SUMMARY

DR. OKSANA LUBOMYRIVNA OPYR (CPSO# 89767)

1. Disposition

On August 15, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required family physician Dr. Opyr to appear before a panel of the Committee to be cautioned with respect to seeing and assessing patients before making medication changes and ensuring that she has a working knowledge of the patient's status. The Committee also advised Dr. Opyr to be clear on her role in the patient's care before making medications changes.

2. Introduction

The Patient's family complained to the College about Dr. Opyr's care, specifically, her actions in discontinuing several of the Patient's medications after not having seen the Patient for over two years and after the Patient's care had been transferred to a new physician. The Patient's family was also concerned that Dr. Opyr was rude during telephone conversations to discuss what had occurred.

Dr. Opyr stated that she did not learn of the transfer of the Patient's care to another doctor until after she had made the changes to the Patient's medications. She advised that she felt the Patient's medication list was unnecessarily long and could be changed to minimize medications, and that she intended to call the Patient's long-term care facility with specific instructions about monitoring but failed to follow through with her usual practice in this case. Dr. Opyr apologized and took responsibility for her error in this case. She noted that she had refilled the Patient's medications many times over the years, and that she did review the Patient's records before making the changes. She advised that has taken remedial steps as a result of this complaint.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee acknowledged the fact that Dr. Opyr took responsibility for her error and acted proactively to improve her practice, but the Committee was concerned about the significant nature of the error in this case. Particularly, the Committee was concerned by Dr. Opyr's decision to discontinue several medications of a patient whom she had not seen for over two years, and about whose current status she was unaware. Her decision to do so was particularly concerning given that the Patient had just been assessed by cardiology, who had not changed any of her medications, and because the medications were (in Dr. Opyr's own words) vitally important for the Patient.

Although Dr. Opyr indicated that she was unaware of the fact that the Patient's care had been transferred to another physician and was no longer her patient, the Committee was of the view that given the passage of time since Dr. Opyr had seen the Patient or prescribed her medications, it would have been prudent for her to have taken steps to determine what, if any, care the Patient had received in the interim and to clarify her role in the Patient's care.

The Committee noted that even if Dr. Opyr was under the impression that the Patient was still under her care, she acted inappropriately in making significant changes to her medications without first assessing the Patient, as set out in the College's policy on *Prescribing Drugs*. She also then apparently failed to contact the long-term care facility to ensure that the Patient was being properly monitored after discontinuing several medications, to ensure the Patient' safety.

In the circumstances, the Committee determined that it was appropriate to require Dr. Opyr to attend for a caution as set out above, and to issue advice as set out above.

In terms of the quality of Dr. Opyr's communication, the Committee had only divergent information from the parties, which it was unable to reconcile, and it was therefore not in a position to determine with any certainty what transpired. The Committee noted that it expects physicians to ensure that they communicate with patients and their family members in a professional manner at all times.