SUMMARY

DR. MARC NICHOLAS ENGFIELD (CPSO #78968)

1. Disposition

On May 12, 2017, the Inquiries, Complaints and Reports Committee ("the Committee") required Dr. Engfield (Internal Medicine) to appear before a panel of the Committee to be cautioned with respect to falsifying a medical record and failing to ensure that he had the necessary competence to change his scope of practice to chronic pain management. The Committee also accepted Dr. Engfield's signed undertaking.

2. Introduction

The College received information from the Centres for Pain Management ("CPM"), indicating that a female patient who had received treatment at CPM was found deceased in November 2015, ten days after Dr. Engfield performed peripheral blocks on her. The record indicated that Dr. Engfield had prescribed hyrdromorphone 4 mg as needed (a total of 1620 tablets) and a seven-month supply of gabapentin 300 mg (at a dose of 7 tablets per day) to the patient when he saw her ten days before her death.

In addition, the College received information from the Narcotics Monitoring System ("NMS") raising concerns about Dr. Engfield's narcotics prescribing.

Subsequently the Committee approved the Registrar's appointment of investigators to conduct a review of Dr. Engfield's practice.

3. Committee Process

As part of this investigation, the Registrar appointed a Medical Inspector to review a number of Dr. Engfield's patient charts, interview Dr. Engfield and submit a written report to the

Committee.

A Panel of the Committee constituted to consider cases that include narcotics prescribing issues, consisting of public and physician members, met to review the relevant records and documents related to the investigation. 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 considered the initial report of the Medical Inspector, who concluded that the care Dr. Engfield provided to his patients in his chronic pain management practice did not meet the standard of care and that Dr. Engfield's pain management practice was concerning in a number of areas, including that Dr. Engfield prescribed high doses and large amounts of opioids, frequently changed the doses and types of opioids he prescribed, and continued to prescribe opioids despite evidence of abuse. The Committee also considered the Medical Inspector's final report in which he opined that Dr. Engfield failed to meet the standard of practice in 24 out of 26 charts reviewed and exposed patients to risk of harm or injury in 18 out of 26 cases. The Medical Inspector indicated that he and Dr. Engfield discussed during their interview that Dr. Engfield had altered a patient chart by having the patient sign a backdated long-term opiate treatment ("LTOT") contract. Dr. Engfield admitted to the Medical Inspector that he had backdated the contract and expressed remorse. After the interview, the Medical Inspector found a second record that Dr. Engfield might have altered by backdating the LTOT contract.

In his response to the Medical Inspector's report, Dr. Engfield indicated that he has been transitioning from internal medicine to chronic pain management since February 2014. He

acknowledged that the investigation revealed his training has been insufficient but indicated that he is committed to remediating his practice. Dr. Engfield described changes to his narcotics prescribing practice and education he has taken and plans to take to improve his narcotics prescribing and medical record-keeping.

As a result of this investigation, the Committee had concerns about Dr. Engfield's chronic pain management practice. The Committee noted that its concerns would be satisfied, in part, if an undertaking could be obtained from Dr. Engfield to address the issues in question. Such an undertaking was obtained; it is posted on the public register and remains there while it is in effect. The Committee is satisfied that the terms of the undertaking (which include supervision, professional education and reassessment) are important measures to ensure that Dr. Engfield's ongoing and future narcotics prescribing is safe and effective for patients.

However, the Committee was concerned by Dr. Engfield's admission that he falsified a patient record after the investigation had begun by having the patient sign an LTOT contract that he had backdated. The Committee shared the Medical Inspector's perspective that this attempt to alter the medical record demonstrated a serious lack of judgement on Dr. Engfield's part. In the Committee's view, the regulations on this issue are clear and Dr. Engfield's conduct was clearly prohibited. Dr. Engfield is expected to know and make himself aware of applicable rules and regulations.

In addition, the Committee was disturbed by Dr. Engfield's apparent failure to prepare adequately for his change in scope of practice from internal medicine to chronic pain management. Dr. Engfield failed to ensure that he had completed adequate training to practice competently in his new scope of practice and, in so doing, put patients at risk of significant harm by prescribing narcotics inappropriately and dangerously.

The Committee acknowledged that Dr. Engfield has taken important steps to improve his practice but was concerned by his ethical lapse and the deficiencies in his care. Therefore, in

addition to accepting Dr. Engfield's undertaking, the Committee determined that it was also appropriate to require him to appear before a panel of the Committee to be cautioned, so the Committee may impress upon him its concerns with his ethics and his chronic pain management and provide direction to him about steps the Committee believes he must take in order to avoid future difficulties.