

SUMMARY

DR. SETH NII OBODAI SAI ABORHEY (CPSO# 105038)

1. Disposition

On January 13, 2016, the Inquiries, Complaints and Reports Committee (“the Committee”) ordered Dr. Aborhey to complete a specified continuing education and remediation program (“SCERP”) focused on prescribing narcotics and on professional behaviour. The SCERP requires Dr. Aborhey to:

- Complete a course in safe opioid prescribing
- Undergo coaching/instruction in professionalism and medical ethics
- Pursue self-directed learning about prescribing narcotics for chronic pain and professional behaviour
- Engage in focused education sessions with a College-approved clinical supervisor for six months, with a focus on prescribing narcotics, followed by reassessment by a College-approved assessor six months following the completion of the SCERP.

2. Introduction

A family member complained to the College that Dr. Aborhey prescribed a large amount of narcotics to the patient, who was experiencing ongoing pain from an injury, without taking an appropriate history. The patient died of a drug overdose which the Coroner concluded was likely accidental.

Dr. Aborhey stated that he prescribed narcotic medication on a temporary basis to this patient who had chronic pain, and who did not disclose a full medical history. Dr. Aborhey provided a letter of opinion from a family physician, which was supportive of Dr. Aborhey’s care.

3. Committee Process

As part of this investigation, the Committee retained an Independent Opinion provider (“IO provider”) whose practice focuses on chronic pain. The IO provider reviewed the entire written investigative record and submitted a written report to the Committee.

The Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint, as well as College policies and relevant legislation.

4. Committee’s Analysis

The IO provider opined that Dr. Aborhey did not meet the standard in his care for the patient, he demonstrated some variability in his judgement (in that while his initial approach to prescribing narcotics was reasonable, he later failed to take sufficient caution), and he exposed a high risk patient to increased risk. The IO provider also opined that Dr. Aborhey (whose practice was restricted such that he was working with a clinical supervisor) fell below the standard in not discussing the patient’s case earlier and more fully with his clinical supervisor.

The Committee agreed with the IO provider’s conclusions, acknowledging that while patients with chronic pain deserve appropriate analgesia, this particular patient had several risk factors that should have led Dr. Aborhey to be much more careful in his approach to prescribing narcotics. The Committee concurred that Dr. Aborhey should have shared information about this case earlier and more candidly with his supervisor. The Committee also noted that Dr. Aborhey demonstrated poor judgement in visiting the patient’s family member immediately after learning of the patient’s death, which made the family member feel uncomfortable.

In addition to the SCERP outlined above, the Committee also advised Dr. Aborhey about: his approach to prescribing narcotics and recognizing high risk patients for opioid abuse; and the importance of demonstrating professional behaviour at all times.