

Summary of Discipline Committee Hearing



DR. JOY COUREY

Hearing Date: May 5, 2016

ALLEGATIONS OF PROFESSIONAL MISCONDUCT

- dispensed the wrong medication, either personally or through an auxiliary
- failed to report the missing codeine either to the police or to Health Canada
- an act or omission inconsistent with the Act or the Regulation
- failed to maintain the standards of practice
- unprofessional conduct

BRIEF SUMMARY

The member had treated the dog for several years for a number of chronic diseases which required prescriptions including, prednisone and codeine. The dog weighed about 40-45kg.

In late April, the dog's owner went to the member's clinic to pick up 100 x 5 mg tablets of prednisone which had been prescribed by the member. The dog was to take one to two tablets every 24 to 48 hours. Instead 100 x 15 mg codeine tablets was dispensed.

At this time, the dog was also taking approximately 30 mg of codeine each day. The dog subsequently developed a severe rash and began scratching uncontrollably.

In early May, clinic staff discovered their narcotics log did not balance and the clinic was missing 100 x 15 mg codeine tablets.

Neither the member, nor another veterinarian at the clinic reported the missing codeine to police or Health Canada.

Not realizing the dispensing error that had occurred, in mid-May, the member recommended increasing the dog's prednisone (which was actually codeine) from 5 mg daily to 10 mg daily for five days, then to 7.5 mg daily for five days, then back down to 5 mg daily. As a result of the dispensing error, the dog's approximate daily codeine doses actually went from 45 mg of codeine to 60 mg for five days, then 52.5 mg for five days, then back to 45 mg. In the meantime, the dog was receiving no prednisone as a result of the dispensing error that occurred.

The dog was seen at an emergency clinic in mid-May. At the time, the dog was taking approximately 60 mg of codeine daily. The veterinarian at the emergency clinic recommended increasing the

prednisone (which was actually codeine) to 10 mg twice per day.

In late May, the member recommended increasing the dog's codeine dosage to two 15 mg tablets three times each day in addition to the increased prednisone prescribed by the emergency clinic. This meant the dog was taking about 90 mg of codeine each day following the visit to the emergency clinic and approximately 150 mg of codeine each day following the appointment with the member.

A couple of days later, the member noted that the dog could continue to take 10 mg of prednisone twice a day and two 15 mg tablets of codeine three times per day. As such, the dog continued to take approximately 150 mg codeine each day.

The dog's condition showed no improvement. At the end of May, the dog's owners discussed possible euthanasia with the member.

At the end of May, the Member increased the prednisone to two and one half tablets twice a day for three days, in addition to the two 15 mg tablets of codeine three times per day. The dog was at this point taking approximately 165 mg of codeine each day and no prednisone.

In early June, the dog's owners brought the dog to see the member for a re-check thinking the dog may need to be euthanized. The owners brought in the dog's medication and it was then that the Member discovered the pill vial labelled prednisone 5 mg and dispensed in late April, actually contained 15 mg codeine pills.

The member immediately admitted there had been a dispensing error and that this accounted for 100 x 15 mg codeine pills going missing from the clinic. The member had no explanation as to how the error occurred other than human error on the part of staff. The member admitted responsibility for the conduct of the auxiliaries and accepted responsibility for the dispensing error.

PLEA AND DECISION

The Member admitted the allegations as outlined in the Agreed Statement of Facts, including an admission of professional misconduct.

PENALTY

- Reprimand

- Suspension of the Member's licence for one month, two weeks of which is to be suspended if the Member completes a paper of a minimum of 1,000 words with appropriate references on proper dispensing and the supervision of auxiliaries.
- The Member will pay costs to the College of \$2,000.
- Pursuant to legislation, this matter is published including the member's name.

PANEL'S REASONING

In its deliberation, the Panel examined the Agreed Statement of Facts. This document contained the medical records from the member's clinic and the emergency clinic.

The Panel found that either the member or an auxiliary did dispense codeine to the dog, rather than the prescribed drug prednisone. The Panel found no evidence that the missing codeine was reported to either the police or to Health Canada.

The Panel, through deliberation after reviewing all materials presented to it, determined the member failed to maintain the standards of practice, and conducted herself in an unprofessional manner.

The Panel recognized and acknowledged the limits on its role when evaluating documents presented to it. The Panel understands that it must be satisfied that the Joint Submission as to Penalty and Costs falls within an acceptable range, and should only rebuke this submission if the Panel believed it had put the administration of justice into disrepute and was contrary to the public interest.

In determining the penalty, the Panel reviewed two similar cases.

The member had erred, especially in the failure to report the discrepancy in the quantity of a controlled drug that was missing from the drug log. The public must insist that all medications, especially controlled drugs such as narcotics, are properly labelled and dispensed. Failure to do so, in an accidental ingestion situation for example, could prove to be disastrous or potentially life threatening. Therefore, the Panel agreed this inaction did fail to protect the public interest, maintain the standards of practice, and would be perceived as being unprofessional by the profession.

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PANEL'S REASONING CONT'D

It is the Panel's opinion that the member, through her cooperation with the process, responses to the College and clients, and admissions to the Panel, is very mindful of the need to prevent this from recurring. The Panel is aware that the member has instituted protocols concerning the labeling and dispensing of prescription drugs and the supervision of auxiliaries who are also tasked to do so.