SUMMARY

DR. DANIEL HENRI MOQUIN (CPSO# 64177)

1. Disposition

On August 17, 2016, the Inquiries, Complaints and Reports Committee ("the Committee") ordered family physician Dr. Moquin to complete a specified continuing education and remediation program ("SCERP"). The SCERP requires Dr. Moquin to:

- review the College's policies #5-16, *Prescribing Drugs* and #4-12, *Medical Records*, and the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*, and prepare written summaries of each document, with reference to how they are applicable to his situation as well as how he has made or plans to make changes to his practice;

- successfully complete the Medical Record-Keeping Course, the Pain and Addictions Primer, and the Safe Prescribing Course and provide the College with proof of successful completion;

- undergo a reassessement.

2. Introduction

The family member of a deceased patient complained to the College about Dr. Moquin's care of the patient. The patient was discovered dead in her bed at home. The family member believed that Dr. Moquin was responsible for the patient's death, as he had abruptly cut off the patient's narcotics, leading to a difficult withdrawal, increasing the patient's stress, which caused a heart attack.

Dr. Moquin provided a review of his care of the patient, which included his stopping the patient's opioids and narcotics some months before her death, due to concerns about the risk of abuse and overdose.

The Coroner determined that the cause of the patient's death was accidental positional asphyxia in the presence of combined oxycodone, amitriptyline and benzodiazepine toxicity.

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." In this case, the Committee referred to the Policy Statements noted above.

4. Committee's Analysis

The Committee did not agree with the family member's view that Dr. Moquin was "responsible for" the patient's death. In the time between Dr. Moquin's decision to stop prescribing opioids and benzodiazepines and the patient's death, Dr. Moquin arranged for a psychiatric consultation, made a referral to a pain clinic, and had the patient see a mental health worker regularly. Further, there was information to suggest that the patient had accessed drugs from non-medical sources (i.e., "street" drugs). The Committee noted that the Coroner did not determine that the patient died from cardiac causes.

The Committee was concerned, however, with Dr. Moquin's approach when he had concerns about a patient's narcotic usage. A physician must take steps to manage such a situation appropriately and kindly, in the best interests of the patient. This would include a full clinical assessment, review of the medical record, discussion of alternatives to opioids or consideration and discussion of potential withdrawal symptoms. The Committee did not see documentation of this in Dr. Moquin's chart for this patient, nor of a full discussion with the patient of the rationale for his decision to stop the medications in question.

Further, Dr. Moquin's documentation respecting the patient in general was sparse. The chart contained no opiate risk tools, functional evaluations of the patient, pain scales or narcotics contracts with urine drug screens, all of which are useful in managing a patient, such as this patient, who had issues with medication overuse and/or compliance. Nor was there documentation of Dr. Moquin's thought process or rationale for the treatment provided, any plan for withdrawal of narcotics, or any alternative pain management strategies. The chart did not

contain documentation of any frank discussion with the patient about her abuse of medications. The chart notes needed to be more extensive, and to include documentation of adequate physical examinations. It was difficult, from the chart, to follow what conditions Dr. Moquin was treating.

Adding to the Committee's concern was the fact that Dr. Moquin was the subject of a recent previous complaint to the College in which he was cautioned, which raised issues about his care of a patient with alcoholic hepatitis.

For these reasons, the Committee imposed a SCERP to improve Dr. Moquin's management of pain, addictions and prescribing, and his medical record-keeping.