SUMMARY

DR. YAMEEN AARON KHAN (CPSO# 94325)

1. Disposition

On December 13, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required general practitioner Dr. Khan to appear before a panel of the Committee to be cautioned with respect to documenting regular functional assessments and risk assessments to support medication dosage changes and on-going treatment plans in the treatment of patients with non-cancer pain, with homework to review the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain and to provide a summary (with a particular focus on the components of a functional assessment and risk assessment).

2. Introduction

Dr. Khan provided care to the patient between 2012 and 2017. An agency acting on the patient's behalf complained to the College that Dr. Khan provided the patient with ineffective management of chronic pain, including sub-therapeutic doses of medications; removed fentanyl from the patient's medication regime without proper taper, resulting in the patient experiencing "horrendous withdrawal"; failed to take the patient's level of comprehension and other challenges into consideration when providing care; and failed to provide an adequate report of the patient's participation in care (the agency asserted that the reason for terminating care had impeded the patient's ability to secure a new physician).

In his initial response to the complaint, Dr. Khan outlined the care he provided to the patient. Dr. Khan also explained that he reviewed the narcotic contracts with the patient before signing, and that while the patient's level of comprehension may be "mildly diminished", he believed the patient fully understood the discussions (which repeatedly occurred following his narcotic contract violations and refusals to accept specialist care or counselling). Finally, Dr. Khan denied that he compromised the patient's ability to secure a new physician and that he had not

communicated with another physician (Dr. X) for the purpose of "sabotaging" the patient's chances to be accepted as a patient by another physician group.

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 record confirmed that Dr. Khan adequately treated the patient's pain from a pharmacological perspective, prescribing appropriate dosages of opioids. Furthermore, the record indicated that Dr. Khan properly tapered the patient's fentanyl patches and provided him with appropriate follow-up care, including assessing and minimizing his symptoms by supporting him with medication to diminish the effects of his withdrawal. The Committee did not share the Agency's concerns with respect to prescribing, dosages and tapering. The Committee was also satisfied that the general care Dr. Khan provided to the patient was appropriate.

The Committee was troubled by the fact that Dr. Khan prescribed the patient narcotics for chronic, non-malignant pain without documenting a rationale to support dosage changes. In the Committee's view, Dr. Khan should have documented risk assessments and functional assessments to support dosage changes and the ongoing treatment plan. Given these deficiencies, the Committee determined that Dr. Khan would benefit from education. The Committee initially wished Dr. Khan to undertake self-directed education, and asked him to sign a remedial agreement. However, as Dr. Khan did not respond to the College's attempts to

communicate with him regarding the remedial agreement, the Committee concluded that it was appropriate to require Dr. Khan to attend at the College to be cautioned in this regard.

The Committee found that there was no information before it substantiating a concern that Dr. Khan did not take the patient's "level of comprehension and other challenges" into consideration when providing him with care (when the patient himself provided information to the College, he did not state this as a concern). In any event, if the patient's level of comprehension was in fact not sufficient for him to understand how to use fentanyl patches safely, that in itself would have been an appropriate reason for Dr. Khan to discontinue the patches and prescribe other medications to the patient. On the other hand, if the patient did comprehend what he had agreed to when signing narcotics contracts, it was appropriate for Dr. Khan to discontinue prescribing the patches given the repeated narcotic contract violations. Either way, the Committee was satisfied that Dr. Khan's decision to stop prescribing fentanyl to the patient was reasonable.

The Committee was satisfied that Dr. Khan's decision to terminate the patient from his practice was justified and properly executed. However, the Committee could not opine on whether Dr. Khan's reason for terminating care dissuaded Dr. X from accepting the patient into his practice, or directly impacted the patient's mental distress and/or led to thoughts of self-harm. Given that the Committee was limited to a documentary review only, it was also not in a position to determine with any certainty what, exactly, Dr. Khan may or may not have told Dr. X.