SUMMARY

DR. KARIN ALEXANDRA JABLONOWSKI (CPSO #83490)

1. Disposition

On May 14, 2018, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Jablonowski to attend at the College to be cautioned in person with respect to breaching her undertaking with regard to her failure to comply with the College's policy, *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation.*

In addition, the Committee ordered psychiatrist Dr. Jablonowski to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Jablonowski to:

- Practice under the guidance of a Clinical Supervisor acceptable to the College for six months
- Attend and successfully complete the next available session of the Medical Record-Keeping Course offered through the University of Toronto and the Safe Opioid Prescribing Course through a course provider indicated by the College
- Review and provide to the College a written summary of specific resources
- Undergo a reassessment of her practice by an assessor selected by the College approximately six months after the completion of the remediation.

2. Introduction

A patient complained to the College that Dr. Jablonowski closed her office in November 2016 without notice, leaving the patient without continuity of care and treatment.

Dr. Jablonowski responded that she closed her practice for medical reasons and wanted to focus on her recovery. She indicated that patients received letters advising them of her office closure and providing instructions on how to obtain copies of their medical records. She

indicated that the voicemail recording at her former practice also provided patients with information about her office closure.

3. Committee Process

A Mental Health 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 College asked Dr. Jablonowski to provide a copy of the notification letter she said her patients received, but Dr. Jablonowski did not do so. In addition, the College investigator telephoned Dr. Jablonowski's former practice and noted that the voicemail recording prompted callers to leave a message but did not advise of Dr. Jablonowski's decision to close her practice or indicate where patients could access their medical records, as Dr. Jablonowski claimed it did.

The Committee noted that there was no information in the investigative record to indicate that Dr. Jablonowski informed the patient that she planned to close her office or that she advised the patient how to obtain follow-up psychiatric care. Dr. Jablonowski made no arrangements regarding the ongoing prescription of psychotropic medications that she had been prescribing at high doses to the patient for an extended period of time. This left the patient's family physician in a difficult position, though the situation was managed effectively and the patient's subjective account was that it resulted in an improvement in her overall condition.

In light of all the above, the Committee was concerned that Dr. Jablonowski failed to close her practice according to College policy. The Committee was aware that Dr. Jablonowski entered into an undertaking with the College in April 2017 to cease practice until certain terms were

met. The undertaking Dr. Jablonowski entered into with the College requires her to abide by College policy #2-07, *Practice Management Considerations for Physicians Who Cease to Practise, Take an Extended Leave of Absence or Close Their Practice Due to Relocation.*

By failing to close her close her practice according to College policy, the Committee concluded that Dr. Jablonowski breached her undertaking with the College and decided to require her to attend at the College to be cautioned on this issue.

The Committee also had concerns about Dr. Jablonowski's medical record-keeping in this case. There was no documentation in the medical record of Dr. Jablonowski's decision to cease to practice or any details of arrangements she made for the patient's care following the closure of her practice, as recommended by the College's policy.

In addition, it appears that Dr. Jablonowski failed to document every encounter with the patient. There were few notes from 2015 until September 2016 documenting the patient's clinical course and treatment, though prescriptions showed that Dr. Jablonowski had contact with the patient over this period.

In regard to the medical care, the Committee noted that Dr. Jablonowski documented that she was considering a diagnosis of PTSD for the patient, but there was little focus in the medical record of the specific symptoms of PTSD. In addition, Dr. Jablonowski referred the patient to the Centre for Addiction and Mental Health (CAMH) for PTSD. The referral application was in the record, but there was no note to indicate that the patient was assessed at CAMH.

Most importantly, the Committee was concerned by Dr. Jablonowski's prescribing in this case. The fact that another physician started the patient on benzodiazepines did not justify Dr. Jablonowski's decision to continue to prescribe these medications to the patient in high doses for years. The patient had a family history of alcoholism and a personal history of alcohol and cocaine abuse, and Dr. Jablonowski's prescribing without sustained benefit was inappropriate

and left the patient very vulnerable to withdrawal symptoms. The patient's condition and ability to function deteriorated markedly under Dr. Jablonowski's care.

In light of the above, the Committee determined that the SCERP described above was warranted in this case.