- and-

Dr. Sarah Jones

REDACTED SETTLEMENT AGREEMENT

The College of Physicians and Surgeons of Nova Scotia (the "**College**") and Dr. Sarah Jones, a medical practitioner in the Province of Nova Scotia, and a member of the College, hereby agree with and consent to the following in accordance with the provisions of the *Medical Act*:

I. General Overview

1. Dr. Jones graduated from Dalhousie Medical School in 2007. She completed her family medicine residency through Dalhousie University in 2009, and received her Certification in the College of Family Physicians later that year.

2. After completing her residency, Dr. Jones worked for a number of months as a locum in Rawdon, Nova Scotia, before joining a Family Practice office ("the Family Practice Clinic") in Halifax Regional Municipality in January 2010, where she worked until October 2015. During that time, she typically worked Monday to Friday, as well as the duty clinic (for same day pre-booked patients) Wednesday evenings and some weekends. She saved a portion of each Wednesday and Friday afternoon for housecalls and paperwork.

3. On August 21, 2015 the College's Registrar was provided with information from the Nova Scotia Health Authority's Pharmacy Services. One of Dr. Jones' patients, Patient X, had been admitted to the hospital, and Dr. Jones had called the hospital to advise the pharmaceutical service that despite certain opioids having been recently prescribed to Patient X, he had been weaned off certain of these opioids and should not be given Oxyneo in particular.

4. The pharmacist investigated the matter further and learned from community pharmacies that Dr. Jones had prescribed large quantities of opioids to Patient X in recent weeks and months, and picked up these medications herself for delivery to the patient. Faced with information that Patient X had been weaned off a medication that had been recently prescribed, and with the information about Dr. Jones' prescribing practices for this patient, the pharmacist contacted the province's Prescription Monitoring Program and the College's Registrar.

5. The Registrar reviewed the pharmacist's concerns and the documentation that was provided. He had concerns that the amount of opioids prescribed for this patient was excessive, dangerous and inappropriate; that the advice from Dr. Jones to the hospital that Patient X had been weaned from certain opioids was inconsistent with the prescribing

history; and that the practice of Dr. Jones picking up the opioid prescriptions she had prescribed for Patient X and delivering them to the patient was unusual and raised concerns about possible personal use or diversion.

6. The Registrar reported the matter to the police and filed a complaint, seeking a response from Dr. Jones.

7. Investigation Committee "A", formed in accordance with the *Medical Act*, was responsible for the investigation of this complaint. It was brought together on August 21, 2015 to consider the information provided by the pharmacist. It determined it was in the public interest to issue an interim suspension of Dr. Jones' licence to practice medicine. Upon receipt of a response from Dr. Jones and the provision of additional information, this interim suspension was lifted on September 8, 2015. Dr. Jones resumed practice at that time, after giving an undertaking to provide no further medical care to Patient X and to voluntarily restrict herself from prescribing narcotic and controlled substances. However, based on additional concerns described more fully herein commencing at paragraph 89 the Committee issued an interim suspension of Dr. Jones' licence to practice on October 29, 2015.

8. The licence suspension has remained in effect since that time.

9. Criminal charges were laid against Dr. Jones for fraud of a value exceeding five thousand dollars contrary to Section 380(1)(a) of the *Criminal Code*, and for possession of oxycodone, contrary to the *Controlled Drugs and Substances Act*. The College's Investigation Committee conducted certain aspects of its investigation prior to the laying of criminal charges. The College then agreed to hold its investigation in abeyance, with some limited exceptions, pending the outcome of the criminal trial.

10. During the criminal trial, Dr. Jones brought a *Charter* motion to exclude certain evidence obtained during the police investigation. Dr. Jones' *Charter* motion was successful and certain evidence was excluded. On October 13, 2017, Dr. Jones was acquitted of all charges against her.

11. Upon completion of the criminal trial, Investigation Committee "A" resumed its investigation and by a decision dated October 1, 2018, referred various matters to the Hearing Committee. In the course of its investigation, the College learned that Dr. Jones had prescribed opioid medications to Patient X in such excessive amounts as to defy any acceptable standard of practice. The amounts that were prescribed could not have been safely ingested by one patient. While Dr. Jones has provided some explanations as to what happened to some of the prescribed medication, the College remains uncertain as to what happened to prescribed medications that were not consumed by Patient X. It has no evidence of diversion or personal use by Dr. Jones, but has been unable to conclude what happened to this medication.

12. Dr. Jones acknowledges that the physician-patient relationship with Patient X blurred over the years. At one point she was prescribing opioids to Patient X every four or five days, and visiting him at home multiple times a week. She was picking up his prescriptions and letting him direct his own care. She did not take the necessary steps to extricate herself from a relationship with a patient who was not open to other methods to manage his illness, and required an extremely high dose of opioids. She spent hours a week driving to and from his house.

13. Dr. Jones' explanation for why she engaged in this behavior is that she was a young, naïve physician who got in over her head with a single patient whose pain she was not able to control. Audits of the remainder of Dr. Jones' medical practice apart from Patient X establish she had a strong knowledge of prescribing standards and practices and was providing good clinical care to patients. Dr. Jones acknowledges her prescribing to Patient X defied good clinical opioid prescribing by someone who should have known better.

14. In the end, the College is left with no satisfactory explanation of why Dr. Jones prescribed in the manner she did and conducted herself the way she did with Patient X. The College is left with no satisfactory explanation of what became of the excess opioids. The College believes it has exhausted all avenues of investigation and that these matters will remain unresolved.

15. The information obtained by the College as a result of its investigation is set out below.

II. FACTS

Patient X

16. Shortly after commencing her practice at the Family Practice Clinic in January, 2010, Dr. Jones took on Patient X as a patient. He was a gentleman in his sixties who had been previously followed by a neurologist but who needed a family doctor.

17. Dr. Jones determined that Patient X was unable to give a clear account of his medical history. Over the course of the first few appointments, and with the help of medical records she learned details of his history and medication profile. She had discussions with him as early as the second appointment about the importance of taking his medications only as prescribed, and having just one prescriber.

18. Dr. Jones states that Patient X agreed to sign an opioid contract, but there is no documentation of this in his electronic record. Dr. Jones states that the opioid contract must have been misfiled.

19. Patient X presented to Dr. Jones with a number of medical co-morbidities, including chronic pain in his right hip, knee and foot, stemming from multiple sources.

20. Based on her initial assessment of Patient X, Dr. Jones concluded that his pain was not well controlled. He was on short and long acting opioids, as well as high doses of benzodiazepines. Dr. Jones felt his pain was not being properly treated. His symptoms progressed over the years. Dr. Jones prescribed Patient X increasing amounts of opioids until his admission to hospital in August 2015.

Prescribing

21. Attached as Schedule "A" to this Settlement Agreement is a compilation of Dr. Jones' prescriptions to Patient X and MSI billing entries. This compilation covers from January 2010 to August 2015. As demonstrated from the compilation, there were frequent strength switches and dosage adjustments.

22. Dr. Jones prescribed Patient X 33,282 tablets of oxycodone from August 7, 2014 to August 12, 2015, totaling 584,220mg of oxycodone.

23. In the one month prior to Patient X's admission to hospital (July 20 – August 19, 2015), Dr. Jones prescribed him a total of 47,700mg of oxycodone.

24. On several occasions throughout the period of time Dr. Jones treated Patient X and as early as 2011, there was evidence of the effect of opioid use on Patient X, which showed demonstrable harm to him. This included instances of choking, falls, and confusion with dosing. Dr. Jones was aware of these effects. Examples include:

    (a) On July 9, 2015, Patient X had a fall. He had previously told Dr. Jones he was having trouble swallowing 80mg tablets of Oxyneo, but on July 9, 2015, Dr. Jones prescribed another 180 Oxyneo 80mg tablets. Dr. Jones acknowledges she typically wrote one-month prescriptions for Patient X. Dr. Jones prescribed Patient X Oxyneo 80mg pills because he wanted to try them again, even though he was having trouble swallowing them, and was choking on them. She did this on repeated occasions.

    (b) On July 19, 2015, Patient X complained of constipation since increasing his Oxyneo dose. Dr. Jones prescribed 690 Oxyneo 20mg tablets. This was in addition to a prior one-month prescriptions for 512 Oxyneo 10mg and 570 Oxycodone 10mg Immediate Release, prescribed during previous visits. This is one example in what constituted a pattern of a similar prescribing trend.

25. Dr. Jones did not do pill counts with Patient X. She states that she would eyeball the bottle and determine approximately what should be left in the bottle from the previous visit. Dr. Jones states that Patient X advised her from time to time that his cat ate the unused pills or that he dropped some in the toilet. She states that she observed pills in the toilet on one occasion. The College was unable to obtain reliable third party information to verify whether some of the medications were lost in this fashion.

26. Dr. Jones did not keep a running tally of how many used and unused pills Patient X might have been accumulating over the course of their visits. She states she would only think back to the most recent prescription in an effort to determine how many pills Patient X might have left over. Dr. Jones acknowledges she should have accurately tracked what was being consumed and that the practice of eyeballing was inappropriate. She acknowledges pill counts should have been done. She acknowledges that the probability for pills to be leftover, missing, not accounted for, diverted, consumed in excess or inappropriately by Patient X, or anyone else, presented a real danger to Patient X and the public.

27. Dr. Jones did not conduct any urine tests on Patient X to determine medication levels in his system.

28. Dr. Jones acknowledges that the amount of opioids prescribed to Patient X while under her care was excessive, dangerous, and inappropriate. She admits that she continued to prescribe high doses of opioids after there was demonstrable harm to the patient, such as choking, falling, and confusion with dosing. She admits her care fell below standard with respect to prescribing for Patient X. Dr. Jones also acknowledges her practice of regularly prescribing 30-day prescriptions was inappropriate. She admits she should have been giving Patient X smaller quantities of opioids.

Housecalls

29. Patient X travelled to the Family Practice Clinic for appointments until July 2010. At that time, he was in a motor vehicle accident during which his vehicle was destroyed. Dr. Jones agreed to make housecalls to Patient X's home, which was approximately 85 kilometres away. Dr. Jones says she typically reserved housecalls for palliative patients, however, she felt Patient X had a number of issues including medical, social, and financial issues that prevented him from attending appointments at the Family Practice Clinic. Further, Dr. Jones said transportation was an obstacle for Patient X, and he did not have a support system, other than one "friend" and roommate (Ms. Y).

30. When Dr. Jones first agreed to do housecalls for Patient X, Dr. Jones thought it would be temporary. However, Patient X's health continued to decline and his financial situation got worse. She continued to do housecalls for the remainder of the time she treated Patient X. For example, in 2014, Dr. Jones billed MSI for 31 housecalls to Patient X.

31. Dr. Jones was not compensated for the hours it took to complete the significant number of trips she made for house calls over the span of five years. She also failed to submit MSI billings in a timely manner on at least 11 occasions, resulting in her not being at all compensated by MSI for numerous house calls. Dr. Jones did claim the kilometres for her travel on her income tax returns.

Storage of Medication

32. Dr. Jones states that the times Patient X asserted that his cat ate his pills, or he dropped some in the toilet, should have raised concerns about safe storage and usage of a significant amount of opioid medications.

33. Dr. Jones admits she should have been stricter with Patient X. While Dr. Jones required Patient X to use blister packs on at least one occasion, Patient X refused to continue to use them. In the *R v. Jones* criminal trial, Patient X testified that he told Dr. Jones he did not want blister packs, and that Ms. Y told him he would end up in the "loony bin" if he used them.

34. Dr. Jones admits she should have insisted on blister packaging as a minimum assurance the opioids were being stored and consumed properly and safely.

Picking up Prescriptions

35. Over the course of 2010, Patient X's health continued to fail. Following his car accident in July 2010 he did not have access to a vehicle. He became housebound. According to Dr. Jones, he had difficulty getting his prescriptions from the pharmacy. Dr. Jones indicated in her response to the College that she contacted his pharmacy to ask about medication deliveries, however, this was not a service they were able to provide. Two and a half years later, in her February 2, 2018 interview, Dr. Jones told the Investigation Committee she could not recall whether she spoke to any other pharmacies in the Bridgewater area regarding the potential for a pharmacy to deliver to Patient X. She also did not investigate whether Social Services would pay to have Patient X's medications delivered. Dr. Jones agrees she should have investigated both of these options.

36. Dr. Jones began picking up Patient X's prescriptions and bringing them to the housecall visits commencing in July, 2010. Dr. Jones says that this was the only patient for whom she did this. Her practice was to pick up Patient X's prescriptions at the pharmacy in a stapled bag and deliver the medication to him at his home. When Dr. Jones arrived at Patient X's house, she states she handed him the medication while still in the stapled bag. Dr. Jones states she would then observe (or assist if required) Patient X open the bag along with each individual pill bottle and place the medication in his appropriate bottles.

37. Dr. Jones continued this practice until a few months later, when the Prescription Monitoring Program ("PMP") called her and they discussed the practice of picking up Patient X's prescriptions. The PMP had been contacted by the College of Pharmacists regarding potential concerns associated with the delivery of medications by Dr. Jones to Patient X. Dr. Jones recalls PMP asking if Patient X was completely housebound, and Dr. Jones responded that he was not. PMP indicated that Patient X needed to have some responsibility for his own health, and that he should be picking up his own prescriptions. As a result, Dr. Jones stopped picking up Patient X's prescriptions as of October 23, 2010.

38. Dr. Jones' recollection is that after she stopped picking up Patient X's prescriptions, Ms. Y started to do this. However, Dr. Jones states that Ms. Y was inconsistent and unreliable in terms of getting Patient X's prescriptions to him. Further, Patient X eventually moved out of Ms. Y's house, in January 2012. Patient X still did not have a vehicle. He advised Dr. Jones in 2010 that his vehicle was destroyed, and Dr. Jones did not believe he had driven since. Around January 2012, Dr. Jones started picking up his prescriptions again. She did not seek advice from or advise PMP prior to doing so, despite her earlier discussion with them. Dr. Jones continued to pick up Patient X's prescriptions and deliver them until August, 2015, when Patient X was hospitalized and her medical license was suspended.

39. When Dr. Jones first started to deliver Patient X's medications, she states that she obtained signed documentation from Patient X. She did not continue this practice. She let things slip. Dr. Jones admits she should have received signed documentation from this patient for every delivery of opioid medication.

40. Information obtained by the College from the pharmacy which dispensed Patient X's medications establishes that some time following Patient X's discharge from the hospital when he required medication, he picked it up on a regular basis, and was quite often by himself. He received rides to the pharmacy from other people, but did not have any issues getting his medications at that time.

41. Dr. Jones admits that picking up Patient X's prescriptions was inappropriate. She also admits that she failed to maintain the appropriate physician/patient boundary by frequently picking up and delivering Patient X's opioid medication. She also admits that she did not advise the PMP that she was picking up Patient X's prescriptions again, and that she should have contacted the PMP for further advice when she resumed this practice.

Compliance

42. Patient X's medical record demonstrates he refused Dr. Jones' referrals to specialists, refused her advice to go to the Emergency Department, and frequently refused to follow her advice and treatments. Dr. Jones does not know how to explain why she tolerated Patient X's behavior. Dr. Jones admits she failed to maintain the appropriate

physician/patient boundaries by permitting Patient X to direct his own care. She says that she should have been stricter with Patient X and that she should have insisted that Patient X go to the Emergency Department more often, and see the specialists that Dr. Jones recommended.

Seniors Community Health Team

43. The Seniors' Community Health Team ("SCHT") attended at Patient X's home in late May 2014 following a referral from an ER physician. A detailed report was prepared which does not appear in Dr. Jones' chart. The report was sent to Dr. Jones on June 2, 2014. The report states that Patient X "welcomes a visit from the SCHT Pharmacist to discuss his current medication". One of the report's stated goals was "referral to SCHT Pharmacist for a medication review and teaching."

44. A SCHT progress note from June 4, 2014 indicates that "Dr. Jones returned my call and reported that (Patient X) asked her to call and cancel any future visits. (Patient X) was upset that someone had come to his home, very attached to his schedule, which was interrupted."

45. Dr. Jones cannot explain why the SCHT report is not in Patient X's chart, other than to say that documents were often misfiled at the Family Practice Clinic. Dr. Jones recalls discussing the SCHT visit with Patient X. She states he was very upset by the visit and did not want anyone to return. He refused to undergo the medication review.

46. Dr. Jones admits that this is another example of her letting Patient X direct his own care. She acknowledges that she should have insisted on the assessment and medication review.

Excess Medications

47. Dr. Jones states that because she wrote numerous prescriptions for Patient X, and made frequent dose adjustments, there were often excess medications left over from the previous prescription. She has denied ever expecting or intending Patient X to ingest all of the prescribed medications. She says that some of the medication was returned by her to a drop box at the Family Practice Clinic as set out in the following paragraphs. She also refers to the previous information about medication eaten by Patient X's cat or ending up in the toilet. Finally, evidence at the criminal trial from Patient X indicated that visitors would attend at Patient X's residence, enter his room and go through his medication pill box.

48. Dr. Jones made multiple references in the chart to Patient X's excess medications being returned to "the pharmacy".

49. In two letters to the PMP, one in 2012 and one in 2014, Dr. Jones indicated all unused tablets were returned to "the pharmacy".

50. The College obtained information from the pharmacies from which Dr. Jones obtained Patient X's prescriptions and was advised by staff at these pharmacies that excess medication was not returned to these pharmacies.

51. In her response to the College, and her interviews with the Investigation Committee, Dr. Jones stated her usual practice was actually not to return the opioid medications to the pharmacies herself, but to return them to a drop box at the Family Practice Clinic, from where she understood they would be returned by clinic staff to a pharmacy.

52. The drop box at the clinic was maintained in the office manager's office, which was open and unlocked at all times. The drop box itself was unlocked and accessible to anyone who was in the office. The drop box was occasionally emptied into a larger box by clinic staff. The larger box was kept in the medication sample room. The medication sample room remained unlocked at all times while the clinic was open. Dr. Jones did not count the pills she says she returned to the drop box and kept no record of them.

53. On January 12, 2016, the Investigation Committee interviewed the office manager at the Family Practice Clinic. She only recalled personally observing Dr. Jones putting medications in the drop box approximately three to four times a year. The office manager said that as of early 2016, medications had not been returned to the pharmacy in about two and a half years.

54. As part of the College's investigation, the contents of the larger box which had not been returned to the pharmacy in about two and a half years were inventoried by the Family Practice Clinic and there were no opioids in the box. There were some medications in the larger box that were identified as prescribed to Patient X, but there were no opioids among them.

55. Dr. Jones admits that her actions regarding the excess medication posed a risk to public safety. The drop box was an unlocked cardboard box, with no log book kept by Dr. Jones or the Family Practice Clinic. Dr. Jones admits that she knew that she should have brought the unused medications immediately and directly to a pharmacy and that she failed to properly and safely dispose of Patient X's excess opiate medication. She further acknowledges that her chart entries and her responses to PMP indicating the medications had been returned immediately to the pharmacy, were inaccurate.

Record Keeping

56. Dr. Jones says that her usual practice with housecall patients was to bring her computer and complete the progress note for the visit simultaneously while she was with the patient (as Dr. Jones would in her office practice). However, Patient X did not have internet and Dr. Jones therefore could not access or enter progress notes at his house. As a result, her practice with Patient X was to take handwritten notes of her visits. Dr. Jones states she made the notes in a notepad, which Dr. Jones would bring to each visit with Patient X (allowing her to refer back to other visits in recent months).

57. Dr. Jones states that typically every few months, she would insert Patient X's progress notes into the electronic chart, at which time she would shred the paper notes. She admits that she did not transfer to the electronic chart her handwritten progress notes for visits with Patient X as regularly as she should have. She also acknowledges that she was inconsistent in terms of how long it took her to enter progress notes. Dr. Jones says she became accustomed to relying on the paper records for her visits with Patient X, as accessing the chart was not an option during the encounters, and for this reason she did not prioritize transferring the handwritten notes to the electronic record.

58. Some of Dr. Jones' chart entries were entered many months and in some cases up to a year after the visits being charted. For example, Dr. Jones' encounters from March 1, 6 and 11, 2014 were entered on November 28, 2014. Dr. Jones' encounters from March 20, 25, 28 and 31, 2014 were entered on March 8, 2015. Dr. Jones' encounters from December 12, 19, 22 and 30, 2014 and January 5, 15, and 22, 2015 were entered on August 21, 2015. Dr. Jones' encounters from January 2, 2015 was entered on March 8, 2015. Dr. Jones' January 28 and February 12, 2015 encounters were entered on August 24, 2015.

59. After Patient X's admission to hospital on August 19, 2015, Dr. Jones realized that she had not entered progress notes into Patient X's electronic chart in quite some time. She states she thought it was important for Patient X's chart to be up to date in the event the hospital required any information. Dr. Jones started to enter Patient X's progress notes into the system on Friday, August 21. Dr. Jones cannot recall for certain, but believes she made a number of entries in the afternoon, and then again after completing her duty clinic at approximately 7:00 p.m. that night.

60. Later that evening, at approximately 9:00 p.m., after Dr. Jones returned home for the evening, she received a telephone call from the Registrar of the College advising that her licence had been suspended. After that call and over the next few days, Dr. Jones continued to transfer progress notes for Patient X. As a result, there are a number of entries on August 21, 22 and 24, 2015 that were subsequent to Dr. Jones' telephone conversation with the Registrar when she learned her licence had been suspended.

61. Dr. Jones says she did not know that transferring notes from her notepad to the EMR would be considered practicing medicine and that it was not until she received legal counsel the next week that she realized she should have avoided the EMR.

62. Dr. Jones admits that she failed to meet documentation standards by making late entries into Patient X's record, and failing to properly document Patient X's prescriptions, medication use and treatment. Dr. Jones also admits that editing Patient X's patient record after she was suspended constitutes practicing medicine while suspended.

Weaning

63. Dr. Jones says that in June 2015, Patient X's opioid requirements were reaching levels very concerning to her. They were significantly higher than any other patients in her practice. She discussed a gradual wean of his dose and he agreed.

64. Between June 1, 2015 and August 7, 2015, Patient X could not be successfully weaned off Oxyneo. For two months, he remained on very high levels of opioids.

65. On August 7, 2015, Dr. Jones resumed Patient X's Oxyneo weaning schedule by reducing his dose by 20mg every three days. She prescribed 525 Oxyneo Extended Release 10mg tablets (25 days' supply) with handwritten instructions outlining each step of the weaning process.

66. At his August 12, 2015 visit, Dr. Jones discovered Patient X had not been weaning his Oxyneo dose as recommended, yet she wrote him another prescription. This prescription was for 690 Oxyneo 20mg tablets.

67. Two days later, on August 14, 2015, Patient X stated he was no longer taking Oxyneo 20mg as instructed. He had started to reduce his dose two weeks prior on his own because of side effects. He showed Dr. Jones his bottle of Oxyneo 20mg - there were only a few tablets missing. He had no symptoms of opioid withdrawal and no acute pain. Dr. Jones decided to quickly wean him off the remainder of his long acting opioids. She decreased his Oxyneo 20mg to two tablets three times daily.

68. On August 16, 2015, Dr. Jones checked Patient X's Oxyneo bottle and it contained the correct number of tablets. She did not see any signs of increased pain or opioid withdrawal and felt it safe and appropriate to further decrease his dose. She suggested he decrease his daily Oxyneo dose by 20mg, which was approximately a 16% dose reduction.

69. On August 18, 2015, Patient X informed Dr. Jones that he stopped taking Oxyneo. He was still taking Oxycodone IR I0mg tabs and he was averaging 2 tablets three times daily. On August 19, 2015 he was admitted to hospital.

70. Dr. Jones agrees that it is concerning that Patient X was apparently completely weaned off significantly high doses of opioids in what was essentially an 18-day window. He did not exhibit any signs of withdrawal or increased pain. He went from being on Oxyneo for three years, to not taking any at all, in just under three weeks. On August 7, 2015, Dr. Jones prescribed a 25 days' supply of Oxyneo Extended Release 10mg tablets, and 10 days later Patient X was completely weaned off them.

71. During the month prior to his hospital admission, Dr. Jones was still providing Patient X prescriptions averaging over 1500mg of opioids per day, notwithstanding that he was not compliant in taking his medications as prescribed.

72. Dr. Jones admits that she failed to meet the expected standards of practice respecting the prescription of opioids to Patient X during the weaning period. Dr. Jones admits that she demonstrated poor judgment when she repeatedly prescribed large amounts of opioids during the weaning period, while failing to accurately monitor what he was actually taking. She eyeballed medication amounts in the bottles. She also admits that she failed to act on indications that Patient X was not using the opioid medication properly or safely.

Referral to Specialist

73. In Dr. Jones' referral letter to a gastroenterologist on August 31, 2011, she did not disclose the full extent of Patient X's opioid use, only referring to "oxycodone 10mg prn".

74. The chart note for Dr. Jones' visit with Patient X on August 21, 2011 (ten days before Dr. Jones' referral letter) lists all of the medications later outlined in Dr. Jones' referral letter to the gastroenterologist, with the exception of two non-opioid medications. Included in the list on the August 21, 2011 progress note is: "Oxycodone Hydrochloride 10mg tablet".

75. Dr. Jones cannot recall for certain why she did not disclose the full list of Patient X's opioids in her letter to the gastroenterologist. However, she advised the College that she assumes that when she prepared the referral letter to the specialist she either referred back to her August 21, 2011 progress note for Patient X and simply copied that list, or referred to Patient X's cumulative patient profile, which must not have been up to date.

76. Dr. Jones admits that (either way) this was sloppy practice and it was inappropriate to not ensure the specialist had a full understanding of Patient X's opioid use. Dr. Jones admits she should have taken more time to prepare a complete outline of Patient X's medication.

Discussions with hospital pharmacist, August, 2015

77. On August 20, 2015, after Patient X was admitted to hospital, Dr. Jones spoke with a pharmacist. Dr. Jones called him to clarify Patient X's medication list and left a message. When he called back, they had a discussion about what medications Patient X was currently taking.

78. At 11:17 am on August 20, 2015, Dr. Jones sent the hospital pharmacist a fax with an "updated medication list" for Patient X. The updated medication list included "Oxycodone 10 mg IR 1-2 tabs q4hr prn", but did not include the recently filled prescriptions of Oxyneo Extended Release Tabs 10 mg (filled August 7, 2015), 20 mg (filled August 12, 2015) and 80 mg (filled July 31, 2015) because Patient X had been recently weaned off the Oxyneo.

79. During the pharmacist's testimony in the criminal trial of *R. v. Jones*, the pharmacist was asked about his discussion with Dr. Jones and his understanding as to what Patient X was currently taking or prescribed. The pharmacist responded: "That there was only an intermittent PRN or as-needed dose of Oxycodone immediate release that he is currently taking for pain."

Communication with Community Pharmacists

80. The pharmacists at the dispensing pharmacy where Dr. Jones picked up Patient X's medication questioned her about the prescriptions for Patient X. When the pharmacists inquired about the many changes to the medications and the volume of medication, they were advised by Dr. Jones that she was working with a pain clinic to try to get his doses under control.

81. The pharmacists took reassurance from the information provided by Dr. Jones that she was working with a pain clinic. They nonetheless contacted the PMP to question the situation and were advised that PMP was aware of the situation.

82. Dr. Jones never worked with or contacted a pain clinic or pain specialist to discuss Patient X. She states she does not recall telling pharmacists that she was working with a pain clinic.

PMP Correspondence

83. On April 27, 2012, Dr. Jones received a letter from the PMP requesting information about her prescriptions to Patient X due to the quantity of opioids prescribed by Dr. Jones to Patient X. The PMP is a government funded program implemented to promote the appropriate use of, and control the misuse and abuse of, narcotic and controlled medications.

84. Dr. Jones responded to the PMP on June 14, 2012 outlining her care of Patient X and explaining why he was receiving such high doses of opioids. Dr. Jones' response was misleading, false and incomplete. Specifically, Dr. Jones made the following statements:

Statement in Dr. Jones' June 14, 2012 letter	**Dr. Jones' admissions regarding each statement**
"I have had frequent conversations with my peer physicians and pharmacists regarding treatment of this patient";	While there were conversations with colleagues, they focused on Patient X's social situation and not on medications. Dr. Jones' colleagues have no recollection of discussions of narcotic management. There were discussions with pharmacists, but according to the pharmacists Dr. Jones told them she was working in concert with a pain specialist. Dr. Jones does not recall this but acknowledges there was no pain specialist.
"[A]fter I saw the improvement in his quality of life I realized the importance of continuing these medications."	There was no improvement in Patient X's quality of life.
"There is no history of substance abuse/misuse and I do not have any concerns that he is using these medications inappropriately."	Dr. Jones had, or should have had, concerns that Patient X was using the medications appropriately.
"He is an extremely compliant patient."	Patient X was not compliant at all.
"He does have a signed narcotic contract which I got Patient X to fill out when he first joined my practice."	There is no evidence of any signed narcotic contract. Dr. Jones says it must have been misfiled.
"Each time I write a prescription for this patient I call the pharmacy to discuss exactly what the plan is and I am very open to feedback/suggestions from the pharmacist."	Dr. Jones did not call the pharmacist to discuss the plan when she wrote prescriptions.
"We are starting to wean his medication a little bit at a time until we find the correct balance between good pain control while maximizing his quality of life."	There was no weaning until 2015. Patient X did not have a good quality of life.

85. Based on Dr. Jones' response including the above false statements, on June 19, 2012, the PMP wrote Dr. Jones indicating that the program had determined that no further action was required.

86. On January 2, 2014, Dr. Jones received another letter from the PMP regarding prescriptions to Patient X and asking her for a response. Dr. Jones responded on February 25, 2014 again outlining her care of Patient X and why he was receiving such high doses

of opioids. Dr. Jones' response was misleading, false and incomplete. Specifically, Dr. Jones made the following statements:

Statement in Dr. Jones' February 25, 2014 letter	**Dr. Jones' admissions regarding each statement**
"I follow this patient extremely closely and I also work very close with his pharmacy."	Dr. Jones did not work very closely with Patient X's pharmacy.
"I do not have any concerns and neither does his pharmacy of this patient misusing his medication."	Dr. Jones had, or should have had, major concerns about Patient X's medication. Dr. Jones had given misleading information to the pharmacy that she was working with a pain specialist in response to the pharmacists' questions about the volume of opioids
"My confidence with this matter stems from the fact that I am his sole prescriber…he only uses 1 pharmacy and I follow him extremely closely."	Even though Dr. MacDougall of the PMP previously raised it as a concern, Dr. Jones is silent on the fact that she was picking up the prescriptions.
"I also have a signed opioid contract in this patient's chart."	There was no signed opioid contract in Patient X's chart. As noted, Dr. Jones states this was misfiled.
"He does not exhibit any drug abuse/misuse behaviour and he is very compliant."	Patient X was not "very compliant", or compliant at all.
"These trials have resulted in numerous prescriptions but all unused medication has been returned to the pharmacy for proper disposal. In an effort to prevent confusion and ensure safety, as soon as we try a different medication, all unused tablets from the previous prescription are returned immediately."	Dr. Jones did not return any unused medication to the dispensing pharmacy and certainly did not do so immediately. Dr. Jones did not have an accurate count of how much unused medication there was. Her response to PMP suggests she was keeping a close eye on this.
"I call the pharmacist and discuss each and every prescription I write for this patient as well as the management plan so we are all on the same page."	Dr. Jones did not call the pharmacist to discuss each and every prescription for Patient X. There was no management plan. Dr. Jones and the pharmacist were not "all on the same page."

87. Based on Dr. Jones' response including the above false statements, on February 27, 2014, the PMP wrote Dr. Jones thanking her for her response and indicating that the program had determined that no further action was required.

88. Dr. Jones says that she was a young doctor in 2012 and 2014, with less than five years of experience. She states that when she received the letters from the PMP she was nervous and anxious. She believes the 2012 letter was the first letter she had ever received from the PMP. She states she realized that she was in over her head with respect to treating Patient X's pain, but acknowledges she failed to reach out for assistance from the PMP, the College or her colleagues. She perceived the PMP letters as criticizing her practice, and admits that she tried to defend her practice in her responses, which ultimately resulted in overstating and misstating the facts and misleading the PMP.

Dr. Jones' behavior after filing of Complaint

Meeting with Dr. Grant, Registrar

89. On October 27, 2015, Dr. Jones and her legal counsel met with Dr. Gus Grant, Registrar, to discuss the complaint.

90. At the meeting, Dr. Jones told Dr. Grant information about her health that was untrue. Two days after the meeting she instructed her legal counsel to advise Dr. Grant that the information was untrue. Dr. Jones later provided information to the College attributing her behaviour to severe stress and side effects of a sleeping medication, details of which are subject to a publication ban.

91. [Redacted].

92. [Redacted].

Communication with Colleagues

93. During the course of the investigation, information was received from Dr. Jones' colleagues at the Family Practice Clinic.

94. The colleagues advised that after the College complaint was filed, during the period of time August 24, 2015 to October 19, 2015, Dr. Jones texted them numerous times about matters that later were learned to be untrue. Dr. Jones later provided information to the College attributing her behaviour to severe stress and side effects of a sleeping medication, details of which are subject to a publication ban.

95. [Redacted].

96. [Redacted].

97. [Redacted].

98. [Redacted].

99. [Redacted].

100. [Redacted].

101. Dr. Jones now admits that she provided false, misleading and/or incomplete information to her physician colleagues and the Registrar.

102. [Redacted].

103. Dr. Jones believes her statements to her colleagues and to the Registrar were due to severe stress and reactions to sleeping medication she had taken at that time. As noted in the following paragraphs, the psychiatrist retained by the College to assess Dr. Jones concluded that the medication taken by Dr. Jones at the time of these statements could explain that behavior.

Psychiatric Evaluations

104. During the course of its investigation, the Investigation Committee ordered two psychiatric evaluations of Dr. Jones, one at the early stages of the investigation and one at later stages when additional information was known. Both were performed by a psychiatrist retained by the College who has frequently provided expert opinion evidence. The psychiatrist was provided with relevant information about the complaint, including the conversations from October, 2015 between Dr. Jones and her colleagues and Dr. Jones and the Registrar.

105. The psychiatrist diagnosed Dr. Jones with adjustment disorder on both occasions.

106. In his initial assessment dated November 30, 2015, he concluded that Dr. Jones did not appear to have an enduring mental health issue which would fundamentally impact her fitness to practice medicine.

107. The psychiatrist stated in his first report that Dr. Jones would benefit from ongoing treatment with a counsellor who she had seen in October and November 2015. The College later obtained the notes from this counsellor.

108. Dr. Jones stopped seeing the counsellor on the advice of her criminal defence counsel.

109. Dr. Jones wanted to return to a counsellor after the criminal proceedings were over. However, Dr. Jones contacted Doctors Nova Scotia and since she was no longer a member of Doctors Nova Scotia, she did not have any benefit coverage for counselling and could not participate in the Professional Support Program.

110. Dr. Jones has no money of her own, having been out of work for nearly 3.5 years. As a result, despite her wishes to do so, Dr. Jones has not been able to seek professional counselling or assistance since seeing the initial counsellor.

111. With respect to the second assessment conducted by the psychiatrist retained by the College in July, 2018, he reviewed additional information gathered during the investigation and again indicated there was no medical reason why Dr. Jones should not be permitted to practice.

112. Regarding recommendations for return to practice, the psychiatrist recommended:

(a) Dr. Jones would benefit from resolution of the matter before the College "as expediently as possible and that lack of resolution will only exacerbate Dr. Jones' psychological distress".

(b) Dr. Jones would benefit from an ongoing therapeutic relationship.

(c) Dr. Jones practice in a group environment and that the College might require mentorship for a period of time.

113. In his report of July 15, 2018, he diagnosed Dr. Jones with "Adjustment disorder, chronic, with anxious mood". He also noted that Dr. Jones was under "extreme stress" in the fall of 2015 after her licence was suspended.

114. He also noted in his July 15, 2018 report that the sleeping medication Dr. Jones was taking in the fall of 2015 could explain the behaviour that occurred at about that time, involving her communications with the Registrar and with her physician colleagues. [redacted]

115. [Redacted[].

116. [Redacted[].

117. [Redacted].

118. Dr. Jones has not taken the sleeping medication in question since the fall of 2015.

Practice Audits

119. During the course of the Investigation Committee's investigation, it ordered two audits of Dr. Jones' practice. The first was dated October 23, 2015 and the second took place on March 13, 2018. Different assessors conducted each audit. One audit focused on the care provided by Dr. Jones during the time she was taking medication in the fall of 2015, and the other audit covered her practice prior to that time.

120. Neither audit identified concerns with clinical care provided by Dr. Jones to the patients whose charts were examined. One assessor stated that Dr. Jones "asks good questions, listens well, and documents all of the findings clearly in the charts". She was impressed with Dr. Jones thoroughness with patients and in her charting technique. The second assessor concluded that overall, very good clinical care was provided and that Dr. Jones had excellent medical records.

121. Patient X's chart was excluded from these practice reviews and was reviewed instead in detail by the Investigation Committee.

Expert Reports

122. The College obtained one expert report respecting Dr. Jones' prescribing history with Patient X. The expert concluded that Dr. Jones fell well below the standard of care with respect to her prescribing practices with Patient X.

123. Dr. Jones provided the Investigation Committee with two expert reports during the course of the investigation. Both experts conceded that Dr. Jones did not meet the standard of

care with respect to Dr. Jones' care of Patient X. Both experts supported a return to work for Dr. Jones, with certain restrictions in place. One of the experts concluded that Dr. Jones was a relatively inexperienced physician who found herself clinically over her head and who tried her best but ultimately failed in her care of Patient X.

III. REFERRAL OF MATTERS TO HEARING COMMITTEE

124. The Investigation Committee upon completion of its investigation has referred various matters to the Hearing Committee. In its Amended Notice of Hearing the College alleges that Dr. Jones committed professional misconduct, demonstrated conduct unbecoming a physician, acted with incompetence and demonstrated incapacity in the following respects:

1. With respect to the care provided to the Patient from January 2010 to August 2015, Dr. Jones failed to meet the accepted standards of practice of medicine respecting the prescription of opioids, by engaging in practices including the following:

    (a) prescribing amounts of opioid medication to the Patient that were excessive, unsafe or otherwise inappropriate;

    (b) failing to properly monitor the Patient's use of opioids;

    (c) failing to monitor the system for safe storage of opioids in the Patient's home;

    (d) continuing to prescribe high doses of opioids after there was demonstrable harm to the patient, such as choking, falling and confusion with dosing;

    (e) failing to properly and safely dispose of opioid medication;

    (f) failing to properly document the Patient's opioid medication and use;

    (g) continuing to prescribe large quantities of opioids during an alleged weaning period in July and August, 2015; and/or

    (h) failing to obtain and/or retain a written prescribing agreement with the Patient.

2. With respect to the care provided to the Patient from January 2010 to August 2015, Dr. Jones failed to maintain the appropriate physician/patient boundaries by engaging in practices including the following:

    (a) frequently picking up and delivering the Patient's opioid medication and removing the Patient's unused opioid medication from his residence;

    (b) ignoring and/or failing to act on indications that the Patient was not using the opioid medication properly or safely;

    (c) ignoring and/or failing to act on indications that the Patient was not storing opioid medication properly or safely and/or

    (d) permitting the Patient to direct his own care.

3. In Dr. Jones' June 14, 2012 and February 25, 2014 letters to the Prescription

Monitoring Program, she violated the accepted standards of practice and *Code of Ethics* by doing one or more of the following:

(a) providing false, misleading and/or incomplete information respecting:

(i) the Patient's medical history and quality of life;

(ii) the Patient's level of compliance;

(iii) the existence of a signed narcotics contract;

(iv) the filling of prescriptions;

(v) the disposition of excess medication;

(vi) her level of consultation with pharmacists and her colleagues about the Patient; and/or

(vii) the weaning of the Patient;

(b) failing to advise that she had resumed the pick-up and delivery of medication to the Patient;

4. During Dr. Jones' October 27, 2015 meeting with Dr. D.A. Gus Grant, Registrar of the College, she violated the standards of the profession, the Canadian Medical Association's *Code of Ethics* and the duty to cooperate under the *Medical Act* by providing false, misleading and/or incomplete information [redacted].

5. Dr. Jones violated accepted standards of practice and the Canadian Medical Association's *Code of Ethics* by providing false, misleading and/or incomplete information to pharmacists, including information that she was working with a pain specialist regarding prescriptions for the Patient when that was not the case.

6. Between August and October 2015, Dr. Jones violated accepted standards of practice and the Canadian Medical Association's *Code of Ethics* by providing false, misleading and/or incomplete information [redacted] to her physician colleagues [redacted].

7. Dr. Jones failed to meet accepted documentation standards by engaging in practices including the following:

(a) failing to retain an alleged written prescribing agreement with the Patient;

(b) failing to properly document the Patient's prescriptions and treatment; and/or

(c) making a number of excessively late entries into the Patient's record.

8. Dr. Jones practiced medicine while suspended by editing a large number of patient encounters on the Patient's electronic record while her licence to practice medicine was suspended by the College.

IV. ADMISSIONS

125. Dr. Jones admits the particulars of the above allegations and acknowledges that collectively they constitute professional misconduct, incompetence and incapacity.

V. DISPOSITION

126. Dr. Jones agrees to the following:

(a) Dr. Jones' licence to practice medicine is suspended for a period of 36 months. She will receive credit for her time suspended on an interim basis and, accordingly, her suspension is considered fully served.

(b) Dr. Jones will provide no medical care to Patient X at any time in the future if she holds a medical licence.

(c) As Dr. Jones has been out of practice for a period greater than 3 years, she is required to meet the provisions of section 16 of the regulations under the *Medical Act* prior to return to practice. This regulation requires physicians who have been out of practice for 3 years or more to complete a competence assessment prior to returning to practice. For purposes of the competence assessment Dr. Jones will be issued a Clinical Assessment licence, whereby Dr. Jones will not be considered the most responsible physician, and will not bill for her services. With successful completion of the competence assessment (as determined by the Registration Committee), she can then apply for a Restricted Licence to practice medicine as the most responsible physician, as set out in subparagraph 126(g). The terms of the competence assessment for Dr. Jones are set out in the document attached as Schedule "B" to this Settlement Agreement. The costs of this competence assessment shall be paid by Dr. Jones as set out in Schedule "B".

(d) While engaged in the competence assessment outlined in Schedule "B", Dr. Jones must commence counselling with a therapist who will be provided by the College with a copy of this Settlement Agreement in order to understand the context in which the counselling is required. Counselling sessions must occur on a monthly basis or such other more frequent basis as recommended by the therapist. Prior to Dr. Jones applying for a Restricted Licence upon completion of the competence assessment outlined in Schedule "B", the therapist is required to provide a report to the College's Professional Conduct Compliance Office either confirming Dr. Jones' fitness to return to practice or identifying any concerns for follow up with the Hearing Committee.

(e) While engaged in the competence assessment outlined in Schedule "B", Dr. Jones must maintain contact with her family physician who will be provided by the College with a copy of this Settlement Agreement. Dr. Jones agrees to see her family physician on at least a monthly basis or more frequent basis as recommended by her physician while participating in the competence assessment. Prior to Dr. Jones applying for a Restricted Licence upon completion of the competence assessment outlined in Schedule "B", the physician is required to provide a report to the College's Professional Conduct Compliance Office either confirming Dr. Jones' fitness to return to practice or identifying any concerns for follow up with the Hearing Committee.

(f) Prior to commencing the competence assessment outlined in Schedule "B", Dr. Jones must supply a hair sample to a testing agency selected by the College, in such manner as determined by the College and must test negative for any of the Prohibited Substances set out in subparagraph 126 (g)(vii). The cost of this test shall be initially paid for by the College and then reimbursed by Dr. Jones in the same manner as ongoing tests described in subparagraph 126(g)(viii).

(g) When the Professional Conduct Compliance Office determines that Dr. Jones has met the criteria set out in subparagraphs (a) to (f) above, she may apply to the College's Registration Committee for a Restricted Licence. If she is issued a Restricted Licence, she may return to practice under a Restricted Licence, with the following conditions and restrictions, and such other conditions as the Registration Committee may determine are necessary based on the recommendations coming out of the competence assessment set out in Schedule "B" and based on the requirements set out in the *Medical Act* for a restricted licence:

(i) Dr. Jones must complete the following remedial education, at her cost, at the first available opportunity following her return to practice in accordance with Schedule "B":

A. The *Understanding Boundaries and Managing Risks Inherent in the Doctor Patient Relationship* course provided by Western University;

B. Ethics education as determined by the Physician Performance Department.

(ii) Dr. Jones will have a permanent restriction on her medical licence preventing her from prescribing Narcotics (under the *Controlled Drugs and Substances Act* Schedule I) and cannabis (under the *Controlled Drugs and Substances Act* Schedule II). Dr. Jones will prominently place a College approved sign to that effect in her clinic waiting room and examination room.

(iii) Dr. Jones will have a restriction on her licence preventing her from prescribing benzodiazepines, and zopiclone, zolpidem, zaleplon or additional members of this class of drugs that may emerge (collectively the "Z-drugs"), for a minimum period of 2 years following her return to practice. Dr. Jones will prominently place a College approved sign to that effect in her clinic waiting room and examination room. Upon completion of the 2-year period she may apply to the Hearing Committee of the day for a variation of this restriction and the Hearing Committee will consider whether it is in the public interest at that time to vary or remove this restriction.

(iv) Dr. Jones will be required to notify Health Canada that she has relinquished her privileges for the drugs identified in subparagraph (ii). The Registrar will provide Dr. Jones with a letter template she agrees to sign and return to the College for forwarding to Health Canada with an explanatory letter from the College.

(v) Dr. Jones' practice will be subject to the supervision requirements set out in Schedule "C" to this Settlement Agreement for a period of two years following return to practice. The costs of the supervision shall be paid by Dr. Jones as set out in Schedule "C" at the time supervision is provided.

(vi) Dr. Jones will not practice as a sole practitioner (in an office with no other practising physicians) for a minimum period of two years following her return to practice. The Physician Performance Department must approve of the location of Dr. Jones' practice for this first two-year period. If, following the two year period, Dr. Jones wishes to practice by herself, she will be required to apply to the Hearing Committee for approval.

(vii) Dr. Jones shall abstain from taking any opioids, benzodiazepines, cannabis, and Z-drugs unless expressly prescribed by a physician (the "Prohibited Substances"). Dr. Jones must notify the College of any prescriptions for the Prohibited Substances within 24 hours of such prescription.

(viii) For a period of five years, Dr. Jones shall participate in a program of monitoring (the "Monitoring Program") to be conducted by such testing agency as may be approved by the College. The Monitoring Program shall test for the presence of any Prohibited Substances at such times and in such manner as will be specified in a protocol provided by the College, which will, to the extent possible utilize hair testing as the means to test for Prohibited Substances. Testing shall not occur more than four times per year for the first two years, and no more than six times in total for the remaining three years. Reasonable accommodation shall be given to Dr. Jones' work and travel schedules. The College shall pay the invoice received from the testing agency and shall then remit each invoice for reimbursement from Dr. Jones, who shall remit such reimbursement within 30 days of receipt of the invoice from the College.

(ix) Dr. Jones shall continue in monthly counselling with a therapist for a minimum period of two years, or such greater frequency as recommended by her therapist, at her cost. At the end of the two year period, if the therapist determines additional therapy is needed, Dr. Jones agrees to abide by the recommendations of her therapist. Dr. Jones consents to her therapist immediately reporting to the College at any time any breach of this settlement agreement or any concerns respecting Dr. Jones' fitness to practice. For clarity, the therapist will not be required to provide the College with any portion of Dr. Jones' patient chart or any notes made during the counselling sessions. Dr. Jones agrees to notify the Professional Conduct Compliance Office of the name and contact information of her therapist during the period of time when she is required to see a therapist, and agrees the College may provide a copy of this Settlement Agreement to her current therapist.

(x) Dr. Jones shall continue with regular visits to her family physician at such frequency as recommended by her physician for the first two years following return to practice. Dr. Jones agrees the frequency of her visits will be no less than quarterly, and hereby consents to her family physician

providing quarterly reports to the College respecting her fitness to practice during this two year period.

(xi) Dr. Jones further consents to attending visits with her family physician at such intervals as recommended by her family physician for a period of 10 years following return to practice, and hereby provides her consent for her family physician to report to the College any breach of this settlement agreement or any concerns respecting Dr. Jones' fitness to practice during this ten year period. She agrees to notify the Professional Conduct Compliance Office during this ten year period of the name and contact information of her family physician and agrees the College may provide a copy of this Settlement Agreement to her family physician of the day for this ten year period.

VI. RETENTION OF JURISDICTION

127. Except where otherwise provided in this Settlement Agreement, the Hearing Committee of the College, in its present or successor form, retains jurisdiction over this matter to deal with any issues of interpretation, implementation or variation of this Agreement.

VII. COSTS

128. Dr. Jones agrees to pay costs to the College in the amount of $50,000 inclusive of HST, representing a portion of the College's costs of investigating this matter. In addition, costs of the competence assessment shall be paid by Dr. Jones as set out in Schedule "B", and the cost of the initial hair test outlined in paragraph 126(f) shall be paid by Dr. Jones at the time it is incurred. The $50,000 amount, plus the costs of the competence assessment, is payable over a 10-year period in equal annual instalments due no later than December 1 of each year. The first date an annual payment is due is December 1, 2020 and continuing thereafter until December 1, 2029.

129. Costs are a debt due to the College, recoverable by way of civil action in the event Dr. Jones does not fulfill the obligations set out in the previous paragraph. Dr. Jones agrees that in the event she defaults on any payment under this agreement, the full amount shall be immediately due, and her licence shall be suspended pending payment in full. In the event the full amount is not paid by December 1, 2029, judgment shall be entered against her for the balance of the costs remaining unpaid together with interest compounded at the rate of six percent (6%) per annum.

VIII. PUBLICATION

130. The Registrar shall publish information respecting this Settlement Agreement and the Decision of the Hearing Committee in accordance with subsection 118(2) of the Medical Act.

IX. EFFECTIVE DATE

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

Dated at Halifax, Nova Scotia on _____, 2019.

_____	_____
Witness	Dr. Sarah Jones
	Dated _____, 2019
_____	_____
Witness	Marjorie Hickey, Q.C. Counsel for the College of Physicians and Surgeons of Nova Scotia
	Dated _____, 2019
_____	_____
Witness	Chair Investigation Committee, College of Physicians and Surgeons of Nova Scotia
	Dated _____, 2019
_____	_____
Witness	Chair The Hearing Committee, College of Physicians and Surgeons of Nova Scotia
	Dated _____, 2019

SCHEDULE "A"

MERGED

Date	Drug	Qty	Days Supply	Expected refill date	Actual Refill Date	Early	Health Service Code MSE	Qualifier Code MSE	Description HSC	Diag Name DGC
2010/01/07	PMS-HYDROMORPHONE TAB 2MG	60	10	2010/01/17	2010/02/05					
2010/01/12	HYDROMORPH CONTIN SR CAP 3MG	60	30	2010/02/11	2010/02/05	E				
2010/02/05							8.49	C	LIFESTYLE COUNSELLING	OPIOID TYPE DEPENDENCE NOS
2010/02/05	HYDROMORPH CONTIN SR CAP 3MG	60	30	2010/03/07	2010/04/14					
2010/02/05	PMS-HYDROMORPHONE TAB 2MG	120	20	2010/02/25	2010/03/22					
2010/02/24	HYDROMORPH CONTIN SR CAP 6MG	60	30	2010/03/26	2010/03/22	E				
2010/02/24	PMS-HYDROMORPHONE TAB 1MG	100	25	2010/03/21						
2010/03/22	HYDROMORPH CONTIN SR CAP 6MG	120	60	2010/05/21						
2010/03/22	PMS-HYDROMORPHONE TAB 2MG	100	20	2010/04/11	2010/04/14					
2010/04/14	HYDROMORPH CONTIN SR CAP 3MG	60	30	2010/05/14	2010/07/08					
2010/04/14	PMS-HYDROMORPHONE TAB 2MG	100	20	2010/05/04	2010/06/14					
2010/06/14	PMS-HYDROMORPHONE TAB 2MG	100	20	2010/07/04	2010/07/06					
2010/07/06							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	SHORTNESS OF BREATH
2010/07/06	PMS-HYDROMORPHONE TAB 2MG	100	20	2010/07/26						
2010/07/08	HYDROMORPH CONTIN SR CAP 3MG	60	30	2010/08/07	2010/07/21	E				
2010/07/21	HYDROMORPH CONTIN SR CAP 3MG	120	30	2010/08/20	2010/08/06	E				
2010/07/21	PMS-HYDROMORPHONE TAB 4MG	100	20	2010/08/10	2010/08/06	E				
2010/08/06	HYDROMORPH CONTIN SR CAP 3MG	120	20	2010/08/26						
2010/08/06	PMS-HYDROMORPHONE TAB 4MG	100	20	2010/08/26						
2010/08/23	OXYCONTIN SRT 10MG	180	30	2010/09/22	2010/09/09	E				
2010/08/24	OXY-IR TAB 5MG	100	16	2010/09/09						
2010/08/30	PMS-OXYCODONE IR TAB 10MG	100	30	2010/09/29	2010/09/09	E				
2010/09/09	OXYCONTIN SRT 10MG	240	30	2010/10/09	2010/10/05	E				
2010/09/09	PMS-OXYCODONE IR TAB 10MG	100	17	2010/09/26	2010/09/21	E				
2010/09/21	PMS-OXYCODONE IR TAB 10MG	200	34	2010/10/25	2010/10/12	E				
2010/09/27	OXYCONTIN SRT 40MG	60	30	2010/10/27	2010/10/14	E				
2010/10/05	OXYCONTIN SRT 10MG	200	50	2010/11/24	2011/01/10					
2010/10/12							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ACUTE BRONCHITIS
2010/10/12	PMS-OXYCODONE IR TAB 10MG	100	20	2010/11/01	2010/10/21	E				
2010/10/14	OXYCONTIN SRT 40MG	60	30	2010/11/13	2010/11/08	E				
2010/10/21	PMS-OXYCODONE IR TAB 10MG	100	17	2010/11/07	2010/11/03	E				
2010/11/03	PMS-OXYCODONE IR TAB 10MG	200	33	2010/12/06	2010/11/29	E				
2010/11/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2010/11/04							13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	PROPH VACCINATION INFLUENZA
2010/11/04							13.59	W	PROVINCIAL IMMUNIZATION-TRAY FEE	PROPH VACCINATION INFLUENZA
2010/11/08	OXYCONTIN SRT 40MG	60	30	2010/12/08	2011/03/03					
2010/11/09							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2010/11/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	GEN OSTEOARTHROSIS SITE UNSPEC
2010/11/15	OXYCONTIN SRT 20MG	180	30	2010/12/15	2010/12/04	E				
2010/11/29	PMS-OXYCODONE IR TAB 10MG	200	33	2011/01/01	2011/01/05					
2010/12/04	OXYCONTIN SRT 20MG	180	30	2011/01/03	2010/12/27	E				
2010/12/21	PMS-OXYCODONE IR TAB 5MG	200	16	2011/01/06						
2010/12/27	OXYCONTIN SRT 20MG	180	30	2011/01/26	2011/01/15	E				
2011/01/05	PMS-OXYCODONE IR TAB 10MG	200	33	2011/02/07	2011/01/31	E				
2011/01/10	OXYCONTIN SRT 10MG	100	50	2011/03/01	2011/02/11	E				

2011/01/15							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	GEN OSTEOARTHROSIS SITE UNSPEC
2011/01/15	OXYCONTIN SRT 20MG	180	30	2011/02/14	2011/02/04	E			
2011/01/31							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	GEN OSTEOARTHROSIS SITE UNSPEC
2011/01/31	PMS-OXYCODONE IR TAB 10MG	200	33	2011/03/05	2011/02/28	E			
2011/02/04							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2011/02/04	OXYCONTIN SRT 20MG	180	30	2011/03/06	2011/02/21	E			
2011/02/11							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DERMATOPHYTOSIS OF NAIL
2011/02/11	OXYCONTIN SRT 10MG	150	50	2011/04/02	2011/08/25				
2011/02/21							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2011/02/21	OXYCONTIN SRT 20MG	180	30	2011/03/23	2011/05/31				
2011/02/28							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	CHRONIC RHINITIS
2011/02/28	PMS-OXYCODONE IR TAB 10MG	250	42	2011/04/11	2011/04/04	E			
2011/03/03	OXYCONTIN SRT 40MG	120	30	2011/04/02	2011/03/20	E			
2011/03/20	OXYCONTIN SRT 40MG	120	30	2011/04/19	2011/04/09	E			
2011/03/25							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2011/04/04	PMS-OXYCODONE IR TAB 10MG	225	37	2011/05/11	2011/04/26	E			
2011/04/09	OXYCONTIN SRT 40MG	120	30	2011/05/09	2011/04/30	E			
2011/04/26							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DYSPHAGIA
2011/04/26	PMS-OXYCODONE IR TAB 10MG	225	37	2011/06/02	2011/05/16	E			
2011/04/30	OXYCONTIN SRT 40MG	120	30	2011/05/30	2011/05/22	E			
2011/05/16							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2011/05/16	PMS-OXYCODONE IR TAB 10MG	200	16	2011/06/01	2011/06/12				
2011/05/22	OXYCONTIN SRT 40MG	120	30	2011/06/21	2012/02/20				
2011/05/31	OXYCONTIN SRT 20MG	150	21	2011/06/21	2011/06/16	E			
2011/06/12							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2011/06/12	PMS-OXYCODONE IR TAB 10MG	220	18	2011/06/30	2011/06/24	E			
2011/06/16							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DEPRESSIVE DISORDER NEC
2011/06/16	OXYCONTIN SRT 20MG	210	30	2011/07/16	2011/06/24	E			
2011/06/24	OXYCONTIN SRT 20MG	30	30	2011/07/24	2011/07/10	E			
2011/06/24	PMS-OXYCODONE IR TAB 10MG	175	14	2011/07/08	2011/07/18				
2011/07/04							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	HEMATEMESIS
2011/07/10	OXYCONTIN SRT 20MG	230	28	2011/08/07	2011/07/21	E			
2011/07/18							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2011/07/18	PMS-OXYCODONE IR TAB 10MG	250	20	2011/08/07	2011/08/04	E			
2011/07/21							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ANXIETY STATE UNSPECIFIED
2011/07/21	OXYCONTIN SRT 20MG	240	30	2011/08/20	2011/08/10	E			
2011/08/04	PMS-OXYCODONE IR TAB 10MG	250	20	2011/08/24	2011/08/21	E			
2011/08/10	OXYCONTIN SRT 20MG	240	30	2011/09/09	2011/09/06	E			
2011/08/21							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DEPRESSIVE DISORDER NEC
2011/08/21	PMS-OXYCODONE IR TAB 10MG	250	20	2011/09/10	2011/09/14				
2011/08/25							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2011/08/25	OXYCONTIN SRT 10MG	100	50	2011/10/14	2012/06/22				

2011/09/06							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2011/09/06	OXYCONTIN SRT 20MG	235	29	2011/10/05	2011/09/27	E				
2011/09/14							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DEPRESSIVE DISORDER NEC
2011/09/14	PMS-OXYCODONE IR TAB 10MG	250	20	2011/10/04	2011/10/05					
2011/09/27	OXYCONTIN SRT 20MG	240	30	2011/10/27	2011/10/11	E				
2011/09/26							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2011/10/03							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ANXIETY STATE UNSPECIFIED
2011/10/05	PMS-OXYCODONE IR TAB 10MG	250	20	2011/10/25	2011/10/25					
2011/10/11							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	GEN OSTEOARTHROSIS SITE UNSPEC
2011/10/11	OXYCONTIN SRT 20MG	120	15	2011/10/26	2011/10/25	E				
2011/10/25	OXYCONTIN SRT 20MG	240	30	2011/11/24	2011/11/28					
2011/10/25	PMS-OXYCODONE IR TAB 10MG	200	16	2011/11/10	2011/12/09					
2011/10/26							13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	PROPH VACCINATION INFLUENZA
2011/10/26							15.59	M	PROVINCIAL IMMUNIZATION-TRAY FEE	PROPH VACCINATION INFLUENZA
2011/10/26							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	GEN OSTEOARTHROSIS SITE UNSPEC
2011/11/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ASTHMA UNSPEC NO STATUS ASTH
2011/11/28							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DERMATOPHYTOSIS OF NAIL
2011/11/28	OXYCONTIN SRT 20MG	240	30	2011/12/28	2011/12/21	E				
2011/12/09							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ASTHMA UNSPEC NO STATUS ASTH
2011/12/09	PMS-OXYCODONE IR TAB 10MG	250	20	2011/12/29	2012/01/03					
2011/12/21	OXYCONTIN SRT 20MG	240	30	2012/01/20	2012/01/12	E				
2011/12/22							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	BALANOPOSTHITIS
2012/01/03							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	HYPERPLASIA OF PROSTATE
2012/01/03	PMS-OXYCODONE IR TAB 10MG	250	20	2012/01/23	2012/01/26					
2012/01/12							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2012/01/12	OXYCONTIN SRT 20MG	240	30	2012/02/11	2012/02/01	E				
2012/01/26							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2012/01/26	PMS-OXYCODONE IR TAB 10MG	250	20	2012/02/15	2012/02/14	E				
2012/02/01	OXYCONTIN SRT 20MG	240	30	2012/03/02	2012/03/11					
2012/02/02							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2012/02/14	PMS-OXYCODONE IR TAB 10MG	250	20	2012/03/05	2012/03/01	E				
2012/02/20							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2012/02/20	OXYCONTIN SRT 40MG	120	30	2012/03/21						
2012/03/01							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DYSPHAGIA
2012/03/01	PMS-OXYCODONE IR TAB 10MG	250	20	2012/03/21	2012/03/20	E				
2012/03/11							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	CELLULITIS/ABSCESS UNSPEC SITE
2012/03/11	OXYCONTIN SRT 20MG	240	30	2012/04/10	2012/03/27	E				
2012/03/20							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION DESCRIBED AS LIMITED	DISORDER CARBOHYD TRANS/MET NOS
2012/03/20	PMS-OXYCODONE IR TAB 10MG	250	20	2012/04/09	2012/04/09					
2012/03/27							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT PELVIS/THIGH

2012/03/27	OXYCONTIN SRT 20MG	160	20	2012/04/16	2012/04/13	E			
2012/04/09							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2012/04/09	PMS-OXYCODONE IR TAB 10MG	240	20	2012/04/29	2012/04/28	E			
2012/04/13							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2012/04/13	OXYCONTIN SRT 20MG	240	30	2012/05/13	2012/04/20	E			
2012/04/20	OXYCONTIN SRT 20MG	240	30	2012/05/20	2012/05/19	E			
2012/04/21							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	CONTUSION OF THIGH
2012/04/28							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	INJ BLOOD VESSEL LOW EXTREM NOS
2012/04/28	PMS-OXYCODONE IR TAB 10MG	250	20	2012/05/18	2012/05/14	E			
2012/05/14							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	UNSPEC HEMORRHOIDS NO COMPL
2012/05/14	PMS-OXYCODONE IR TAB 10MG	250	20	2012/06/03	2012/06/01	E			
2012/05/19							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	HYPERPLASIA OF PROSTATE
2012/05/19	OXYCONTIN SRT 20MG	240	30	2012/06/18	2012/06/05	E			
2012/06/01							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	REGIONAL ENTERITIS UNSPEC SITE
2012/06/01	PMS-OXYCODONE IR TAB 10MG	250	20	2012/06/21	2012/06/18	E			
2012/06/05							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2012/06/05	OXYCONTIN SRT 20MG	240	30	2012/07/05					
2012/06/16							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/06/18	PMS-OXYCODONE IR TAB 10MG	250	20	2012/07/08	2012/07/06	E			
2012/06/22							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/06/22	OXYCONTIN SRT 10MG	180	60	2012/08/21					
2012/06/25	OXYNEO EXTENDED RELEASE TAB 20MG	180	30	2012/07/25	2012/07/12	E			
2012/06/26							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/07/06							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/07/06	PMS-OXYCODONE IR TAB 10MG	250	20	2012/07/26	2012/07/24	E			
2012/07/12							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/07/12	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2012/08/11	2012/08/05	E			
2012/07/24							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/07/24	PMS-OXYCODONE IR TAB 10MG	250	20	2012/08/13	2012/08/13				
2012/07/26							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/07/28	OXYNEO EXTENDED RELEASE TAB 10MG	120	20	2012/08/17	2012/09/27				
2012/08/05							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2012/08/05	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2012/09/04	2012/09/04				
2012/08/13							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PROSTATITIS UNSPECIFIED
2012/08/13	PMS-OXYCODONE IR TAB 10MG	250	31	2012/09/13	2012/08/31	E			
2012/08/17							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PROSTATITIS UNSPECIFIED
2012/08/17	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	2012/09/16	2012/10/04				

2012/09/31							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2012/08/31	PMS-OXYCODONE IR TAB 10MG	250	31	2012/10/01	2012/09/23	E				
2012/09/04	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2012/10/04	2012/09/13	E				
2012/09/13							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2012/09/13	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2012/10/13	2012/10/15					
2012/09/23	PMS-OXYCODONE IR TAB 10MG	250	20	2012/10/13	2012/10/11	E				
2012/09/27	OXYNEO EXTENDED RELEASE TAB 10MG	200	30	2012/10/27	2012/12/03					
2012/10/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2012/10/04	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	2012/11/03	2012/11/05					
2012/10/11							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2012/10/11	PMS-OXYCODONE IR TAB 10MG	250	20	2012/10/31	2012/10/26	E				
2012/10/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2012/10/15	OXYNEO EXTENDED RELEASE TAB 20MG	210	30	2012/11/14	2012/11/20					
2012/10/26							13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	PROPH VACCINATION INFLUENZA
2012/10/26							13.59	M	PROVINCIAL IMMUNIZATION-TRAY FEE	PROPH VACCINATION INFLUENZA
2012/10/26							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DEPRESSIVE DISORDER NEC
2012/10/26	PMS-OXYCODONE IR TAB 10MG	250	20	2012/11/15	2012/11/13	E				
2012/10/29	OXYNEO EXTENDED RELEASE TAB 80MG	60	30	2012/11/28	2014/01/19					
2012/11/05							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ASTHMA UNSPEC NO STATUS ASTH
2012/11/05	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	2012/12/05	2013/05/07					
2012/11/13	PMS-OXYCODONE IR TAB 10MG	250	20	2012/12/03	2012/11/29	E				
2012/11/20							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2012/11/20	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2012/12/20	2012/12/07	E				
2012/11/29	PMS-OXYCODONE IR TAB 10MG	250	20	2012/12/19	2012/12/17	E				
2012/12/03	OXYNEO EXTENDED RELEASE TAB 10MG	200	30	2013/01/02	2012/12/20	E				
2012/12/07							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2012/12/07	OXYNEO EXTENDED RELEASE TAB 20MG	240	26	2013/01/02	2012/12/29	E				
2012/12/17							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2012/12/17	PMS-OXYCODONE IR TAB 10MG	300	25	2013/01/11	2013/01/03	E				
2012/12/20							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2012/12/20	OXYNEO EXTENDED RELEASE TAB 10MG	250	20	2013/01/09	2013/01/24					
2012/12/29	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2013/01/28	2013/01/14	E				
2013/01/03	PMS-OXYCODONE IR TAB 10MG	300	25	2013/01/28	2013/01/21	E				
2013/01/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	CANDIDIASIS OF MOUTH
2013/01/14							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN LIMB

2013/01/14	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2013/02/13	2013/01/30	E				
2013/01/21	PMS-OXYCODONE IR TAB 10MG	300	25	2013/02/15	2013/02/11	E				
2013/01/24							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ASTHMA UNSPEC NO STATUS ASTH
2013/01/24	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	2013/02/23	2013/02/21	E				
2013/01/30	OXYNEO EXTENDED RELEASE TAB 20MG	224	28	2013/02/27	2013/02/13	E				
2013/01/31							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2013/02/11	PMS-OXYCODONE IR TAB 10MG	300	25	2013/03/08	2013/02/26	E				
2013/02/13	OXYNEO EXTENDED RELEASE TAB 20MG	224	28	2013/03/13	2013/03/06	E				
2013/02/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2013/02/21							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2013/02/21	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	2013/03/23	2013/03/18	E				
2013/02/26	PMS-OXYCODONE IR TAB 10MG	300	25	2013/03/23	2013/03/15	E				
2013/03/06	OXYNEO EXTENDED RELEASE TAB 20MG	224	28	2013/04/03	2013/03/24	E				
2013/03/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN LIMB
2013/03/15	PMS-OXYCODONE IR TAB 10MG	300	25	2013/04/09	2013/04/02	E				
2013/03/18	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	2013/04/17	2013/04/09	E				
2013/03/24							8.49	C	LIFESTYLE COUNSELLING	DISORDER CARBOHYD TRANS/MET NOS
2013/03/24	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2013/04/23	2013/04/15	E				
2013/04/02	PMS-OXYCODONE IR TAB 10MG	300	25	2013/04/27	2013/04/22	E				
2013/04/09	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	2013/05/09	2013/04/26	E				
2013/04/15	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2013/05/15	2013/05/21					
2013/04/22	PMS-OXYCODONE IR TAB 10MG	300	25	2013/05/17	2013/05/13	E				
2013/04/26	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	2013/05/16	2013/05/16					
2013/05/07	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	2013/06/06	2013/07/22					
2013/05/13	PMS-OXYCODONE IR TAB 10MG	300	25	2013/06/07	2013/05/28	E				
2013/05/16							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ACUTE BRONCHITIS
2013/05/16	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	2013/06/05	2013/06/04	E				
2013/05/21							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ACUTE BRONCHITIS
2013/05/21	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	2013/06/20	2013/06/10	E				
2013/05/28	PMS-OXYCODONE IR TAB 10MG	300	25	2013/06/22	2013/06/17	E				
2013/06/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DERMATOPHYTOSIS OF NAIL
2013/06/04	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	2013/06/24	2013/06/20	E				
2013/06/10	OXYNEO EXTENDED RELEASE TAB 20MG	240	26	2013/07/06	2013/06/28	E				
2013/06/17	PMS-OXYCODONE IR TAB 10MG	300	25	2013/07/12	2013/07/04	E				
2013/06/20	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	2013/07/10	2013/07/08	E				
2013/06/21							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DYSFUNCTION OF EUSTACHIAN TUBE

2013/06/28	OXYNEO EXTENDED RELEASE TAB 20MG	240	26	2013/07/24	2013/07/12	E				
2013/07/04	PMS-OXYCODONE IR TAB 10MG	300	25	2013/07/29	2013/07/18	E				
2013/07/08	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/07/28	2013/08/01					
2013/07/12	OXYNEO EXTENDED RELEASE TAB 20MG	240	26	2013/08/07	2013/08/16					
2013/07/18	PMS-OXYCODONE IR TAB 10MG	350	29	2013/08/16	2013/08/06	E				
2013/07/19							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DYSURIA
2013/07/22	OXYNEO EXTENDED RELEASE TAB 40MG	140	28	2013/08/19	2013/08/09	E				
2013/08/01	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/08/21	2013/08/26					
2013/08/06	PMS-OXYCODONE IR TAB 10MG	350	29	2013/09/04	2013/08/22	E				
2013/08/09	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	2013/09/08	2013/09/19					
2013/08/16	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	2013/09/15	2013/09/04	E				
2013/08/22	PMS-OXYCODONE IR TAB 10MG	350	29	2013/09/20	2013/09/10	E				
2013/08/26	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/09/15	2013/09/13	E				
2013/09/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2013/09/04	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	2013/10/04	2013/10/05					
2013/09/10	PMS-OXYCODONE IR TAB 10MG	350	29	2013/10/09	2013/09/28	E				
2013/09/13							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	REFLUX ESOPHAGITIS
2013/09/13	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/10/03	2013/10/01	E				
2013/09/19							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2013/09/19	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	2013/10/19	2013/10/18	E				
2013/09/28							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2013/09/28	PMS-OXYCODONE IR TAB 10MG	350	29	2013/10/27	2013/10/11	E				
2013/10/01	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/10/21	2013/10/15	E				
2013/10/02							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2013/10/05	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	2013/11/04	2013/11/04					
2013/10/11	PMS-OXYCODONE IR TAB 10MG	350	29	2013/11/09	2013/10/28	E				
2013/10/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2013/10/15	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/11/04	2013/11/01	E				
2013/10/18							13.99	L	PROVINCIAL IMMUNIZATION INJECTIONS	PROPH VACCINATION INFLUENZA
2013/10/18							13.99	M	PROVINCIAL IMMUNIZATION-TRAY FEE	PROPH VACCINATION INFLUENZA
2013/10/18	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	2013/11/17	2013/11/09	E				
2013/10/28							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	BRONCHITIS NOT SPEC ACUTE/CHR
2013/10/28	PMS-OXYCODONE IR TAB 10MG	350	29	2013/11/26	2013/11/15	E				
2013/11/01	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/11/21	2013/11/18	E				
2013/11/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	OBESITY
2013/11/04	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	2013/12/04	2013/12/02	E				

2013/11/09	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	2013/12/09	2013/12/09				
2013/11/15	PMS-OXYCODONE IR TAB 10MG	350	29	2013/12/14	2013/11/29	E			
2013/11/18	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/12/08	2013/12/06	E			
2013/11/29							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN LIMB
2013/11/29	PMS-OXYCODONE IR TAB 10MG	350	29	2013/12/28	2013/12/13	E			
2013/12/02							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DYSPHAGIA
2013/12/02	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	2014/01/01	2013/12/20	E			
2013/12/06	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2013/12/26	2013/12/16	E			
2013/12/09	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	2014/01/08	,2013/12/29	E			
2013/12/13	PMS-OXYCODONE IR TAB 10MG	350	29	2014/01/11	2013/12/29	E			
2013/12/16							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	OP WND KNEE/LEG/ANKLE NO COMPL
2013/12/16	OXYNEO EXTENDED RELEASE TAB 10MG	250	20	2014/01/05	2013/12/23	E			
2013/12/20							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	OP WND KNEE/LEG/ANKLE NO COMPL
2013/12/20	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	2014/01/19	2014/01/09	E			
2013/12/23							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	OP WND KNEE/LEG/ANKLE NO COMPL
2013/12/23	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2014/01/12	2014/01/06	E			
2013/12/29	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	2014/01/28	2014/03/01				
2013/12/29	PMS-OXYCODONE IR TAB 10MG	350	29	2014/01/27	2014/01/14	E			
2014/01/06	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2014/01/26	2014/01/24	E			
2014/01/09							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	HYPERPLASIA OF PROSTATE
2014/01/09	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	2014/02/08	2014/01/30	E			
2014/01/14	PMS-OXYCODONE IR TAB 10MG	350	29	2014/02/12	2014/01/27	E			
2014/01/19							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	AC SUPP OTIT MEDIA NO DRUM RUPT
2014/01/19	OXYNEO EXTENDED RELEASE TAB 80MG	90	30	2014/02/18	2014/03/20				
2014/01/24							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2014/01/24	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2014/02/13	2014/02/08	E			
2014/01/27	PMS-OXYCODONE IR TAB 10MG	350	29	2014/02/25	2014/02/11	E			
2014/01/30	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	2014/03/01	2014/02/17	E			
2014/02/04	HYDROMORPH CONTIN SR CAP 24MG	90	30	2014/03/06					
2014/02/06							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RASH/OTH NONSPEC SKIN ERUPTION
2014/02/08	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2014/02/28	2014/02/24	E			
2014/02/11							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DYSURIA
2014/02/11	PMS-OXYCODONE IR TAB 10MG	350	29	2014/03/12	2014/02/26	E			
2014/02/17							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	REGIONAL ENTERITIS UNSPEC SITE
2014/02/17	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	2014/03/19	2014/03/08	E			

2014/02/24							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	REGIONAL ENTERITIS UNSPEC SITE
2014/02/24	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	2014/03/16	2014/03/06	E				
2014/02/26	PMS-OXYCODONE IR TAB 10MG	350	29	2014/03/27	2014/03/11	E				
2014/02/27							8.49	C	LIFESTYLE COUNSELLING	PERSIST DISORD INIT/MAINT SLEEP
2014/03/01	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	2014/03/31	2014/04/05					
2014/03/06	OXYNEO EXTENDED RELEASE TAB 10MG	350	15	2014/03/21	2014/03/28					
2014/03/08	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	2014/04/07	2014/03/31	E				
2014/03/11	PMS-OXYCODONE IR TAB 10MG	350	29	2014/04/09	2014/03/25	E				
2014/03/20	OXYNEO EXTENDED RELEASE TAB 80MG	84	28	2014/04/17	2014/04/15	E				
2014/03/25							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ANXIETY STATE UNSPECIFIED
2014/03/25	PMS-OXYCODONE IR TAB 10MG	350	29	2014/04/23	2014/04/10	E				
2014/03/28							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT SHOULDER REGION
2014/03/28	OXYNEO EXTENDED RELEASE TAB 10MG	360	30	2014/04/27	2014/04/21	E				
2014/03/31							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT SHOULDER REGION
2014/03/31	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	2014/04/30	2014/04/24	E				
2014/04/05	OXYNEO EXTENDED RELEASE TAB 40MG	180	30	2014/05/05	2014/05/04	E				
2014/04/10	PMS-OXYCODONE IR TAB 10MG	350	14	2014/04/24	2014/04/29					
2014/04/15	OXYNEO EXTENDED RELEASE TAB 80MG	90	30	2014/05/15	2014/05/31					
2014/04/21							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT SHOULDER REGION
2014/04/21							93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING ASPIRATION IF NECESSARY	PAIN IN JOINT SHOULDER REGION
2014/04/21	OXYNEO EXTENDED RELEASE TAB 10MG	360	30	2014/05/21	2014/05/11	E				
2014/04/24	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/05/24	2014/05/16	E				
2014/04/29	PMS-OXYCODONE IR TAB 10MG	350	14	2014/05/13	2014/05/14					
2014/05/04	OXYNEO EXTENDED RELEASE TAB 40MG	240	30	2014/06/03	2014/06/23					
2014/05/11	OXYNEO EXTENDED RELEASE TAB 10MG	360	24	2014/06/04	2014/05/26	E				
2014/05/14	PMS-OXYCODONE IR TAB 10MG	350	14	2014/05/28	2014/05/29					
2014/05/16	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/06/15	2014/06/07	E				
2014/05/26	OXYNEO EXTENDED RELEASE TAB 10MG	360	24	2014/06/19	2014/06/13	E				
2014/05/29	PMS-OXYCODONE IR TAB 10MG	350	14	2014/06/12	2014/06/17					
2014/05/31	OXYNEO EXTENDED RELEASE TAB 80MG	90	30	2014/06/30	2014/08/07					
2014/06/07							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ANXIETY STATE UNSPECIFIED
2014/06/07	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/07/07	2014/07/08					
2014/06/13	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/07/13	2014/07/04	E				
2014/06/17	PMS-OXYCODONE IR TAB 10MG	350	14	2014/07/01	2014/07/02					
2014/06/23	OXYNEO EXTENDED RELEASE TAB 40MG	270	30	2014/07/23	2014/07/17	E				

2014/07/02							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PERSIST DISORD INIT/MAINT SLEEP
2014/07/02	PMS-OXYCODONE IR TAB 10MG	350	14	2014/07/16	2014/07/15	E				
2014/07/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	HYPERPLASIA OF PROSTATE
2014/07/04	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/08/03	2014/07/25	E				
2014/07/08							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	BALANOPOSTHITIS
2014/07/08	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/08/07	2014/07/31	E				
2014/07/15	PMS-OXYCODONE IR TAB 10MG	350	14	2014/07/29	2014/07/29					
2014/07/17	OXYNEO EXTENDED RELEASE TAB 40MG	270	30	2014/08/16	2014/12/22					
2014/07/25	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/08/24	2014/08/15	E				
2014/07/29	PMS-OXYCODONE IR TAB 10MG	350	14	2014/08/12	2014/08/14					
2014/07/31	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/08/30	2014/08/25	E				
2014/08/07	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	2014/09/06	2014/09/08					
2014/08/14	PMS-OXYCODONE IR TAB 10MG	350	14	2014/08/28	2014/09/02					
2014/08/15	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/09/14	2014/09/04	E				
2014/08/25							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	INFECTIVE OTITIS EXTERNA UNSPEC
2014/08/25	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/09/24	2014/09/17	E				
2014/09/02	PMS-OXYCODONE IR TAB 10MG	350	14	2014/09/16	2014/09/15	E				
2014/09/04	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/10/04	2014/09/24	E				
2014/09/08							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2014/09/08	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	2014/10/08	2014/09/30	E				
2014/09/15	PMS-OXYCODONE IR TAB 10MG	350	14	2014/09/29	2014/09/28	E				
2014/09/17							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2014/09/17	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/10/17	2014/10/07	E				
2014/09/24							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	INFECTIVE OTITIS EXTERNA UNSPEC
2014/09/24	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/10/24	2014/10/16	E				
2014/09/28	PMS-OXYCODONE IR TAB 10MG	350	14	2014/10/12	2014/10/14					
2014/09/30							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2014/09/30	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	2014/10/30	2014/10/30					
2014/10/07	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/11/06	2014/10/23	E				
2014/10/14	PMS-OXYCODONE IR TAB 10MG	350	14	2014/10/28	2014/10/28					
2014/10/16	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/11/15	2014/11/06	E				
2014/10/23	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/11/22	2014/11/12	E				
2014/10/28							13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	DIABETES MELL NO COMPL TYPE II
2014/10/28							13.69	M	PROVINCIAL IMMUNIZATION-TRAY FEE	DIABETES MELL NO COMPL TYPE II
2014/10/28							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2014/10/28	PMS-OXYCODONE IR TAB 10MG	350	14	2014/11/11	2014/11/10	E				

2014/10/30							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	OP WND KNEE/LEG/ANKLE NO COMPL
2014/10/30	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	2014/11/29	2014/11/18	E				
2014/11/06							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	REFLUX ESOPHAGITIS
2014/11/06	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/12/06	2014/11/28	E				
2014/11/10							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2014/11/10	PMS-OXYCODONE IR TAB 10MG	350	14	2014/11/24	2014/11/24					
2014/11/12							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	URINARY TRACT INFECT SITE NOS
2014/11/12	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	2014/12/12	2014/12/01	E				
2014/11/17							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2014/11/17							93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING ASPIRATION IF NECESSARY	PAIN IN JOINT LOWER LEG
2014/11/18							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2014/11/18	OXYNEO EXTENDED RELEASE TAB 80MG	150	30	2014/12/18	2015/04/25					
2014/11/24	PMS-OXYCODONE IR TAB 10MG	350	14	2014/12/08	2014/12/08					
2014/11/28	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2014/12/28	2014/12/19	E				
2014/12/01	OXYNEO EXTENDED RELEASE TAB 20MG	540	30	2014/12/31	2014/12/12	E				
2014/12/04							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	UNSPEC HEMORRHOIDS NO COMPL
2014/12/08	PMS-OXYCODONE IR TAB 10MG	350	14	2014/12/22	2014/12/22					
2014/12/12	OXYNEO EXTENDED RELEASE TAB 20MG	540	30	2015/01/11	2015/03/14					
2014/12/19							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2014/12/19							93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING ASPIRATION IF NECESSARY	PAIN IN JOINT LOWER LEG
2014/12/19	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	2015/01/18	2014/12/30	E				
2014/12/22	OXYNEO EXTENDED RELEASE TAB 40MG	270	30	2015/01/21	2015/01/05	E				
2014/12/22	PMS-OXYCODONE IR TAB 10MG	350	14	2015/01/05	2015/01/02	E				
2014/12/30							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2014/12/30	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	2015/01/21	2015/01/12	E				
2015/01/02	PMS-OXYCODONE IR TAB 10MG	350	14	2015/01/16	2015/01/15	E				
2015/01/05							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2015/01/05	OXYNEO EXTENDED RELEASE TAB 40MG	300	25	2015/01/30	2015/01/17	E				
2015/01/12	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	2015/02/03	2015/01/22	E				
2015/01/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2015/01/15	PMS-OXYCODONE IR TAB 10MG	350	14	2015/01/29	2015/01/26	E				
2015/01/17	OXYNEO EXTENDED RELEASE TAB 40MG	250	20	2015/02/06	2015/01/28	E				
2015/01/22	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	2015/02/13	2015/02/08	E				

2015/01/26	PMS-OXYCODONE IR TAB 10MG	350	14	2015/02/09	2015/02/12					
2015/01/28							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ASTHMA UNSPEC NO STATUS ASTH
2015/01/28	OXYNEO EXTENDED RELEASE TAB 40MG	360	30	2015/02/27	2015/02/17	E				
2015/02/08	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	2015/03/02	2015/02/24	E				
2015/02/12	PMS-OXYCODONE IR TAB 10MG	350	14	2015/02/26	2015/02/27					
2015/02/17	OXYNEO EXTENDED RELEASE TAB 40MG	360	30	2015/03/19	2015/03/02	E				
2015/02/24	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	2015/03/18	2015/03/09	E				
2015/02/27							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2015/02/27	PMS-OXYCODONE IR TAB 10MG	350	14	2015/03/13	2015/03/12	E				
2015/03/02							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	CELLULITIS/ABSCESS UNSPEC SITE
2015/03/02	OXYNEO EXTENDED RELEASE TAB 40MG	360	30	2015/04/01						
2015/03/09							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2015/03/09	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	2015/03/31	2015/03/22	E				
2015/03/12							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2015/03/12							93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING ASPIRATION IF NECESSARY	PAIN IN JOINT LOWER LEG
2015/03/12	PMS-OXYCODONE IR TAB 10MG	350	14	2015/03/26	2015/03/25	E				
2015/03/14							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2015/03/14							CDM1		CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM	DIABETES MELL NO COMPL TYPE II
2015/03/14	OXYNEO EXTENDED RELEASE TAB 20MG	630	30	2015/04/13	2015/03/27	E				
2015/03/16							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2015/03/22	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/04/16	2015/04/04	E				
2015/03/25	PMS-OXYCODONE IR TAB 10MG	350	14	2015/04/08	2015/04/07	E				
2015/03/27							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC
2015/03/27	OXYNEO EXTENDED RELEASE TAB 20MG	630	30	2015/04/26	2015/04/12	E				
2015/03/30							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ACUTE BRONCHITIS
2015/04/04	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/04/29	2015/04/20	E				
2015/04/07	PMS-OXYCODONE IR TAB 10MG	350	14	2015/04/21	2015/04/23					
2015/04/12	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	2015/05/12	2015/05/06	E				
2015/04/15							3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN JOINT LOWER LEG
2015/04/15							93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING ASPIRATION IF NECESSARY	PAIN IN JOINT LOWER LEG
2015/04/20	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/05/15	2015/05/04	E				
2015/04/23	PMS-OXYCODONE IR TAB 10MG	350	14	2015/05/07	2015/05/07					
2015/04/25	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	2015/05/25	2015/05/22	E				

2015/05/04	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/05/29	2015/05/19	E			
2015/05/07	PMS-OXYCODONE IR TAB 10MG	350	14	2015/05/21	2015/05/17	E			
2015/05/08	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	2015/06/07	2015/06/01	E			
2015/05/17	PMS-OXYCODONE IR TAB 10MG	350	14	2015/05/31	2015/05/29	E			
2015/05/19	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/06/13	2015/06/05	E			
2015/05/22	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	2015/06/21	2015/06/17	E			
2015/05/29	PMS-OXYCODONE IR TAB 10MG	350	14	2015/06/12	2015/06/11	E			
2015/06/01							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ESSENTIAL HYPERTENSION UNSPEC
2015/06/01	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	2015/07/01	2015/06/26	E			
2015/06/05							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PURE HYPERCHOLESTEROLEMIA
2015/06/05	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/06/30	2015/06/24	E			
2015/06/11	PMS-OXYCODONE IR TAB 10MG	450	19	2015/06/30	2015/06/27	E			
2015/06/17							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	POLYNEUROPATHY IN DIABETES
2015/06/17	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	2015/07/17	2015/07/09	E			
2015/06/24	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/07/19	2015/07/06	E			
2015/06/26							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	REFLUX ESOPHAGITIS
2015/06/26	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	2015/07/26	2015/07/19	E			
2015/06/27							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	ACUTE BRONCHITIS
2015/06/27	PMS-OXYCODONE IR TAB 10MG	450	19	2015/07/16	2015/07/13	E			
2015/07/06							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	EDEMA
2015/07/06	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/07/31	2015/07/22	E			
2015/07/09							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	DIABETES MELL NO COMPL TYPE II
2015/07/09	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	2015/08/08	2015/07/31	E			
2015/07/13							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PNEUMONIA ORGANISM UNSPECIFIED
2015/07/13	PMS-OXYCODONE IR TAB 10MG	450	19	2015/08/01	2015/07/28	E			
2015/07/19							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	EDEMA
2015/07/19	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	2015/08/18	2015/08/12	E			
2015/07/22							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	EDEMA
2015/07/22	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/08/16	2015/08/07	E			
2015/07/28							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	REFLUX ESOPHAGITIS
2015/07/28	PMS-OXYCODONE IR TAB 10MG	450	19	2015/08/16	2015/08/10	E			
2015/07/31							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	HYPERPLASIA OF PROSTATE
2015/07/31	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	2015/08/30					
2015/08/07							3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	RENAL COLIC

2015/08/07	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	2015/09/01			
2015/08/10	PMS-OXYCODONE IR TAB 10MG	450	19	2015/08/29			
2015/08/12					3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN LIMB
2015/08/12	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	2015/09/11			
2015/08/14					3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN LIMB
2015/08/16					3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN LIMB
2015/08/18					3.03	DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	PAIN IN LIMB

PMP

Date Filled	License No	Page Reference or Rx #	Drug Name	Qty	Days Supply	Pharmacy Name	Expected Refill Date	Actual Refill Date	Rx Early	Event Type	Information source
2010/01/07	14434	9004116	PMS-HYDROMORPHONE TAB 2MG	60	10	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/01/17	2010/02/05		Rx	PMP
2010/01/12	14434	9004117	HYDROMORPH CONTIN SR CAP 3MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/02/11	2010/02/05	E	Rx	PMP
2010/02/05	14434	9004186	HYDROMORPH CONTIN SR CAP 3MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/03/07	2010/04/14		Rx	PMP
2010/02/05	14434	9004187	PMS-HYDROMORPHONE TAB 2MG	120	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/02/25	2010/03/22		Rx	PMP
2010/02/24	14434	9004233	HYDROMORPH CONTIN SR CAP 6MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/03/26	2010/03/22	E	Rx	PMP
2010/02/24	14434	9004234	PMS-HYDROMORPHONE TAB 1MG	100	25	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/03/21			Rx	PMP
2010/03/22	14434	9004301	HYDROMORPH CONTIN SR CAP 6MG	120	60	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/05/21			Rx	PMP
2010/03/22	14434	9004300	PMS-HYDROMORPHONE TAB 2MG	100	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/04/11	2010/04/14		Rx	PMP
2010/04/14	14434	9004355	HYDROMORPH CONTIN SR CAP 3MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/05/14	2010/07/08		Rx	PMP
2010/04/14	14434	9004356	PMS-HYDROMORPHONE TAB 2MG	100	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/05/04	2010/06/14		Rx	PMP
2010/06/14	14434	9004491	PMS-HYDROMORPHONE TAB 2MG	100	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/07/04	2010/07/06		Rx	PMP
2010/07/06	14434	9004558	PMS-HYDROMORPHONE TAB 2MG	100	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/07/26			Rx	PMP
2010/07/08	14434	9004566	HYDROMORPH CONTIN SR CAP 3MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/08/07	2010/07/21	E	Rx	PMP
2010/07/21	14434	9004603	HYDROMORPH CONTIN SR CAP 3MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/08/20	2010/08/06	E	Rx	PMP
2010/07/21	14434	9004602	PMS-HYDROMORPHONE TAB 4MG	100	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/08/10	2010/08/06	E	Rx	PMP
2010/08/06	14434	9004638	HYDROMORPH CONTIN SR CAP 3MG	120	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/08/26			Rx	PMP
2010/08/06	14434	9004639	PMS-HYDROMORPHONE TAB 4MG	100	20	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/08/26			Rx	PMP
2010/08/23	14434	9004680	OXYCONTIN SRT 10MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/09/22	2010/09/09	E	Rx	PMP
2010/08/24	14434	9004686	OXY-IR TAB 5MG	100	16	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/09/09			Rx	PMP
2010/08/30	14434	9004698	PMS-OXYCODONE IR TAB 10MG	100	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/09/29	2010/09/09	E	Rx	PMP
2010/09/09	14434	9004727	OXYCONTIN SRT 10MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/10/09	2010/10/05	E	Rx	PMP
2010/09/09	14434	9004728	PMS-OXYCODONE IR TAB 10MG	100	17	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/09/26	2010/09/21	E	Rx	PMP
2010/09/21	14434	9004757	PMS-OXYCODONE IR TAB 10MG	200	34	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/10/25	2010/10/12	E	Rx	PMP
2010/09/27	14434	9004772	OXYCONTIN SRT 40MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/10/27	2010/10/14	E	Rx	PMP
2010/10/05	14434	9004790	OXYCONTIN SRT 10MG	200	50	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/11/24	2011/01/10		Rx	PMP
2010/10/12	14434	78009658	PMS-OXYCODONE IR TAB 10MG	100	20	SHOPPERS DRUG MART - STORE 2018	2010/11/01	2010/10/21	E	Rx	PMP
2010/10/14	14434	9004804	OXYCONTIN SRT 40MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/11/13	2010/11/08	E	Rx	PMP
2010/10/21	14434	9004819	PMS-OXYCODONE IR TAB 10MG	100	17	ATLANTIC SUPERSTORE PHARMACY - STORE 313	2010/11/07	2010/11/03	E	Rx	PMP
2010/11/03	14434	9057505	PMS-OXYCODONE IR TAB 10MG	200	33	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2010/12/06	2010/11/29	E	Rx	PMP
2010/11/08	14434	9057590	OXYCONTIN SRT 40MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2010/12/08	2011/03/03		Rx	PMP
2010/11/15	14434	9057712	OXYCONTIN SRT 20MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2010/12/15	2010/12/04	E	Rx	PMP
2010/11/29	14434	9058009	PMS-OXYCODONE IR TAB 10MG	200	33	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/01/01	2011/01/05		Rx	PMP
2010/12/04	14434	9058136	OXYCONTIN SRT 20MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/01/03	2010/12/27	E	Rx	PMP
2010/12/21	14434	9058479	PMS-OXYCODONE IR TAB 5MG	200	16	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/01/06			Rx	PMP
2010/12/27	14434	9058567	OXYCONTIN SRT 20MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/01/26	2011/01/15	E	Rx	PMP
2011/01/05	14434	9058705	PMS-OXYCODONE IR TAB 10MG	200	33	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/02/07	2011/01/31	E	Rx	PMP
2011/01/10	14434	9058830	OXYCONTIN SRT 10MG	100	50	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/03/01	2011/02/11	E	Rx	PMP
2011/01/15	14434	9058946	OXYCONTIN SRT 20MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/02/14	2011/02/04	E	Rx	PMP
2011/01/31	14434	9059271	PMS-OXYCODONE IR TAB 10MG	200	33	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/03/05	2011/02/28	E	Rx	PMP
2011/02/04	14434	9059369	OXYCONTIN SRT 20MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/03/06	2011/02/21	E	Rx	PMP
2011/02/11	14434	9059541	OXYCONTIN SRT 10MG	150	50	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/04/02	2011/08/25		Rx	PMP
2011/02/21	14434	9059729	OXYCONTIN SRT 20MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/03/23	2011/05/31		Rx	PMP
2011/02/28	14434	9059879	PMS-OXYCODONE IR TAB 10MG	250	42	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/04/11	2011/04/04	E	Rx	PMP
2011/03/03	14434	9059969	OXYCONTIN SRT 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/04/02	2011/03/20	E	Rx	PMP

2011/03/20	14434	9060246	OXYCONTIN SRT 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/04/19	2011/04/09	E	Rx	PMP
2011/04/04	14434	9060811	PMS-OXYCODONE IR TAB 10MG	225	37	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/05/11	2011/04/26	E	Rx	PMP
2011/04/09	14434	9060763	OXYCONTIN SRT 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/05/09	2011/04/30	E	Rx	PMP
2011/04/26	14434	9061072	PMS-OXYCODONE IR TAB 10MG	225	37	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/06/02	2011/05/16	E	Rx	PMP
2011/04/30	14434	9061194	OXYCONTIN SRT 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/05/30	2011/05/22	E	Rx	PMP
2011/05/16	14434	9061517	PMS-OXYCODONE IR TAB 10MG	200	16	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/06/01	2011/06/12		Rx	PMP
2011/05/22	14434	9061630	OXYCONTIN SRT 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/06/21	2012/02/20		Rx	PMP
2011/05/31	14434	9061846	OXYCONTIN SRT 20MG	150	21	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/06/21	2011/06/16	E	Rx	PMP
2011/06/12	14434	9062108	PMS-OXYCODONE IR TAB 10MG	220	18	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/06/30	2011/06/24	E	Rx	PMP
2011/06/16	14434	9062181	OXYCONTIN SRT 20MG	210	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/07/16	2011/06/24	E	Rx	PMP
2011/06/24	14434	9062351	OXYCONTIN SRT 20MG	30	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/07/24	2011/07/10	E	Rx	PMP
2011/06/24	14434	9062352	PMS-OXYCODONE IR TAB 10MG	175	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/07/09	2011/07/18		Rx	PMP
2011/07/10	14434	9062672	OXYCONTIN SRT 20MG	230	28	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/08/07	2011/07/21	E	Rx	PMP
2011/07/18	14434	9062824	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/08/07	2011/08/04	E	Rx	PMP
2011/07/21	14434	9062904	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/08/20	2011/08/10	E	Rx	PMP
2011/08/04	14434	9063158	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/08/24	2011/08/21	E	Rx	PMP
2011/08/10	14434	9063249	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/09/09	2011/09/06	E	Rx	PMP
2011/08/21	14434	9063462	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/09/10	2011/09/14		Rx	PMP
2011/08/25	14434	9063541	OXYCONTIN SRT 10MG	100	50	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/10/14	2012/06/22		Rx	PMP
2011/09/06	14434	9063750	OXYCONTIN SRT 20MG	235	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/10/05	2011/09/27	E	Rx	PMP
2011/09/14	14434	9063961	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/10/04	2011/10/05		Rx	PMP
2011/09/27	14434	9064259	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/10/27	2011/10/11	E	Rx	PMP
2011/10/05	14434	9064449	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/10/25	2011/10/25		Rx	PMP
2011/10/11	14434	9064540	OXYCONTIN SRT 20MG	120	15	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/10/26	2011/10/25	E	Rx	PMP
2011/10/25	14434	9064875	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/11/24	2011/11/28		Rx	PMP
2011/10/25	14434	9064876	PMS-OXYCODONE IR TAB 10MG	200	16	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/11/10	2011/12/09		Rx	PMP
2011/11/28	14434	9065490	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/12/28	2011/12/21	E	Rx	PMP
2011/12/09	14434	9065761	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2011/12/29	2012/01/03		Rx	PMP
2011/12/21	14434	9066049	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/01/20	2012/01/12	E	Rx	PMP
2012/01/03	14434	9066215	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/01/23	2012/01/26		Rx	PMP
2012/01/12	14434	9066441	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/02/11	2012/02/01	E	Rx	PMP
2012/01/26	14434	9066698	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/02/15	2012/02/14	E	Rx	PMP
2012/02/01	14434	9066836	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/03/02	2012/03/11		Rx	PMP
2012/02/14	14434	9067098	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/03/05	2012/03/01	E	Rx	PMP
2012/02/20	14434	9067194	OXYCONTIN SRT 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/03/21			Rx	PMP
2012/03/01	14434	9067419	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/03/21	2012/03/20	E	Rx	PMP
2012/03/11	14434	9067617	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/04/10	2012/03/27	E	Rx	PMP
2012/03/20	14434	9067765	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/04/09	2012/04/09		Rx	PMP
2012/03/27	14434	9067919	OXYCONTIN SRT 20MG	160	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/04/16	2012/04/13	E	Rx	PMP
2012/04/09	14434	9068158	PMS-OXYCODONE IR TAB 10MG	240	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/04/29	2012/04/28	E	Rx	PMP
2012/04/13	14434	9068268	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/05/13	2012/04/20	E	Rx	PMP
2012/04/20	14434	9068429	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/05/20	2012/05/19	E	Rx	PMP
2012/04/28	14434	9068574	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/05/18	2012/05/14	E	Rx	PMP
2012/05/14	14434	9068893	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/06/03	2012/06/01	E	Rx	PMP
2012/05/19	14434	9069033	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/06/18	2012/06/05	E	Rx	PMP
2012/06/01	14434	9069252	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/06/21	2012/06/18	E	Rx	PMP
2012/06/05	14434	9069331	OXYCONTIN SRT 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/07/05			Rx	PMP
2012/06/18	14434	9069554	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/07/08	2012/07/06	E	Rx	PMP
2012/06/22	14434	9069640	OXYCONTIN SRT 10MG	180	60	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/08/21			Rx	PMP
2012/06/25	14434	9069707	OXYNEO EXTENDED RELEASE TAB 20MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/07/25	2012/07/12	E	Rx	PMP

2012/07/06	14434	9069916	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/07/26	2012/07/24	E	Rx	PMP
2012/07/12	14434	9070036	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/09/11	2012/09/05	E	Rx	PMP
2012/07/24	14434	9070310	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/08/13	2012/08/13		Rx	PMP
2012/07/28	14434	9070375	OXYNEO EXTENDED RELEASE TAB 10MG	120	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/08/17	2012/09/27		Rx	PMP
2012/08/05	14434	9070530	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/09/04	2012/09/04		Rx	PMP
2012/08/13	14434	9070695	PMS-OXYCODONE IR TAB 10MG	250	31	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/09/13	2012/08/31	E	Rx	PMP
2012/08/17	14434	9070784	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/09/16	2012/10/04		Rx	PMP
2012/08/31	14434	9071033	PMS-OXYCODONE IR TAB 10MG	250	31	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/10/01	2012/09/23	E	Rx	PMP
2012/09/04	14434	9071074	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/10/04	2012/09/13	E	Rx	PMP
2012/09/13	14434	9071266	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/10/13	2012/10/15		Rx	PMP
2012/09/23	14434	9071482	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/10/13	2012/10/11	E	Rx	PMP
2012/09/27	14434	9071597	OXYNEO EXTENDED RELEASE TAB 10MG	200	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/10/27	2012/12/03		Rx	PMP
2012/10/04	14434	9071711	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/11/03	2012/11/05		Rx	PMP
2012/10/11	14434	9071839	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/10/31	2012/10/26	E	Rx	PMP
2012/10/15	14434	9071924	OXYNEO EXTENDED RELEASE TAB 20MG	210	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/11/14	2012/11/20		Rx	PMP
2012/10/26	14434	9072181	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/11/15	2012/11/13	E	Rx	PMP
2012/10/29	14434	9072225	OXYNEO EXTENDED RELEASE TAB 60MG	60	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/11/28	2014/01/19		Rx	PMP
2012/11/05	14434	9072391	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/12/05	2013/05/07		Rx	PMP
2012/11/13	14434	9072546	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/12/03	2012/11/29	E	Rx	PMP
2012/11/20	14434	9072720	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/12/20	2012/12/07	E	Rx	PMP
2012/11/29	14434	9072894	PMS-OXYCODONE IR TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2012/12/19	2012/12/17	E	Rx	PMP
2012/12/03	14434	9073004	OXYNEO EXTENDED RELEASE TAB 10MG	200	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/01/02	2012/12/20	E	Rx	PMP
2012/12/07	14434	9073145	OXYNEO EXTENDED RELEASE TAB 20MG	240	28	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/01/02	2012/12/29	E	Rx	PMP
2012/12/17	14434	9073349	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/01/11	2013/01/03	E	Rx	PMP
2012/12/20	14434	9073438	OXYNEO EXTENDED RELEASE TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/01/09	2013/01/24		Rx	PMP
2012/12/29	14434	9073555	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/01/28	2013/01/14	E	Rx	PMP
2013/01/03	14434	9073654	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/01/28	2013/01/21	E	Rx	PMP
2013/01/14	14434	9073840	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/02/13	2013/01/30	E	Rx	PMP
2013/01/21	14434	9074018	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/02/15	2013/02/11	E	Rx	PMP
2013/01/24	14434	9074099	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/02/23	2013/02/21	E	Rx	PMP
2013/01/30	14434	9074193	OXYNEO EXTENDED RELEASE TAB 20MG	224	28	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/02/27	2013/02/13	E	Rx	PMP
2013/02/11	14434	9074412	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/03/08	2013/02/26	E	Rx	PMP
2013/02/13	14434	9074464	OXYNEO EXTENDED RELEASE TAB 20MG	224	28	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/03/13	2013/03/06	E	Rx	PMP
2013/02/21	14434	9074644	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/03/23	2013/03/18	E	Rx	PMP
2013/02/26	14434	9074723	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/03/23	2013/03/15	E	Rx	PMP
2013/03/06	14434	9074900	OXYNEO EXTENDED RELEASE TAB 20MG	224	28	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/04/03	2013/03/24	E	Rx	PMP
2013/03/15	14434	9075077	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/04/09	2013/04/02	E	Rx	PMP
2013/03/18	14434	9075131	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/04/17	2013/04/09	E	Rx	PMP
2013/03/24	14434	9075251	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/04/23	2013/04/15	E	Rx	PMP
2013/04/02	14434	9075420	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/04/27	2013/04/22	E	Rx	PMP
2013/04/09	14434	9075583	OXYNEO EXTENDED RELEASE TAB 10MG	300	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/05/09	2013/04/26	E	Rx	PMP
2013/04/15	14434	9075710	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/05/15	2013/05/21		Rx	PMP
2013/04/22	14434	9075848	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/05/17	2013/05/13	E	Rx	PMP
2013/04/26	14434	9075938	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/05/16	2013/05/16		Rx	PMP
2013/05/07	14434	9076153	OXYNEO EXTENDED RELEASE TAB 40MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/06/06	2013/07/22		Rx	PMP
2013/05/13	14434	9076281	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/06/07	2013/05/28	E	Rx	PMP
2013/05/16	14434	9076363	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/06/05	2013/06/04	E	Rx	PMP
2013/05/21	14434	9076438	OXYNEO EXTENDED RELEASE TAB 20MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/06/20	2013/06/10	E	Rx	PMP
2013/05/28	14434	9076586	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/06/22	2013/06/17	E	Rx	PMP
2013/06/04	14434	9076732	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/06/24	2013/06/20	E	Rx	PMP

2013/06/10	14434	9076843	OXYNEO EXTENDED RELEASE TAB 20MG	240	26	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/07/06	2013/06/28	E	Rx	PMP
2013/06/17	14434	9076970	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/07/12	2013/07/04	E	Rx	PMP
2013/06/20	14434	9077084	OXYNEO EXTENDED RELEASE TAB 10MG	300	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/07/10	2013/07/08	E	Rx	PMP
2013/06/28	14434	9077224	OXYNEO EXTENDED RELEASE TAB 20MG	240	26	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/07/24	2013/07/12	E	Rx	PMP
2013/07/04	14434	9077302	PMS-OXYCODONE IR TAB 10MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/07/29	2013/07/18	E	Rx	PMP
2013/07/08	14434	9077376	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/07/26	2013/08/01		Rx	PMP
2013/07/12	14434	9077452	OXYNEO EXTENDED RELEASE TAB 20MG	240	26	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/08/07	2013/08/16		Rx	PMP
2013/07/18	14434	9077562	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/08/16	2013/08/06	E	Rx	PMP
2013/07/22	14434	9077620	OXYNEO EXTENDED RELEASE TAB 40MG	140	28	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/08/19	2013/08/09	E	Rx	PMP
2013/08/01	14434	9077820	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/08/21	2013/08/26		Rx	PMP
2013/08/06	14434	9077895	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/09/04	2013/08/22	E	Rx	PMP
2013/08/09	14434	9077973	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/09/08	2013/09/19		Rx	PMP
2013/08/16	14434	9078093	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/09/15	2013/09/04	E	Rx	PMP
2013/08/22	14434	9078190	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/09/20	2013/09/10	E	Rx	PMP
2013/08/26	14434	9078270	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/09/15	2013/09/13	E	Rx	PMP
2013/09/04	14434	9078418	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/10/04	2013/10/05		Rx	PMP
2013/09/10	14434	9078552	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/10/09	2013/09/28	E	Rx	PMP
2013/09/13	14434	9078616	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/10/03	2013/10/01	E	Rx	PMP
2013/09/19	14434	9078743	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/10/19	2013/10/18	E	Rx	PMP
2013/09/28	14434	9078919	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/10/27	2013/10/11	E	Rx	PMP
2013/10/01	14434	9078973	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/10/21	2013/10/15	E	Rx	PMP
2013/10/05	14434	9079053	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/11/04	2013/11/04		Rx	PMP
2013/10/11	14434	9079169	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/11/09	2013/10/28	E	Rx	PMP
2013/10/15	14434	9079226	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/11/04	2013/11/01	E	Rx	PMP
2013/10/18	14434	9079296	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/11/17	2013/11/09	E	Rx	PMP
2013/10/28	14434	9079448	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/11/26	2013/11/15	E	Rx	PMP
2013/11/01	14434	9079536	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/11/21	2013/11/18	E	Rx	PMP
2013/11/04	14434	9079577	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/12/04	2013/12/02	E	Rx	PMP
2013/11/09	14434	9079719	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/12/09	2013/12/09		Rx	PMP
2013/11/15	14434	9079821	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/12/14	2013/11/29	E	Rx	PMP
2013/11/18	14434	9079864	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/12/08	2013/12/06	E	Rx	PMP
2013/11/29	14434	9080082	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/12/28	2013/12/13	E	Rx	PMP
2013/12/02	14434	9080119	OXYNEO EXTENDED RELEASE TAB 20MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/01	2013/12/20	E	Rx	PMP
2013/12/06	14434	9080204	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2013/12/26	2013/12/16	E	Rx	PMP
2013/12/09	14434	9080258	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/08	2013/12/29	E	Rx	PMP
2013/12/13	14434	9080356	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/11	2013/12/29	E	Rx	PMP
2013/12/16	14434	9080419	OXYNEO EXTENDED RELEASE TAB 10MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/05	2013/12/23	E	Rx	PMP
2013/12/20	14434	9080530	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/19	2014/01/09	E	Rx	PMP
2013/12/23	14434	9080597	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/12	2014/01/06	E	Rx	PMP
2013/12/29	14434	9080661	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/28	2014/03/01		Rx	PMP
2013/12/29	14434	9080660	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/27	2014/01/14	E	Rx	PMP
2014/01/06	14434	9080804	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/01/26	2014/01/24	E	Rx	PMP
2014/01/09	14434	9080895	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/02/08	2014/01/30	E	Rx	PMP
2014/01/14	14434	9081024	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/02/12	2014/01/27	E	Rx	PMP
2014/01/19	14434	9081136	OXYNEO EXTENDED RELEASE TAB 80MG	90	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/02/18	2014/03/20		Rx	PMP
2014/01/24	14434	9081233	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/02/13	2014/02/08	E	Rx	PMP
2014/01/27	14434	9081281	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/02/25	2014/02/11	E	Rx	PMP
2014/01/30	14434	9081344	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/01	2014/02/17	E	Rx	PMP
2014/02/04	14434	9081432	HYDROMORPH CONTIN SR CAP 24MG	90	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/06			Rx	PMP

2014/02/08	14434	9081518	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/02/28	2014/02/24	E	Rx	PMP
2014/02/11	14434	9081555	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/12	2014/02/26	E	Rx	PMP
2014/02/17	14434	9081716	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/19	2014/03/08	E	Rx	PMP
2014/02/24	14434	9081843	OXYNEO EXTENDED RELEASE TAB 10MG	350	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/16	2014/03/06	E	Rx	PMP
2014/02/26	14434	9081909	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/27	2014/03/11	E	Rx	PMP
2014/03/01	14434	9081950	OXYNEO EXTENDED RELEASE TAB 40MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/31	2014/04/05		Rx	PMP
2014/03/06	14434	9082053	OXYNEO EXTENDED RELEASE TAB 10MG	350	15	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/03/21	2014/03/28		Rx	PMP
2014/03/06	14434	9082106	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/04/07	2014/03/31	E	Rx	PMP
2014/03/11	14434	9082141	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/04/09	2014/03/25	E	Rx	PMP
2014/03/20	14434	9082357	OXYNEO EXTENDED RELEASE TAB 80MG	84	28	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/04/17	2014/04/15	E	Rx	PMP
2014/03/25	14434	9082430	PMS-OXYCODONE IR TAB 10MG	350	29	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/04/23	2014/04/10	E	Rx	PMP
2014/03/28	14434	9082488	OXYNEO EXTENDED RELEASE TAB 10MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/04/27	2014/04/21	E	Rx	PMP
2014/03/31	14434	9082532	OXYNEO EXTENDED RELEASE TAB 20MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/04/30	2014/04/24	E	Rx	PMP
2014/04/05	14434	9082649	OXYNEO EXTENDED RELEASE TAB 40MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/05/05	2014/05/04	E	Rx	PMP
2014/04/10	14434	9082723	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/04/24	2014/04/29		Rx	PMP
2014/04/15	14434	9082846	OXYNEO EXTENDED RELEASE TAB 80MG	90	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/05/15	2014/05/31		Rx	PMP
2014/04/21	14434	9082949	OXYNEO EXTENDED RELEASE TAB 10MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/05/21	2014/05/11	E	Rx	PMP
2014/04/24	14434	9083002	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/05/24	2014/05/16	E	Rx	PMP
2014/04/29	14434	9083094	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/05/13	2014/05/14		Rx	PMP
2014/05/04	14434	9083193	OXYNEO EXTENDED RELEASE TAB 40MG	240	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/06/03	2014/06/23		Rx	PMP
2014/05/11	14434	9083329	OXYNEO EXTENDED RELEASE TAB 10MG	360	24	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/06/04	2014/05/26	E	Rx	PMP
2014/05/14	14434	9083397	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/05/28	2014/05/29		Rx	PMP
2014/05/16	14434	9083453	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/06/16	2014/06/07	E	Rx	PMP
2014/05/26	14434	9083617	OXYNEO EXTENDED RELEASE TAB 10MG	360	24	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/06/19	2014/06/13	E	Rx	PMP
2014/05/29	14434	9083690	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/06/12	2014/06/17		Rx	PMP
2014/05/31	14434	9083731	OXYNEO EXTENDED RELEASE TAB 80MG	90	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/06/30	2014/08/07		Rx	PMP
2014/06/07	14434	9083853	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/07/07	2014/07/08		Rx	PMP
2014/06/13	14434	9084029	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/07/13	2014/07/04	E	Rx	PMP
2014/06/17	14434	9084098	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/07/01	2014/07/02		Rx	PMP
2014/06/23	14434	9084212	OXYNEO EXTENDED RELEASE TAB 40MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/07/23	2014/07/17	E	Rx	PMP
2014/07/02	14434	9084342	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/07/16	2014/07/15	E	Rx	PMP
2014/07/04	14434	9084400	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/08/03	2014/07/25	E	Rx	PMP
2014/07/08	14434	9084498	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/08/07	2014/07/31	E	Rx	PMP
2014/07/15	14434	9084663	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/07/29	2014/07/29		Rx	PMP
2014/07/17	14434	9084711	OXYNEO EXTENDED RELEASE TAB 40MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/08/16	2014/12/22		Rx	PMP
2014/07/25	14434	9084823	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/08/24	2014/08/15	E	Rx	PMP
2014/07/29	14434	9084874	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/08/12	2014/08/14		Rx	PMP
2014/07/31	14434	9084924	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/08/30	2014/08/25	E	Rx	PMP
2014/08/07	14434	9085071	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/09/06	2014/09/08		Rx	PMP
2014/08/14	14434	9085231	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/08/28	2014/09/02		Rx	PMP
2014/08/15	14434	9085257	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/09/14	2014/09/04	E	Rx	PMP
2014/08/25	14434	9085439	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/09/24	2014/09/17	E	Rx	PMP
2014/09/02	14434	9085575	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/09/16	2014/09/15	E	Rx	PMP
2014/09/04	14434	9085633	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/10/04	2014/09/24	E	Rx	PMP
2014/09/08	14434	9085713	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/10/08	2014/09/30	E	Rx	PMP
2014/09/15	14434	9085865	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/09/29	2014/09/28	E	Rx	PMP
2014/09/17	14434	9085931	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/10/17	2014/10/07	E	Rx	PMP
2014/09/24	14434	9086057	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/10/24	2014/10/16	E	Rx	PMP
2014/09/28	14434	9086136	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/10/12	2014/10/14		Rx	PMP
2014/09/30	14434	9086195	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/10/30	2014/10/30		Rx	PMP

2014/10/07	14434	9086338	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/11/06	2014/10/23	E	Rx	PMP
2014/10/14	14434	9086480	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/10/28	2014/10/28		Rx	PMP
2014/10/16	14434	9086549	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/11/15	2014/11/06	E	Rx	PMP
2014/10/23	14434	9086693	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/11/22	2014/11/12	E	Rx	PMP
2014/10/28	14434	9086808	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/11/11	2014/11/10	E	Rx	PMP
2014/10/30	14434	9086865	OXYNEO EXTENDED RELEASE TAB 80MG	120	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/11/29	2014/11/18	E	Rx	PMP
2014/11/06	14434	9087021	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/12/06	2014/11/28	E	Rx	PMP
2014/11/10	14434	9087099	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/11/24	2014/11/24		Rx	PMP
2014/11/12	14434	9087142	OXYNEO EXTENDED RELEASE TAB 20MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/12/12	2014/12/01	E	Rx	PMP
2014/11/18	14434	9087261	OXYNEO EXTENDED RELEASE TAB 80MG	150	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/12/18	2015/04/25		Rx	PMP
2014/11/24	14434	9087387	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/12/08	2014/12/08		Rx	PMP
2014/11/28	14434	9087477	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/12/28	2014/12/19	E	Rx	PMP
2014/12/01	14434	9087540	OXYNEO EXTENDED RELEASE TAB 20MG	540	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/12/31	2014/12/12	E	Rx	PMP
2014/12/08	14434	9087693	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2014/12/22	2014/12/22		Rx	PMP
2014/12/12	14434	9087810	OXYNEO EXTENDED RELEASE TAB 20MG	540	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/11	2015/03/14		Rx	PMP
2014/12/19	14434	9087980	OXYNEO EXTENDED RELEASE TAB 10MG	450	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/18	2014/12/30	E	Rx	PMP
2014/12/22	14434	9088038	OXYNEO EXTENDED RELEASE TAB 40MG	270	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/21	2015/01/05	E	Rx	PMP
2014/12/22	14434	9088037	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/05	2015/01/02	E	Rx	PMP
2014/12/30	14434	9088181	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/21	2015/01/12	E	Rx	PMP
2015/01/02	14434	9088221	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/16	2015/01/15	E	Rx	PMP
2015/01/05	14434	9088264	OXYNEO EXTENDED RELEASE TAB 40MG	300	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/30	2015/01/17	E	Rx	PMP
2015/01/12	14434	9088415	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/02/03	2015/01/22	E	Rx	PMP
2015/01/15	14434	9088477	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/01/29	2015/01/26	E	Rx	PMP
2015/01/17	14434	9088511	OXYNEO EXTENDED RELEASE TAB 40MG	250	20	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/02/06	2015/01/28	E	Rx	PMP
2015/01/22	14434	9088646	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/02/13	2015/02/08	E	Rx	PMP
2015/01/26	14434	9088718	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/02/09	2015/02/12		Rx	PMP
2015/01/28	14434	9088777	OXYNEO EXTENDED RELEASE TAB 40MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/02/27	2015/02/17	E	Rx	PMP
2015/02/08	14434	9088972	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/03/02	2015/02/24	E	Rx	PMP
2015/02/12	14434	9089067	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/02/26	2015/02/27		Rx	PMP
2015/02/17	14434	9089136	OXYNEO EXTENDED RELEASE TAB 40MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/03/19	2015/03/02	E	Rx	PMP
2015/02/24	14434	9089297	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/03/18	2015/03/09	E	Rx	PMP
2015/02/27	14434	9089359	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/03/13	2015/03/12	E	Rx	PMP
2015/03/02	14434	9089401	OXYNEO EXTENDED RELEASE TAB 40MG	360	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/04/01			Rx	PMP
2015/03/09	14434	9089544	OXYNEO EXTENDED RELEASE TAB 10MG	462	22	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/03/31	2015/03/22	E	Rx	PMP
2015/03/12	14434	9089666	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/03/26	2015/03/25	E	Rx	PMP
2015/03/14	14434	9089704	OXYNEO EXTENDED RELEASE TAB 20MG	630	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/04/13	2015/03/27	E	Rx	PMP
2015/03/22	14434	9089847	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/04/18	2015/04/04	E	Rx	PMP
2015/03/25	14434	9089922	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/04/08	2015/04/07	E	Rx	PMP
2015/03/27	14434	9089983	OXYNEO EXTENDED RELEASE TAB 20MG	630	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/04/26	2015/04/12	E	Rx	PMP
2015/04/04	14434	9090140	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/04/29	2015/04/20	E	Rx	PMP
2015/04/07	14434	9090189	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/04/21	2015/04/23		Rx	PMP
2015/04/12	14434	9090282	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/05/12	2015/05/08	E	Rx	PMP
2015/04/20	14434	9090448	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/05/15	2015/05/04	E	Rx	PMP
2015/04/23	14434	9090518	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/05/07	2015/05/07		Rx	PMP
2015/04/25	14434	9090545	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/05/25	2015/05/22	E	Rx	PMP
2015/05/04	14434	9090706	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/05/29	2015/05/19	E	Rx	PMP
2015/05/07	14434	9090778	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/05/21	2015/05/17	E	Rx	PMP
2015/05/08	14434	9090804	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/06/07	2015/06/01	E	Rx	PMP
2015/05/17	14434	9090970	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/05/31	2015/05/29	E	Rx	PMP
2015/05/19	14434	9090992	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/06/13	2015/06/05	E	Rx	PMP

2015/05/22	14434	9091072	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/06/21	2015/06/17	E	Rx	PMP
2015/05/29	14434	9091224	PMS-OXYCODONE IR TAB 10MG	350	14	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/06/12	2015/06/11	E	Rx	PMP
2015/06/01	14434	9091256	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/07/01	2015/06/26	E	Rx	PMP
2015/06/05	14434	9091365	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/06/30	2015/06/24	E	Rx	PMP
2015/06/11	14434	9091464	PMS-OXYCODONE IR TAB 10MG	450	19	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/06/30	2015/06/27	E	Rx	PMP
2015/06/17	14434	9091600	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/07/17	2015/07/09	E	Rx	PMP
2015/06/24	14434	9091743	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/07/19	2015/07/06	E	Rx	PMP
2015/06/26	14434	9091784	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/07/26	2015/07/19	E	Rx	PMP
2015/06/27	14434	9091798	PMS-OXYCODONE IR TAB 10MG	450	19	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/07/16	2015/07/13	E	Rx	PMP
2015/07/06	14434	9091969	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/07/31	2015/07/22	E	Rx	PMP
2015/07/09	14434	9092035	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/08/08	2015/07/31	E	Rx	PMP
2015/07/13	14434	9092117	PMS-OXYCODONE IR TAB 10MG	450	19	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/08/01	2015/07/28	E	Rx	PMP
2015/07/19	14434	9092263	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/08/18	2015/08/12	E	Rx	PMP
2015/07/22	14434	9092345	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/08/16	2015/08/07	E	Rx	PMP
2015/07/28	14434	9092461	PMS-OXYCODONE IR TAB 10MG	450	19	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/08/16	2015/08/10	E	Rx	PMP
2015/07/31	14434	9092536	OXYNEO EXTENDED RELEASE TAB 80MG	180	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/08/30			Rx	PMP
2015/08/07	14434	9092665	OXYNEO EXTENDED RELEASE TAB 10MG	525	25	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/09/01			Rx	PMP
2015/08/10	14434	9092717	PMS-OXYCODONE IR TAB 10MG	450	19	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/08/29			Rx	PMP
2015/08/12	14434	9092784	OXYNEO EXTENDED RELEASE TAB 20MG	690	30	ATLANTIC SUPERSTORE PHARMACY - STORE 337	2015/09/11			Rx	PMP

MSI

Service Date MSE	Health Service Code MSE	Qualifier Code MSE	Description HSC	Diag Code1 MSE	Diag Name DGC	Payment Resp MSE
2010/02/05	8.49	C	LIFESTYLE COUNSELLING	30400	OPIOID TYPE DEPENDENCE NOS	MSI
2010/07/06	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	78605	SHORTNESS OF BREATH	MSI
2010/10/12	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4660	ACUTE BRONCHITIS	MSI
2010/11/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2010/11/04	13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	V048	PROPH VACCINATION INFLUENZA	MSI
2010/11/04	13.59	M	PROVINCIAL IMMUNIZATION-TRAY FEE	V048	PROPH VACCINATION INFLUENZA	MSI
2010/11/09	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2010/11/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71500	GEN OSTEOARTHROSIS SITE UNSPEC	MSI
2011/01/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71500	GEN OSTEOARTHROSIS SITE UNSPEC	MSI
2011/01/31	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71500	GEN OSTEOARTHROSIS SITE UNSPEC	MSI
2011/02/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2011/02/11	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	1101	DERMATOPHYTOSIS OF NAIL	MSI
2011/02/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2011/02/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4720	CHRONIC RHINITIS	MSI
2011/03/25	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2011/04/26	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7872	DYSPHAGIA	MSI
2011/05/16	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2011/06/12	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2011/06/16	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	311	DEPRESSIVE DISORDER NEC	MSI
2011/07/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5780	HEMATEMESIS	MSI
2011/07/18	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2011/07/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	30000	ANXIETY STATE UNSPECIFIED	MSI
2011/08/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	311	DEPRESSIVE DISORDER NEC	MSI
2011/08/25	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2011/09/06	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2011/09/14	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	311	DEPRESSIVE DISORDER NEC	MSI
2011/09/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2011/10/05	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	30000	ANXIETY STATE UNSPECIFIED	MSI
2011/10/11	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71500	GEN OSTEOARTHROSIS SITE UNSPEC	MSI
2011/10/26	13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	V048	PROPH VACCINATION INFLUENZA	MSI
2011/10/26	13.59	M	PROVINCIAL IMMUNIZATION-TRAY FEE	V048	PROPH VACCINATION INFLUENZA	MSI
2011/10/26	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71500	GEN OSTEOARTHROSIS SITE UNSPEC	MSI
2011/11/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	49390	ASTHMA UNSPEC NO STATUS ASTH	MSI
2011/11/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	1101	DERMATOPHYTOSIS OF NAIL	MSI
2011/12/09	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	49390	ASTHMA UNSPEC NO STATUS ASTH	MSI
2011/12/22	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	6071	BALANOPOSTHITIS	MSI
2012/01/03	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	600	HYPERPLASIA OF PROSTATE	MSI
2012/01/12	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2012/01/26	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2012/02/02	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2012/02/20	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2012/03/01	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7872	DYSPHAGIA	MSI
2012/03/11	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	6829	CELLULITIS/ABSCESS UNSPEC SITE	MSI
2012/03/20	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2719	DISORDER CARBOHYD TRANS/MET NOS	MSI
2012/03/27	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71945	PAIN IN JOINT PELVIS/THIGH	MSI
2012/04/09	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2012/04/13	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2012/04/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	92400	CONTUSION OF THIGH	MSI
2012/04/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	9048	INJ BLOOD VESSEL LOW EXTREM NOS	MSI
2012/05/14	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4556	UNSPEC HEMORRHOIDS NO COMPL	MSI
2012/05/19	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	600	HYPERPLASIA OF PROSTATE	MSI
2012/06/01	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5559	REGIONAL ENTERITIS UNSPEC SITE	MSI
2012/06/05	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2012/06/18	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/06/22	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/06/26	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/07/06	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/07/12	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/07/24	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/07/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/08/05	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2012/08/13	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	6019	PROSTATITIS UNSPECIFIED	MSI
2012/08/17	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	6019	PROSTATITIS UNSPECIFIED	MSI
2012/08/31	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2012/09/13	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2012/10/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2012/10/11	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2012/10/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2012/10/26	13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	V048	PROPH VACCINATION INFLUENZA	MSI
2012/10/26	13.59	M	PROVINCIAL IMMUNIZATION-TRAY FEE	V048	PROPH VACCINATION INFLUENZA	MSI
2012/10/26	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	311	DEPRESSIVE DISORDER NEC	MSI
2012/11/05	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	49390	ASTHMA UNSPEC NO STATUS ASTH	MSI
2012/11/20	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2012/12/07	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2012/12/17	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2012/12/20	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2013/01/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	1120	CANDIDIASIS OF MOUTH	MSI
2013/01/14	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7295	PAIN IN LIMB	MSI
2013/01/24	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	49390	ASTHMA UNSPEC NO STATUS ASTH	MSI
2013/01/31	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2013/02/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2013/02/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2013/03/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7295	PAIN IN LIMB	MSI
2013/03/24	8.49	C	LIFESTYLE COUNSELLING	2719	DISORDER CARBOHYD TRANS/MET NOS	MSI
2013/05/16	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4660	ACUTE BRONCHITIS	MSI
2013/05/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4660	ACUTE BRONCHITIS	MSI
2013/06/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	1101	DERMATOPHYTOSIS OF NAIL	MSI
2013/06/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	38181	DYSFUNCTION OF EUSTACHIAN TUBE	MSI
2013/07/19	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7881	DYSURIA	MSI
2013/09/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2013/09/13	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	53011	REFLUX ESOPHAGITIS	MSI
2013/09/19	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2013/09/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2013/10/02	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2013/10/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI

2013/10/18	13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	V048	PROPH VACCINATION INFLUENZA	MSI
2013/10/18	13.59	M	PROVINCIAL IMMUNIZATION-TRAY FEE	V048	PROPH VACCINATION INFLUENZA	MSI
2013/10/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	490	BRONCHITIS NOT SPEC ACUTE/CHR	MSI
2013/11/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2780	OBESITY	MSI
2013/11/29	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7295	PAIN IN LIMB	MSI
2013/12/02	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7872	DYSPHAGIA	MSI
2013/12/16	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	8910	OP WND KNEE/LEG/ANKLE NO COMPL	MSI
2013/12/20	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	8910	OP WND KNEE/LEG/ANKLE NO COMPL	MSI
2013/12/23	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	8910	OP WND KNEE/LEG/ANKLE NO COMPL	MSI
2014/01/09	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	600	HYPERPLASIA OF PROSTATE	MSI
2014/01/19	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	38200	AC SUPP OTIT MEDIA NO DRUM RUPT	MSI
2014/01/24	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2014/02/08	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7821	RASH/OTH NONSPEC SKIN ERUPTION	MSI
2014/02/11	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7881	DYSURIA	MSI
2014/02/17	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5559	REGIONAL ENTERITIS UNSPEC SITE	MSI
2014/02/24	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5559	REGIONAL ENTERITIS UNSPEC SITE	MSI
2014/02/27	8.49	C	LIFESTYLE COUNSELLING	30742	PERSIST DISORD INIT/MAINT SLEEP	MSI
2014/03/25	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	30000	ANXIETY STATE UNSPECIFIED	MSI
2014/03/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71941	PAIN IN JOINT SHOULDER REGION	MSI
2014/03/31	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71941	PAIN IN JOINT SHOULDER REGION	MSI
2014/04/21	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71941	PAIN IN JOINT SHOULDER REGION	MSI
2014/04/21	93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING	71941	PAIN IN JOINT SHOULDER REGION	MSI
2014/06/07	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	30000	ANXIETY STATE UNSPECIFIED	MSI
2014/07/02	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	30742	PERSIST DISORD INIT/MAINT SLEEP	MSI
2014/07/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	600	HYPERPLASIA OF PROSTATE	MSI
2014/07/08	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	6071	BALANOPOSTHITIS	MSI
2014/08/25	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	38010	INFECTIVE OTITIS EXTERNA UNSPEC	MSI
2014/09/08	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2014/09/17	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2014/09/24	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	38010	INFECTIVE OTITIS EXTERNA UNSPEC	MSI
2014/09/30	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2014/10/28	13.59	L	PROVINCIAL IMMUNIZATION INJECTIONS	25000	DIABETES MELL NO COMPL TYPE II	MSI
2014/10/28	13.59	M	PROVINCIAL IMMUNIZATION-TRAY FEE	25000	DIABETES MELL NO COMPL TYPE II	MSI
2014/10/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2014/10/30	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	8910	OP WND KNEE/LEG/ANKLE NO COMPL	MSI
2014/11/06	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	53011	REFLUX ESOPHAGITIS	MSI
2014/11/10	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2014/11/12	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	5990	URINARY TRACT INFECT SITE NOS	MSI
2014/11/17	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2014/11/17	93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING	71946	PAIN IN JOINT LOWER LEG	MSI
2014/11/18	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2014/12/04	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4556	UNSPEC HEMORRHOIDS NO COMPL	MSI
2014/12/19	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2014/12/19	93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING	71946	PAIN IN JOINT LOWER LEG	MSI
2014/12/30	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2015/01/05	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2015/01/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2015/01/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	49390	ASTHMA UNSPEC NO STATUS ASTH	MSI
2015/02/27	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2015/03/02	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	6829	CELLULITIS/ABSCESS UNSPEC SITE	MSI
2015/03/09	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2015/03/12	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2015/03/12	93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING	71946	PAIN IN JOINT LOWER LEG	MSI
2015/03/14	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2015/03/14	CDM1		CHRONIC DISEASE MANAGEMENT INCENTIVE PROGRAM	25000	DIABETES MELL NO COMPL TYPE II	MSI
2015/03/16	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2015/03/27	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2015/03/30	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4660	ACUTE BRONCHITIS	MSI
2015/04/15	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	71946	PAIN IN JOINT LOWER LEG	MSI
2015/04/15	93.92	A	INJECTION OF THERAPEUTIC SUBSTANCE INTO JOINT OR LIGAMENT INCLUDING	71946	PAIN IN JOINT LOWER LEG	MSI
2015/06/01	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4019	ESSENTIAL HYPERTENSION UNSPEC	MSI
2015/06/05	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	2720	PURE HYPERCHOLESTEROLEMIA	MSI
2015/06/17	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	3572	POLYNEUROPATHY IN DIABETES	MSI
2015/06/26	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	53011	REFLUX ESOPHAGITIS	MSI
2015/06/27	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	4660	ACUTE BRONCHITIS	MSI
2015/07/06	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7823	EDEMA	MSI
2015/07/09	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	25000	DIABETES MELL NO COMPL TYPE II	MSI
2015/07/13	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	486	PNEUMONIA ORGANISM UNSPECIFIED	MSI
2015/07/19	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7823	EDEMA	MSI
2015/07/22	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7823	EDEMA	MSI
2015/07/28	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	53011	REFLUX ESOPHAGITIS	MSI
2015/07/31	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	600	HYPERPLASIA OF PROSTATE	MSI
2015/08/07	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7880	RENAL COLIC	MSI
2015/08/12	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7295	PAIN IN LIMB	MSI
2015/08/14	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7295	PAIN IN LIMB	MSI
2015/08/16	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7295	PAIN IN LIMB	MSI
2015/08/18	3.03		DIAGNOSTIC INTERVIEW AND EVALUATION, DESCRIBED AS LIMITED	7295	PAIN IN LIMB	MSI

SCHEDULE "B"

COLLEGE OF
PHYSICIANS & SURGEONS
OF NOVA SCOTIA

Return to Practice Assessment Plan for Dr. Sarah Jones

Phase One

Duration: 4 weeks attendance by Dr. Jones, 25 hours per week, where Dr. Jones will have a Clinical Assessment Licence

MRP: Supervisors, Dr. TBD (lead) and Dr. (TBD) alternate (approved by College)

Supervisors' Time Commitment: 10 hours each week– assessment, case discussion, feedback, planning

Setting: Supervisors' Family Practice Office

Costs: 10 hours per week x 4 weeks = $6000
Plus $ 1500 College administrative set up fee

Notes: The administrative set up fee and costs for each phase of this Assessment Plan will be added to the costs amount payable by Dr. Jones under the Settlement Agreement and payable with those costs in equal amounts annually over a ten year period following the issuing of Restricted Licence

Activities:

- Weeks 1 & 2, emphasis on Dr. Jones observing supervisor or other experienced family physician approved by College conduct clinical assessments, counselling and management of patients.
- Week 3, emphasis on Dr. Jones conducting selected clinical assessments under direct observation by supervisor.
- Week 4, continue to observe Dr. Jones conducting selected clinical encounters or procedures; report on and discuss unobserved assessments (indirect supervision with review).
- Review and demonstration of good record-keeping practices: including individual patient visits, procedures and overall record management.
- Review and demonstration of best practices with respect to information management, preventive and chronic care.
- Identification of specific learning needs, point-of-care references.
- Identification of important clinical practice guidelines, point-of-care calculators / risk scoring systems, assessment and record-keeping templates.

- Develop and formalize a learning plan, based on identified area for improvement.

Phase One Activities continued

- At the end of Phase One, the Lead Supervisor will submit a narrative report using the Return to Practice Assessment Summary reporting template. This is a narrative summary that includes a consolidation of findings related to observations, discussion, feedback provided and recommendations on whether Dr. Jones should progress to Phase Two of the supervision plan.

List of Assessment Tools – Phase One

Week 1 & 2

- Field Notes x 10

Week 3 & 4

- Field Notes x 5
- Direct Observation of Clinical Encounter / Procedure x 10
- Patient Record Review x 6 charts
- Chart audit summary tool x 1
- Return to Practice Assessment Summary report template

Supervisor Reporting Requirement

Frequency

- Upon completion of Week 2, submit by fax or Titan File, all completed Field Notes to the College
- Upon completion of Week 4, submit by fax or Titan File, all completed Field Notes Assessment Tools and Summary Report.

Phase Two

Duration: 4 weeks attendance by Dr. Jones, 32 hours per week (weeks 5-8 of Supervision Plan)

MRP: Supervisors, Dr. TBD (lead) and Dr. (TBD) alternate

Supervisor's Time Commitment: 10 Supervisor hours each week– Supervisor performs intermittent observation, assessment, feedback, identifies areas for CPD

Setting: Supervisors' Family Practice Office. Dr. Jones limited to 15 patients per day.

Cost: 10 hours per week x 4 weeks = $6000 to be paid as outlined on page 1

Activities:

- Week 5 - 8, continue to observe Dr. Jones conducting selected clinical encounters or procedures (Supervisor time: 3-4 hours per week).
- Record review for selected visits each clinic day. Focus on quality of record keeping, diagnosis formulation, appropriateness of care (Supervisors time 3-4 hours per week).
- Information management and file review. Focus on updating clinical records (CPPs, incorporating care templates etc) and office processes.
- Review progress on learning plan.

List of Assessment Tools – Phase Two

Weeks 5 – 8

- Direct Observation of Clinical Encounter / Procedure x 10 per week
- Patient Record Review x 10 charts per week
- Chart audit summary tool x 1 per week
- Return to Practice Assessment Summary report template

Supervisor Reporting Requirement

Frequency

- Upon completion of Week 6, submit by fax or Titan File, all completed Assessment Tools to the College.
- Upon completion of Week 8, submit by fax or Titan File, all completed Assessment Tools and Summary Report

At the end of Phase Two, the Lead Supervisor will submit a narrative report using the Return to Practice Assessment Summary reporting template. This is a narrative summary that includes a consolidation of findings related to observations, discussion, feedback provided and recommendations on whether Dr. Jones should progress to Phase Three of the supervision plan.

Phase Three

Duration:	4 weeks attendance by Dr. Jones, 40 hours per week (weeks 9-12 of Supervision Plan)
MRP:	Supervisors, Dr. TBD (lead) and Dr. TBD (alternate)
Supervisor's Time Commitment:	5-10 hours per week
Setting:	Supervisors' Family Practice Office. Dr. Jones limited to 20 patients per day.
Costs:	5 - 10 hours per week x 4 weeks = $3000- $6000 payable as outlined on page 1

Activities:

- Week 9 -12, continue to observe Dr. Jones conducting selected clinical encounters or procedures (2 hours per week).
- Record review for selected patient visits. Case discussion. Focus on quality of record keeping, diagnostic formulation, and appropriateness of care (2 hours per week).
- Information management and file review. Focus on updating clinical records (CPPs, incorporating care templates etc) and office processes (every two weeks)
- Review progress on learning plan. (Every two weeks)

List of Assessment Tools – Phase Three

Week 9 - 12

- Direct Observation of Clinical Encounter / Procedure x 3 – 4 per week
- Patient Record Review x 6 charts per week
- Chart audit summary tool x 1
- Return to Practice Assessment Summary report template

Supervisor Reporting Requirement

Frequency

- At completion of Week 10, submit by fax or Titan File, all completed Assessment Tools to the College

- At completion of Week 12, submit by fax or Titan File, all completed Assessment Tools and Summary Report

At the end of Phase Three, the Lead Supervisor will submit a narrative report using the Return to Practice Assessment Summary reporting template. This is a narrative summary that includes a consolidation of findings related to observations, discussion, feedback provided and summary relating to Dr. Jones's progress towards independent practice.

Summary: Reporting Requirements and Outcomes

The Supervisor will submit completed assessment tools and reports as prescribed in the physician's Assessment Plan. PPD will review reports for quality, clarity and to ensure they are fulfilling the mandate of the Assessment Plan.

The Physician Performance Department will refer Dr. Jones and her associated assessment reports to the Registration Committee following completion of the Return to Practice Assessment.

The Registration Committee will consider the outcome of the assessment reports.

i) Should the reports be **satisfactory,** the Registration Committee will make a decision on issuing a Restricted Licence, incorporating the provisions of the settlement agreement that are relevant to ongoing conditions and restrictions. (For example, the requirement for 2 years of standard level supervision).

ii) Should the reports indicate **satisfactory with recommendations,** the Registration Committee will make a decision on issuing a Restricted Licence, incorporating the provisions of the settlement agreement that are relevant to ongoing conditions and restrictions, and will also incorporate the recommendations from the reports as deemed appropriate.

iii) Should the reports indicate **unsatisfactory practice** to the extent there are too many deficiencies to permit return to practice at that time, the matter will be referred back to the Professional Conduct Department to determine next steps.

Guidance for the Supervisor:Assessment of Family Medicine CanMEDS Competencies

Goal of Supervision Activity	CanMEDs Role(s)	Methods/Resources
Supervisor is considered the Most Responsible Physician Ensure that appropriate clinical assessments are performed for patients presenting to the office. Ensure that individual patient visits are appropriately documented in the patient record. Ensure that appropriate clinical judgement is exercised in the investigation, management and referral of patients.	Medical Expert Communicator	Daily field notes/record review, selected from day sheet Chart based discussion of any records for which there are identified questions or concerns. Direct observation of a clinical encounter and/or operative procedure.
Goal of Supervision Activity	**CanMEDs Role(s)**	**Methods/Resources**
Ensure that the supervised physician works effectively with other team members by: • Communicating effectively • Demonstrating clinical leadership where appropriate • Responding in a timely, collegial and effective manner to concerns identified by staff and colleagues	Leader Collaborator Communicator	Solicit and document the feedback of key staff members, including: nursing leadership, staff charge nurses, medical colleagues and consultants. Document specific examples of positive or negative behaviour brought to the supervisor's attention. Provide feedback and coaching to the supervised physician.
Ensure that the supervised physician is undertaking appropriate professional development, both in terms of general educational needs and	Scholar Professional	Review supervised physician's professional development plan. Assist in the development of an assessment and / or educational plan for areas of identified weakness.

to address any specific weaknesses in performance.		

Oversight and Methods of Assessment
(Tools will be provided in Return to Practice Assessment Assessment Package)

The indications for High Level Clinical Supervision vary considerably. The Supervisor is considered the MRP. Therefore, regardless of the indication, there is a requirement that the Clinical Supervisor participate in all aspects of clinical care.

Method	Approximate Frequency
The Clinical Supervisor will participate in, observe and / or provide feedback on clinical care in all circumstances.	**Daily**
The Clinical Supervisor will approve and countersign all management plans for patient care.	**Daily**
The Clinical Supervisor will use a combination of opportunistic and planned / structured clinical assessment to achieve the goals of supervision.	**Daily**
The Clinical Supervisor will review and countersign all documentation (clinic notes, progress notes, discharge and operative summaries).	**Daily**
The Clinical Supervisor will periodically interview colleagues of the Supervised Physician, for the purpose of: 1. ascertaining whether care meets the expected standard and; 2. ascertaining whether the Supervised Physician's conduct and non-clinical activities meet the expected standard.	**As Required**
Where available, multi-source feedback may supplement or substitute for the interview process.	**Optional**
Structured tests of skill or knowledge as appropriate (including simulation)	**As Available**

Educational Requirement (Continuing Professional Development)

High Level Clinical Supervision will usually entail some degree of focused education and professional development for the supervised physician. The Clinical Supervisor will support the physician in the development of an education plan and identify appropriate resources during the course of supervision. The supervised physician will be required to demonstrate

that any required professional development has been undertaken and applied successfully in practice.

SCHEDULE "C"

COLLEGE OF
PHYSICIANS & SURGEONS
OF NOVA SCOTIA

Standard Level Supervision - Overview

Standard level supervision is implemented to ensure that an acceptable standard of practice is established. It should not be chosen if patient safety concerns exist. Each cycle of Standard level supervision is one year duration, and supervision activities repeat for each subsequent cycle. Standard level supervision requires approximately 20 hours of supervision activities performed by the Supervisor per year. The application of standard level supervision typically occurs in the following circumstances:

- A physician is issued a new Defined licence. Limitations in past training, practice scope or experience require that a Clinical Supervisor be appointed to ensure that practice meets the expected standard and that the physician is effectively supported in areas of known or anticipated weakness.
- A physician is practicing under an established Defined licence, but has been identified as having difficulty meeting the acceptable standard in some areas of practice.
- A physician practicing under a Full / Restricted Licence is found, in the process of a College Investigation, to have assessed deficiencies in one or more standards of practice.
- A physician is found, during the process of College Peer Review, to have significant deficiencies in one or more standards of practice. Remedial activities prescribed by the Practice Improvement Committee fail to have the desired effect.
- A physician, previously practicing under a higher level of clinical supervision / assessment, is required to transition through less direct supervision before returning to unsupervised practice.

In most circumstances, any physician that is being placed on Standard level supervision, will be initially subject to this level for a minimum of 2 years.

Assessment Activities, Tools and Timeline

Activity Description	Reporting Tool	Activity Date (in relation to cycle start date)
Supervisor/DL Introduction The Supervisor will arrange for an introductory meeting with the physician to set up the plan for the supervision cycle. The purpose of this meeting is to ensure the required tasks are completed at the onset of a supervision cycle. These task include identifying Medical Colleagues to be interviewed, reviewing the Record of Contact Questionnaire, and making contact with the Sponsor (where appropriate).	Record of Contact Checklist	8 weeks

Continuing Professional Development Review The Supervisor will discuss and/or review the Record of Contact Questionnaire in order to gain an understanding of the physician's current status in relation to Continuing Professional Development. The purpose of this activity is to gain an understanding of the physician's ongoing learning, to identify any outstanding CPD requirements (compliance/adherence) or to consult with the physician around potential CPD opportunities that are relevant to their practice.	Continuing Professional Development Report	8 weeks
Patient Record Review The Supervisor will conduct an audit of the physician's patient charts. The purpose of this activity is to ensure: - that appropriate clinical judgement is exercised in the investigation, management and referral of patients. - that individual patient visits are appropriately and accurately documented in the patient record. - prescribing patterns are in alignment with current clinical guidelines. With following instructions provided in the Patient Record Review Guide, this activity is typically performed on site to directly review a selection of 10 charts that represent the physician's scope of care provided to patients. The supervisor will input general notes in the Patient Record Worksheets to capture information related to each chart reviewed.	Patient Record Worksheets	12 weeks
Assessment of Patient Charts After the patient chart is complete, the Supervisor will synthesize their findings using the Consolidated Record Review. The purpose of this report is to document the overall quality of the charts that were reviewed. Individual statements on the Consolidated Record Review have been mapped to the CanMed competencies.	Consolidated Record Review	12 weeks

Interim Report At this stage of the Supervision cycle, the Supervisor will summarize their overall assessment of the physician's practice quality. The standards of practice that are being assessed on this report are based on the CanMed competencies.	Interim Report	12 weeks
Direct Observation of a Clinical Encounter or Procedure The Supervisor will observe a patient encounter and/or Medical procedure conducted by the physician. The purpose of this supervision activity is for the Supervisor to provide feedback on the provision of care or the conduct of certain procedures. Choosing what to observe will depend on the physician's scope of practice and may be determined as an area of focus within the Supervision plan. With the consent of each patient, the Supervisor will observe care and then document their observations using the Direct Observation for a Clinical Encounter Worksheet. If a procedure is conducted by the physician, the Supervisor will use the Direct Observation for a Clinical Encounter Worksheet. The Supervisor may choose to review patient record entries that are generated during the observation. This is for the purpose of evaluating documentation accuracy and to gain additional information related to the patient's care.	Direct Observation of a Clinical Encounter OR Direct Observation of an Operative or Medical procedure	24 weeks
Interim Report #2 Upon completion of the direct observation, the Supervisor will summarize their overall assessment of the physician's practice quality. The standards of practice that are being assessed on this report are based on the CanMed competencies.	Interim Report	24 weeks

Medical Colleague Interviews The Supervisor will solicit feedback from four Medical Colleagues of the physician. Two of these interviewees will be selected by the Supervisor or Sponsor, and two of the interviewees will be selected by the physician who is under supervision. The Medical colleague interviews may be performed with allied health professionals who work with the physician. The purpose of these interviews is to: - ascertaining whether care provided by the physician meets the expected standard and; - whether the physician's conduct and non-clinical activities meet the expected standard. The Supervisor will document specific examples of positive or negative behaviour brought to their attention.	Medical Colleague Interviews	36 weeks
Patient Record Review #2 The Supervisor will conduct a second audit of the physician's patient charts. The purpose of this activity is to ensure: - that appropriate clinical judgement is exercised in the investigation, management and referral of patients. - that individual patient visits are appropriately and accurately documented in the patient record. - prescribing patterns are in alignment with current clinical guidelines. With following instructions provided in the Patient Record Review Guide, this activity is typically performed on site to directly review a selection of 10 charts that represent the physician's scope of care provided to patients. The supervisor will input general notes in the Patient Record Worksheets to capture information related to each chart reviewed.	Patient Record Worksheets	36 weeks

Assessment of Patient Charts After the patient chart is complete, the Supervisor will synthesize their findings using the Consolidated Record Review. The purpose of this report is to document the overall quality of the charts that were reviewed. Individual statements on the Consolidated Record Review have been mapped to the CanMed competencies.	Consolidated Record Review	36 weeks
Clinical Supervision Summary At the end of the supervision cycle, the Supervisor will synthesize the information they gained through the different supervision activities in the Clinical Summary Report. The purpose of this report is for the Supervisor to communicate to the College whether the expected practice standards are being met and patient safety thereby assured. This report will also require the supervisor to make a recommendation as to whether the level of supervision should be increased, maintained or reduced/ discontinued.	Clinical Supervision Summary Report	48 weeks

TAB 2

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Our File: 135827

June 24, 2019

VIA TITANFILE

Raymond F. Larkin, Q.C.
Pink Larkin
201-1463 South Park Street
Halifax, NS B3J 3S9

Dear Mr. Larkin:

RE: College of Physicians and Surgeons of Nova Scotia – Dr. Jones

I am writing in advance of the meeting of the Hearing Committee scheduled for the afternoon of June 26, 2019.

I attach a copy of the proposed Settlement Agreement for review by the Hearing Committee during our meeting.

Mr. Clarke and I have been in touch on this matter and believe it will be helpful to the Committee to receive some written submissions in advance of the meeting, respecting case precedents that may have some relevance to the sanction recommended in this case. This letter is being sent following review with Mr. Clarke, and includes cases identified by both of us for the Committee's consideration.

This case is premised on a very unusual factual situation which is fully addressed in the proposed Agreement. In short, Dr. Jones became involved in the care of a gentleman in his sixties who suffered from chronic pain and a number of other issues. The patient is identified as Patient X in the Settlement Agreement.

Dr. Jones took on Patient X as a patient early in her career as a family physician and provided care over roughly a five year period, at which time her medical licence was suspended.

Dr. Jones' opioid prescribing practices for this patient fell significantly outside of the Guidelines in place at the relevant time. The 2010 Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, Recommendation 10 states that "chronic non-cancer pain can be managed effectively in most patients with dosages at or below 200 mg/day of morphine or equivalent." The Guidelines define a "watchful dose" as "morphine or equivalent dose exceeding 200 mg/day." The Guidelines further provide that a watchful dose of 200 mg/day equals 133 mg of oxycodone.

The Settlement Agreement has an attached Schedule "A" that documents the volume of medication ordered by Dr. Jones for Patient X.

Dr. Jones made frequent dosage changes, ordered new medication before the prior medication was scheduled to be finished, picked up the medication herself at the pharmacy and delivered it to the patient's home, did not properly account for any missing medication in the chart, and engaged in other practices with this patient that were outside any acceptable standard of practice.

There were other aberrant behaviours from Dr. Jones relating to her actions, including failing to be accurate in her response to inquiries from the Prescription Monitoring Program, and failing to be accurate and forthright in her communications with pharmacists, her colleagues, and the Registrar of the College, all of which are outlined in the proposed Agreement. The issues regarding communications with Dr. Jones' colleagues and the Registrar arose in circumstances when Dr. Jones was taking a new medication which had a direct effect on her actions at the time. She was assessed by a College appointed psychiatrist, Dr. Scott Theriault, and Dr. Theriault attributed her actions during this particular period of time to the new medication. The details are noted in the Settlement Agreement.

There is a large volume of opioid medication which remains unaccounted for.

Dr. Jones states that because she wrote numerous prescriptions for Patient X and made frequent dose adjustments, there were often excess medications left over from the previous prescription. She has denied ever expecting or intending Patient X to ingest all of the prescribed medications. She says that some of the medication was returned by her to a drop box at the clinic where she worked, and also says that some medication was eaten by Patient X's cat or ended up in his toilet. Finally, evidence at the criminal trial from Patient X indicated that visitors would attend at Patient X's residence, enter his room and go through his medication pill box.

Dr. Jones was found not guilty in a criminal trial on charges of fraud and possession of narcotics. She has tested negative for opioid abuse. The College has determined that the patient involved in this matter is not able to provide reliable evidence. The College has received no credible explanation for what happened to these medications. There is no evidence of diversion by Dr. Jones. While a number of possibilities exist, speculation is not appropriate in the absence of proof.

Against this backdrop of aberrant behaviour with one patient is the College's evidence that the remainder of Dr. Jones' practice met all standards of practice. Two independent assessors conducted practice reviews and concluded Dr. Jones provided very good clinical care and met all standards of documentation.

During the upcoming meeting with the Hearing Committee, the parties will walk the Committee through the Settlement Agreement and will provide oral submissions to the Committee as to why the proposed Agreement should be accepted.

One of the factors the Committee will be considering is the range of dispositions in similar cases. The difficulty is finding comparable case law. Many of the cases either involve multiple patients, or do not involve the dual elements of overprescribing and lack of honesty and candour.

While we were unable to find directly comparable cases, we thought it would be helpful to provide the Committee with the case law that has some arguable relevance, so the Committee can consider this in advance of the meeting.

The facts of many of these cases are distinguishable from the conduct of Dr. Jones. They are intended principally to show the range of dispositions in cases involving opioid overprescribing.

The cases are set out below in chronological order, with the earlier cases perhaps having less relevance:

Cases addressing the over-prescribing of narcotics

Ontario (College of Physicians and Surgeons of Ontario) v. Arnold, 1999 ONCPSD 2

Dr. Arnold was found guilty of professional misconduct for failing to maintain proper records, prescribing extraordinary amounts of narcotics to 23 patients, and failing to have any justification for the dosages that were prescribed.

The facts are very briefly described in the Committee's Decision. The Committee noted that Dr. Arnold had a *"callous disregard for the written and verbally expressed concerns of the family of one of the patients whose use of narcotics was excessive and who clearly was addicted"*. The Discipline Committee found that the overall pattern of narcotic prescribing showed a wanton disregard of the impact on patients. The Discipline Committee noted in their decision:

> The Committee's initial inclination was to revoke Dr. Arnold's certificate of registration. In view of the presentation by the defence regarding precedents in the area of penalty in comparable cases, the Committee did not feel that it could revoke Dr. Arnold's certificate of registration. However, before Dr. Arnold can practise again, he must demonstrate competence and in the future he must practise in a manner such that the protection of the public is assured.

The sanction levied by the Committee included a 12 month suspension, a public reprimand, several remedial and educational requirements, and restrictions on practice including the inability to prescribe narcotics, no ability to see more than 40 patients per day, and the ability for unannounced auditing by the College.

College of Physicians & Surgeons of Ontario v Pontarini, 2000 ONCPSD 21

This case involved a physician who pled guilty and was found criminally responsible for trafficking narcotics, and was sentenced to 18 months of community service. The physician also failed to meet the requisite standard for charting, particularly narcotic medications. In an agreed joint statement, the physician admitted to prescribing opioids, even though they were not necessary for therapeutic reasons.

The physician admitted at the hearing that he had acquiesced to threats and demands of certain patients for prescriptions of oxycodone, even after he had become aware that they were not necessary for proper therapeutic purposes. He also became aware that one or more of these patients was forging his signature on additional prescription forms, but because of the threats and intimidation to which he was subjected, he did not report these activities to the authorities.

The physician was involved in several personal difficulties at the time of the events in question.

There was a joint submission on sanction that included:

- A reprimand
- Nine-month suspension (including a three-month conditional suspension)
- Undertaking to never re-apply for narcotics prescribing privileges
- Undergo a physical review program and practice assessment;
- A restriction on practicing emergency medicine until retrained; and
- Costs of $15,000

Ontario (College of Physicians & Surgeons of Ontario) v Adams, 2000 ONCPSD 23

Dr. Adams, a psychiatrist, practiced primarily as a pain specialist. An investigation into Dr. Adams' practice revealed that he fell below accepted standards of practice for 8 out of 25 patients whose care was reviewed. The discipline committee found Dr. Adams guilty of professional misconduct for his failure to maintain appropriate standards of practice and incompetence in that he displayed a lack of knowledge, skill or judgment.

This decision was based on findings that revealed the following issues:

- Excessive use of parenteral opioids on a long-term basis which did not meet any recognized standard at the time;
- Failure to take a complete history and carry out a physical exam for the eight patients assessed for chronic pain issues;
- Failure to consider a different diagnosis, or to order appropriate investigations to establish a specific diagnosis, in the majority of his patients; and
- Failure to monitor the liver or kidney function of two patients who were prescribed large quantities of Acetaminophen.

The committee was concerned that Dr. Adams had not acknowledged or admitted the problems for which he had been found guilty. Ultimately, the discipline included:

- A reprimand;
- Restrictions on his certificate of registration until he completed, at his own expense with a practice supervisor, a program designed or approved by the College to establish necessary knowledge, skill and judgment;
- Conditions and limitations on his certificate upon returning to full practice (including limits on ability to prescribe narcotics); and
- Review of clinical practice for three years.

College of Physicians & Surgeons of Ontario v. Gale, 2002 ONCPSD 3

In the case of *College of Physicians & Surgeons of Ontario v Gale*, 2002 OCPSD 3 (Decision on Merits and Decision on Penalty), an investigation by the College into Dr. Gale's practice uncovered significant deficiencies in 7/26 patient charts. The committee found Dr. Gale guilty of 12 allegations of professional misconduct by failing to maintain the standard of practice of the profession by prescribing, dispensing, or selling drugs for an improper purpose and by engaging in disgraceful, dishonourable, or unprofessional conduct. Some of these allegations included:

- Administering excessively high doses of opioids, including the rapid escalation of doses, to four patients without documentation of the clinical reasons or consideration to advice given to him by addiction experts;

- Unnecessarily providing heavy sedation/general anaesthesia to patients to whom he administered nerve blocks injections; and
- Failing to meet the standard of care expected from a competent physician during the resuscitation efforts of a now deceased patient.

Aggravating factors included Dr. Gale's lack of empathy for his patients, including the deceased patient, his lack of insight into the dangers of his practice, and the recklessness with which he prescribed opioids. Additionally, he did not appear willing to accept his guilty finding or be willing to modify his practice.

The committee perceived Dr. Gale's attitude to be dangerous and imposed the following penalty:

- A reprimand;
- Revocation of Certificate of Registration; and
- $30,000 in costs.

Dr. Gale appealed the committee's decision. In the appeal, 2003 CanLII 30486 (ON SCDC), the Divisional Court altered the decision by overturning three of the convictions and remitting them back to the College, including:

- Dr. Gale's failure to maintain the standard of practice with respect to his prescription of oral opioids (overturned due to committee's failure to consider contradictory evidence of a witness);
- Dr. Gale's failure to maintain the standard of practice with respect to the administration of high doses of Marcaine to one patient; and
- The general finding of incompetence (as it was based on the totality of the findings).

The Court discussed its general view on the penalty of revocation. The Court referred to the penalty of revocation as "the capital punishment of a professional" and stated that even if they had not set aside any of the findings of guilt, they would have set aside the penalty of revocation as it was "excessive to the point of being unduly harsh".

The Court remitted the penalty back to the College for reconsideration based on the Court's findings.

The committee took into consideration that Dr. Gale had already served a severe penalty which included a two and a half year suspension, followed by a restriction on his license. The committee accepted the joint submission of the parties and ordered that Dr. Gale complete a competency assessment and comply with any recommendations arising out of the assessment.

Hlynka (Re), 2010 CanLII 21054 (MB CPSDC)

Central to the allegations against Dr. Hlynka, was that he had engaged in inappropriate prescribing practices of narcotic medications involving 25 patients, and that during the period in which he had engaged in those inappropriate prescribing practices, his main focus had been to ensure his own supply of narcotic medications, to which he was addicted, without regard to the harm which might have resulted to the patients involved. Dr. Hlynka had prescribed opioids to patients he had not assessed, people he had not met, and others who did not have any medical reasons to do so.

Also central to the allegations against Dr. Hlynka was that he provided false and misleading information to the College in May, 2009 as the College was initiating its investigation into the relevant background facts.

The committee noted aggravating factors included the improper prescribing done repeatedly over an extended period of time (involving 25 identified patients) and the elaborate means taken to hide the prescribing practices. Mitigating factors included a finding that Dr. Hlynka provided reasonable medical care to his patients (besides those to whom he was prescribing narcotics) and a doctor's opinion that his judgment was affected by his own addiction to narcotics.

The Committee ordered the revocation of Dr. Hlynka's certificate of registration and licence;

Dr. Hlynka reapplied six months later and was accepted with restrictions on his licence. Restrictions included:

- Restriction on prescribing narcotics;
- Restriction on treating addiction patients;
- Continued support group and medical care;
- Supervision;
- Random bodily fluid screens; and
- Restriction on ingesting narcotics and alcohol.

College of Physicians & Surgeons of Ontario v. Redekopp, 2011 ONCPSD 43

In the case of *College of Physicians & Surgeons of Ontario v. Redekopp*, 2011 ONCPSD 43 (CanLII), Dr. Redekopp was a general practitioner who had been practicing medicine since 1983. The College initiated an investigation into his practice after receiving information from the police regarding the death of one of his patients (and the death of a second person from an overdose in the house of the patient).

The committee accepted an agreed statement of facts which outlined that a review of 22 charts (including the chart of the deceased patient) by a College expert revealed insufficient record-keeping and documentation, along with a lack of knowledge, skill and judgement evidenced by his prescribing practices which included:

- Prescribing bizarre, and potentially harmful, combinations of drugs;
- Prescribing inadequate doses and quantities of medications; and
- Over-prescribing.

Dr. Redekopp admitted that he failed to maintain the required standard of practice and was found guilty of professional misconduct by the discipline committee. The committee noted as mitigating factors that Dr. Redekopp admitted the allegations, successfully completed a prescribing course, and had no previous history with the College.

The committee accepted a joint submission and ordered the following penalty:

- A reprimand;
- Restrictions on certificate of registration (including the prescription of narcotics and other controlled substances);

- Restrictions must be visibly posted in waiting room;
- Random practice inspections and monitoring;
- Complete Medical Record-Keeping Course; and
- $3,650 in costs.

Coyle, Re 2013 CarswellMan 810

Dr. Coyle was found to have breached his professional duties in relation to prescribing and diverting narcotics to patients, boundary violations in relation to gifts of money, inappropriate billing and creation of misleading medical records, and misrepresentations to the College. In relation to the prescribing of narcotics, Dr. Coyle was found responsible for creating fictitious records of two patients who he had close personal relationships with to cover up his own use of the narcotics and benzodiazepines. Furthermore, Dr. Coyle was found to write prescriptions for Demerol without an adequate assessment of the patients' medical condition and/or inadequate medical rationale for nine different patients.

During the investigation Dr. Coyle provided misleading and false statements to the Registrar, Deputy Registrar, and the Investigations Chair. A joint submission between the College and Dr. Coyle was accepted and included a reprimand, a suspension of 18 months, 17 different conditions imposed on Dr. Coyle's ability to practice, and costs.

In the analysis the Discipline Committee noted that the many restrictions on Dr. Coyle's practice were necessary for ensuring public confidence in his ability to practice medicine:

> As outlined elsewhere in these Reasons, the restrictions on Dr. Coyle's practice are very significant. Those restrictions and conditions have had and will continue to have a major effect on Dr. Coyle's daily activities as a practicing physician. They are designed to protect the public, both in the sense of assuring that Dr. Coyle's patients will receive an acceptable standard of care and of demonstrating that there are effective means of maintaining high standards of competence and professional integrity among physicians, even physicians who have encountered serious difficulties in their professional and personal lives.

Datar (Re), 2016 CanLII 74173 (AB CSPDC)

Dr. Datar provided care to a patient between January 2005 and January 2012, when the patient ultimately died. It was found that he did not meet the minimum standard of care expected of a family physician. A toxicology exam found that multiple medications likely contributed to her death. Specifically, her oxycodone levels were in the "toxic range".

The Hearing Tribunal had significant concerns with respect to the care provided by Dr. Datar beginning on September 15, 2009, which is the date when Dr. Datar first prescribed morphine to the patient. The Hearing Tribunal found that Dr. Datar did not meet minimum expectations when first prescribing patient opioids, and failed to meet minimum expectations when continuing to prescribe the patient with medications that are highly addictive and dangerous when consumed with other medications, including oxycodone and zopiclone, and benzodiazepines. The discipline committee ultimately found that Dr. Datar had been doing the following:

- Prescribing opioids and increasing opioid prescriptions without confirming information provided by the patient;
- Significantly increasing oxycodone while also prescribing other medications with increased risk of toxicity;

- Failing to refer the patient to a psychiatrist as recommended by the patient's gynecologist; and
- Deficiencies in the patient's medical chart which included missing entries from patient encounters, a lack of support for decisions to initiate or increase opioids, no opioid agreement or evidence of urine drug screening, and at least two identified occasions of aberrant medication behaviour with no change in prescribing habits.

The assessed penalty by the Commission was a suspension of 3 months, surrender of triplicate prescription pads until completion of courses, random practice visits (up to four per year, for a period of two years), and costs.

Ontario (College of Physicians and Surgeons of Ontario) v. Proulx, 2018 ONCPSD 16

Dr. Proulx was involved in prescribing large amounts of opioids to his neighbour who had approached him about becoming his family doctor. Over the course of two years, the physician prescribed large doses of narcotics while only seeing the patient in his office twice. The physician would regularly meet the patient at her home, as she cited health and transportation issues.

Dr. Proulx would also pick the patient up and drive her to the pharmacy to obtain her prescriptions, sometimes writing them in the parking lot. Dr. Proulx would prescribe opioids for the patient but would also divert narcotics for himself, as he lied that his own doctor would not prescribe them to him. (There is no evidence of diversion in Dr. Jones' case).

The College was notified of the concerns after the patient attended a hospital and disclosed that she was not taking the large quantities of prescribed opioids as noted in her file.

During the investigation it was found that Dr. Proulx was untruthful about the nature of his conduct, and even contacted Patient A after the complaint was laid. As noted in the discipline decision, honesty and integrity are of central importance in the medical profession:

> *Honesty and Integrity*
>
> 26 There are certain characteristics that a physician must possess that the public and the profession consider vital. Honesty and integrity are two of those critical characteristics that are required not only to uphold the honour and reputation of the profession, but also to maintain public trust in the profession. By his actions, Dr. Proulx demonstrated that he was neither honest, nor an individual with integrity.

Dr. Proulx ultimately resigned and forfeited his licence. The Committee found that he was untruthful and did not cooperate with the investigation committee. The Committee upheld the joint submission for revocation.

Ontario (College of Physicians and Surgeons of Ontario) v. Cameron, 2018 ONCPSD 25

Dr. Cameron was a 65-year old physician. The NMS data (similar to PMP oversight) indicated that Dr. Cameron had been identified as a physician who in 2015 prescribed eight or more patients at least 650 oral morphine equivalents per day and issued at least one prescription exceeding 20,000 oral morphine equivalents. Dr. Cameron's care of his patients fell below the standard of practice of the profession in 18 of 24 charts and Dr. Cameron's care in 16 of 24 charts placed his patients at a risk of harm.

Dr. Cameron had two discipline issues in the past which were seen as aggravating factors for the discipline committee. In 2011, Dr. Cameron failed to attend to a child who was having a life-threatening anaphylactic reaction. Dr. Cameron was aware that the child was in the clinic, and yet did not leave his office at any time to attend to the child or to assist the paramedic while a medical emergency was occurring in the immediate vicinity. In 2013, the Discipline Committee found that Dr. Cameron engaged in disgraceful, dishonourable or unprofessional conduct by unwanted, inappropriate and sexual remarks to two registered practical nurses and unwanted touching of one of them.

Dr. Cameron had a tendency to prescribe narcotics at doses well in excess of those recommended in the relevant clinical guidelines for chronic pain over many years, with few physical exams or other evaluations of the patient's pain or function. The Committee found that:

- He demonstrated questionable and at times very poor judgment in continuing to prescribe large doses of narcotics to patients who had repeatedly demonstrated aberrant behaviour, often at appointments over a period of years, and was too accepting of patients' often questionable explanations for lost, stolen or damaged narcotics;

- He failed to regularly conduct opioid risk assessments, implement narcotics contracts and/or conduct urine drug screening to address repeated aberrant behaviour;

- In respect of at least six patients, he failed to refer patients to specialists, including pain and/or addiction specialists, where indicated;

- In respect of at least seven patients, he failed to react to information from third parties about potential opioid abuse or to follow the advice of consultants who suggested decreasing or discontinuing opioid medications;

- He continued to prescribe high doses of narcotics to patients who may have sustained accidents or injuries due to these prescriptions;

- He prescribed benzodiazepines to patients to whom he was also prescribing high doses of narcotics;

- In respect of at least four patients, he regularly prescribed narcotics to patients also prescribed methadone for addiction without appropriate consultation with the methadone prescriber.

Ultimately, the College & Dr. Cameron signed an agreement where Dr. Cameron agreed to surrender his licence and agree never to reapply to practice medicine.

Ontario (College of Physicians and Surgeons of Ontario) v. Aly, 2018 ONCPSD 33

The physician was 36 years old, and breached her standard of care in relation to four patients. With Patient A and Patient B, the physician did not follow proper practice in terms of prescribing narcotics. It was noted that she did not prescribe narcotics often. In relation to Patient C and Patient D, these were the physician's family members, and she prescribed narcotics above and beyond what was warranted in the situation. The physician did not require three of the four patients in question to sign a narcotics contract, and did not bill OHIP for their medical visits.

The committee stated that an aggravating factor in its decision was that the professional misconduct involved the prescribing of opioids, and therefore posed a serious risk to the patients and public at large:

> 11 The Committee found that Dr. Aly's professional misconduct was serious and posed a high risk of harm to the four patients due to her inappropriate opioid prescribing. It also posed potential harm to the public at large through diversion of the opioids prescribed by Dr. Aly. The Committee was troubled by a lack of knowledge demonstrated by Dr. Aly about proper prescribing of opioids.

The Committee imposed a reprimand, a suspension of (4) months, educational requirements, clinical supervision, a reassessment of the physician's practice and ongoing monitoring.

Ontario (College of Physicians and Surgeons of Ontario) v. Garcia, 2018 ONCPSD 35

Dr. Garcia was found to have been seeing upwards of 111 patients per day, and an average of 10-13 per hour. Ultimately, Dr. Garcia's proper assessment, prescribing, and oversight of patients was poor. Dr. Garcia failed to maintain the proper standards when prescribing controlled substances. At paragraphs 21-22 of their decision, the discipline committee noted:

> *Inappropriate Prescribing*
>
> 21 The public and the profession cannot and indeed will not tolerate a physician who fails to maintain the standard of practice of the profession. Dr. Garcia failed to maintain the standard of practice of the profession in his prescribing of controlled substances. The Committee considered the potential physical and emotional harm that can be inflicted on members of our society who become addicted to a controlled substance through the inappropriate prescribing of those substances. The Committee was very concerned with Dr. Garcia's excessive and inappropriate prescribing of controlled substances to his patients.
>
> 22 The opioid crisis has become a significant public health problem in our society. While there may be several factors that play a role in the opioid crisis, physicians who prescribe narcotics inappropriately or prescribe excessive doses of narcotics to patients contribute to that crisis. Dr. Garcia's prescribing of controlled substances was reckless in terms of the amounts prescribed and monitoring undertaken, which put his patients at a significant risk of harm. In addition, the friends and family members of addicted individuals often become unintended victims. Furthermore, when narcotics are prescribed in excessive amounts or inappropriately, there is a risk for diversion to third party individuals who also may be put in harm's way.

The Discipline Committee accepted a joint recommendation on penalty which included a reprimand, a suspension of eight (8) months, a restriction on licensing pertaining to number of patients who can be seen, a requirement for a patient log for narcotics and other drugs under the *Narcotics Safety and Awareness Act, 2010*, S.O. 2010 c.22, 12 months of supervision, and other administrative requirements.

Ontario (College of Physicians and Surgeons of Ontario) v. Pasternak 2018 ONCPSD 49

Dr. Pasternak did not meet the standard of practice in relation to fifteen patients. In fourteen of the fifteen patients, Dr. Pasternak's care potentially exposed the patient to harm or injury.

The Committee considered the serious nature of the misconduct in this matter. Dr. Pasternak's failure to reassess Patient A, while prescribing large doses of opioids and benzodiazepines over many years, exposed the patient to the overdose that ultimately harmed the patient. In addition, the College expert's review of additional charts demonstrated that Dr. Pasternak's misconduct with respect to Patient A was not an isolated case. Rather, this case reflected a constellation of failures related to Dr. Pasternak's failing to follow guidelines related to opioid and benzodiazepine prescribing, including failing to maintain adequate records, failing to reassess patients prior to renewing prescriptions, and failing to assess for the possibility of diversion, overuse or misuse, which exposed multiple patients to risk of harm. In reviewing the fifteen patient charts of Dr. Pasternak it was noted amongst other things, the following failures to meet the standard of practice:

(i) Failing to document rationale for prescribing;

(ii) Failing to assess reasons for repeated early prescription refills and failure to fully assess the possibility of diversion, overuse or misuse;

(iii) Failing to assess or re-assess, patients for potential adverse risks associated with big doses of opioids and benzodiazepines including the risk of sedation, cognitive impairments and overdose;

(iv) Providing large doses of opioid in the absence of physical assessments; and

(v) Failure to maintain adequate medical records.

Counsel for the College and counsel for Dr. Pasternak made a joint submission as to an appropriate penalty and costs order. The jointly proposed order included a reprimand, the imposition of terms, conditions and limitations on Dr. Pasternak's certificate of registration, and costs payable to the College.

Ontario (College of Physicians and Surgeons of Ontario) v. LeDuc, 2018 ONCPSD 59

Dr. Leduc was found to have breached his professional duties in relation to both boundary issues and prescribing narcotics. In July 2011, Patient A experienced a traumatic personal event and confided in Dr. Leduc. After discussing the events in some detail, and providing counselling, Dr. Leduc hugged Patient A in his office. Over the next two years, Dr. Leduc and Patient A would often hug at the end of an appointment. Despite her past alcohol abuse, Dr. Leduc purchased his patient's meals and alcoholic drinks she ordered.

The College's expert provided an opinion on the narcotics prescribing, and noted that Dr. Leduc's care demonstrated a significant lack of knowledge regarding the safe prescribing habits for narcotics and benzodiazepines. The expert concluded that Dr. Leduc showed a lack of judgment in continuing to prescribe medications to the patient, while being aware of the risk of addiction and harm to the patient. For example, the expert noted that following an ankle fracture in 2007, Dr. Leduc prescribed 120 Percocet tablets over fifteen days and then prescribed over 1300 tablets over the next four months before he began to taper the patient's medication.

At paragraph 30 of their decision, the Discipline Committee discussed the proposed penalty in the context of the current opioid crisis:

> 30 The suspension of Dr. Leduc's certificate of registration for six months provides specific deterrence and general deterrence to the profession. Boundary violations are to be taken seriously and will not be tolerated. Maintaining standards of practice of the profession is also important, and physicians are expected to be current with guidelines around opioid prescribing. This is fundamental to maintain the integrity of the profession and public confidence in light of the current opioid crisis.

The Committee order that Dr. Leduc be reprimanded, have his licence suspended for six (6) months, effective immediately, and that he pay the College's costs.

Ontario (College of Physicians and Surgeons of Ontario) v. Roy, 2018 ONCPSD 66

Dr. Roy was a 73-year physician who was found to be prescribing high doses of opioids to several patients. Upon investigation by the College, the College's reviewer concluded that in 7 of the 20 charts reviewed, Dr. Roy exposed patients to a potential risk of harm. The risk of harm was due to the extremely high doses of opioids that were prescribed in combination with high doses of benzodiazepines and not monitoring the patients closely enough to ensure that they were taking the medications safely.

Dr. Roy was required to sign an Undertaking requiring, amongst other things, that he practise under the guidance of a clinical supervisor acceptable to the College. If unable to obtain a clinical supervisor, Dr. Roy was required to cease to prescribe narcotic drugs, narcotic preparations, controlled drugs, benzodiazepines and other targeted substances, and all other monitored drugs. After not being able to find a suitable clinical supervisor for a few months after the Undertaking had been in place, Dr. Roy admitted to continuing to prescribe opioids to patients, despite the requirements from the College.

The Discipline Committee spoke to the ongoing public opioid crisis:

> 12 The Committee is aware of the current opioid crisis in the community and the major threat it poses to the public. Physicians must not contribute to this health crisis. In this case, Dr. Roy not only breached the June 2017 Undertaking, the number and doses of opioids he prescribed in the short period of time of his breach was shocking and could potentially pose a public safety concern if drugs were diverted. In the Committee's view, such misconduct requires a significant period of suspension.

Ultimately, the Committee found that a three-month suspension of Dr. Roy's certificate of registration was appropriate and fell within the range of suspensions ordered in other similar cases presented to the Committee. The Committee did not accept the submission that as this was Dr. Roy's one and only breach, a one-month suspension was fair and reasonable. The Committee found that a one-month suspension did not reflect the seriousness of the misconduct.

College of Physicians and Surgeons of Nova Scotia v. MacGregor 2019

Dr. MacGregor was the long term family doctor for a patient who had recently been discharged after a lengthy admission to the Abbey Lane Hospital. The patient had a lengthy history of mental illness, and had a substitute decision maker. The substitute decision maker had expressed concerns about prescribing opioids for this patient to Dr. MacGregor over the years.

Following discharge from the hospital Dr. MacGregor prescribed opioids and did not inform the substitute decision maker nor the patient's clinical team from the hospital who were following him. The patient died of an accidental overdose.

An audit by the College showed a number of other concerns respecting Dr. MacGregor's prescribing practices, as well as deficiencies in record keeping.

The matter was resolved by agreement between the College and Dr. MacGregor, whereby she was reprimanded for her failure to follow the relevant opioid prescribing Guidelines, for her inadequate documentation, her failure to collaborate with other treatment providers and for prescribing opioids to a patient at high risk for abuse without appropriate assessment and safeguards.

In addition to the reprimand, Dr. MacGregor was required to attend various remedial education and a re-audit of her practice.

Importance of Honesty

As with the above cases relating to over-prescribing, the cases referenced below addressing honesty concerns can all be distinguished on their facts. They are included to provide some reference points respecting the importance of honesty in the medical profession, and to demonstrate the type of sanctions imposed when honesty is in question.

College of Physicians & Surgeons (Ontario) v. Rassouli-Rashti, 2009 ONCPSD 7

Dr. Rassouli-Rashti interfered with the College's investigation, providing false testimony to the legal counsel of his friend, another physician who was accused of sexual impropriety. While imposing a penalty on Dr. Rassouli-Rashti, the Committee noted:

> In coming to its decision, the Committee considered the serious nature of Dr. Rassouli-Rashti's misconduct. By giving misleading or untrue information to the College, he ignored the most basic rules of honesty and integrity of the profession to which he was aspiring to become a fully certified practitioner. Lying to cover up for a friend is inappropriate conduct. The profession of medicine is given the privilege of regulating itself. In so doing, it is entrusted with the protection of the public. This trust requiresmembers to maintain a standard of professionalism and integrity. Dr. Rassouli-Rashti did not live up to that requirement. By his conduct, he violated his duty to the College, and he let down the membership as well.

The discipline included a suspension of the educational certificate of registration for a period of three (3) months, with a reduction to two months if Dr. Rassouli-Rashti completed, at his own expense, the College's Medical Ethics course and provided proof to the College, a reprimand recorded in the Register, and costs of the hearing in the amount of $5,000, within twelve months of the date of this order.

College of Physicians and Surgeons of Nova Scotia v. Norouzian 2017

Dr. Norouzian and the CPSNS Investigation Committee entered into an informal resolution in December 2016. The resolution included the revocation of the defined licence, and the opportunity to reapply for licensure assuming that he could meet the requisite standards under the *Medical*

Act. Dr. Norouzian had misstated information on his application form and omitted certain information, in order to gain licensure through a process with strict criteria to qualify for this alternative licensing process. The Investigation Committee found that Dr. Norouzian had "been strategically and intentionally dishonest" in relation to the application process with CPSNS. The Investigation Committee noted that failure to complete the application process with integrity must result in the strongest possible sanction.

College of Physicians and Surgeons of Nova Scotia v. Leckey 2018

In *Leckey*, issued in May 2018 by the CPSNS Investigation Committee, Dr. Leckey consented to a reprimand, and agreed to pay costs to the College, for what he admitted was imprecise reporting in relation to MSI billings and the amount of time he was spending with patients.

College of Physicians and Surgeons of Nova Scotia v. Baghaee 2017

In *Baghaee,* the physician in question lied in relation to his qualification under an alternative entry to practice program, in order to secure a practice of family medicine in Nova Scotia. In an informal resolution, the investigation committee revoked his license, but allowed him to reapply approximately 6 months later. Throughout the decision, the committee noted the importance of honesty and integrity, and how dishonesty undermines the profession and the confidence in the eyes of the public.

College of Physicians and Surgeons of Nova Scotia v. Rivas 2019

In its February 2019 decision in *Rivas*, the CPSNS Hearing Committee approved a settlement agreement resulting in a suspension of the physician's licence for three months. Dr. Rivas had failed to follow a 2014 undertaking that required him to have a chaperone present for all female breast examinations. He told the Investigation Committee that he had only performed one breast examination during the period in question, however, his MSI billings indicated that he had performed numerous examinations. The Hearing Committee acknowledged that the suspension was in part warranted because the physician knowingly misled the College with false information.

College of Physicians and Surgeons of Nova Scotia v. Chun 2019

In its March 2019 decision in *Chun*, the CPSNS Hearing Committee approved a settlement agreement that resulted in a reprimand, a suspension for a period of one month, a fine of $5,000 and costs. Dr. Chun participated in dishonest billing and record-keeping practices. In several instances, Dr. Chun did not perform examinations or surgeries, yet billed MSI for the procedures. He also communicated to both the patient's family and family doctor that the procedures had been completed when they had not been. In at least one instance, his dishonesty led to a cancerous growth going undiagnosed for nearly seven years.

College of Physicians and Surgeons of Nova Scotia v. Puthenparumpil 2019

In its May 2019 decision in *Puthenparumpil*, the CPSNS Hearing Committee approved a settlement agreement suspending the physician's license for one month following two patient complaints. The Hearing Committee found that the patient complaints each warranted a reprimand, while the physician's dishonest and inconsistent responses to the College during their investigation warranted a disciplinary sanction beyond a reprimand. In addition to the reprimand

and suspension for dishonest communication with the college, the physician was also ordered to participate in education respecting the need for ethical communications with the College.

Conclusion

As noted, none of these cases are quite on all fours with the unusual circumstances of Dr. Jones. However, they give a sense of the range of dispositions that may be ordered when over-prescribing and dishonesty are elements of the concerns.

During the meeting with the Hearing Committee on June 26, the College will be orally addressing the various purposes of the disposition process, the mitigating and aggravating factors to be considered, and why the College believes the suggested disposition of Dr. Jones' matter is appropriate and should be approved by the Hearing Committee.

We look forward to our discussion at that time.

Yours very truly,

Marjorie Hickey

Marjorie A. Hickey

MAH/km

c. C. Clarke (via email)
c. N. Gaudet