COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

IN THE MATTER OF
A HEARING UNDER THE *HEALTH PROFESSIONS ACT*,
R.S.A. 2000, c. C-7

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DR. ZAHEERALI LAKHANI

DECISION OF THE HEARING TRIBUNAL OF THE COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

I. INTRODUCTION

The Hearing Tribunal held a hearing into the conduct of Dr. Zaheerali Lakhani on April 12, 2018. The members of the Hearing Tribunal were:

Dr. Ralph Strother, Chair
Dr. Gregory Charrois
Ms. Marg Hayne, Public Member.

Mr. Jason Kully acted as independent legal counsel for the Hearing Tribunal.

In attendance at the hearing was Mr. Craig Boyer, legal counsel for the Complaints Director of the College of Physicians & Surgeons of Alberta (the "College"). Dr. Lakhani and his legal counsel, Mr. William Hembroff, were also present. Ms. Michelle Wolf and Ms. Fiona Mitchell attended the hearing as members of the public.

There were no objections to the composition of the Hearing Tribunal or the jurisdiction of the Hearing Tribunal to proceed with a hearing.

II. ALLEGATIONS

The allegation to be considered by the Hearing Tribunal (the "Tribunal") was set out in the Notice of Hearing, dated February 9, 2018, which was as follows:

1. Between November 6, 2012 and February 9, 2013, you did display a lack of knowledge or a lack of skill or judgment in the provision of professional services to your patient, A.B.[1], particulars of which include one or more of the following:

    a. You failed to review the report dated November 23, 2012 from the echocardiogram you had ordered,

    b. You failed to inform your patient of the results of the echocardiogram report dated November 23, 2012,

    c. You failed to have a consent discussion with your patient regarding the options for further investigation or treatment of the mass on or near his right adrenal gland noted on the echocardiogram report dated November 23, 2012.

At the hearing, Dr. Lakhani admitted that the allegation was true and acknowledged that the conduct amounted to unprofessional conduct.

III. PRELIMINARY MATTERS

There were no preliminary matters presented by the parties.

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[1] The Notice of Hearing referred to the patient by his full name, however for the purposes of this decision the patient will be referred to as "A.B.".

IV. EVIDENCE

Exhibits

By agreement the Parties entered an Exhibit Book, containing 9 items. The Exhibit Book was marked as Exhibit 1.

The Exhibit Book contained the following items:

Tab 1: Notice of Hearing dated February 9, 2018
Tab 2: Complaint Reporting Form dated March 18, 2017 from A.B.
Tab 3: Letter of Response dated April 21, 2017 from Dr. Lakhani to Ms. K. Damron
Tab 4: Dr. Lakhani's chart for A.B.
Tab 5: Letter dated May 31, 2017 from Dr. A. Bharmal to K. Damron with medical records for A.B.
Tab 6: Letter dated April 15, 2017 from Dr. Daviduck to K. Damron with medical records for A.B.
Tab 7: CPSA Standards of Practice – Preventing Follow-up Care Failures (as in effect November, 2012)
Tab 8: CPSA Standards of Practice – Preventing Follow-up Care Failures (revised in April 2014)
Tab 9: CPSA Standards of Practice – Patient Records (as in effect November, 2012)

An Agreed Statement of Facts was entered as Exhibit 2.

The hearing proceeded based on the Exhibit Book and Agreed Statement of Facts and no witnesses were called to testify.

V. SUBMISSIONS

Mr. Boyer made a brief opening statement, in which he summarized the contents of the Exhibit Book and the Agreement Statement of Facts. Mr. Boyer explained that Dr. Lakhani admitted the allegation in the Notice of Hearing, and acknowledged that his conduct constituted unprofessional conduct.

Mr. Boyer explained that Dr. Lakhani saw A.B. on November 7, 2012 and that he ordered an echocardiogram for A.B. The echocardiogram was completed on November 23, 2012. The report was returned to Dr. Lakhani but was not viewed by Dr. Lakhani and simply made its way into the file. The echocardiogram report for the chest showed an unexpected but relevant finding that A.B. had a mass on his adrenal gland. Dr. Lakhani met with A.B. again on January 10, 2013 and February 8, 2013 for follow-up visits but did not discuss the results of the echocardiogram at either meeting. A.B. was not advised of this mass or of his treatment options by Dr. Lakhani. A few years later, when the patient was seeing another physician, the echocardiogram was viewed by the second physician. The second physician asked what happened about the mass and it was at that time that A.B. came to understand that there was a mass that was identified but that he was not aware of and that he had not been informed of or what treatment options were.

Mr. Boyer indicated this conduct was the cause of the allegation and particulars in the Notice of Hearing.

Mr. Boyer advised that the allegations were the result of unfortunate circumstances but that the conduct amounted to unprofessional conduct because Dr. Lakhani demonstrated a lack of skill or judgment in the provision of professional services. He indicated there was a failure to review the report, a failure to inform the patient of the report, and a failure to have a discussion with the patient about the options of follow-up and treatment.

He indicated that missing a test result of a significant finding and failing to review and discuss the result with a patient amounts to unprofessional conduct. Mr. Boyer provided the Tribunal with a copy of the Alberta Court of Appeal's decision in *Huang v College of Physicians and Surgeons of Alberta*, 2001 ABCA 230, and a copy of the College of Physicians and Surgeons of Alberta "Summary of Decision of Investigation Committee "D" – Dr. Courtney Mazeroll" in support of this position.

Mr. Hembroff also made brief submissions on behalf of Dr. Lakhani. Mr. Hembroff explained that Dr. Lakhani had been seeing A.B. for a number of years and that he had sent A.B. for a number of tests in November 2012 to identify specific problems and to help Dr. Lakhani identify what problems may be there and how to treat the symptoms presented. He stated that Dr. Lakhani took appropriate steps to assist A.B in dealing with his problems.

Mr. Hembroff noted that one of the tests was the echocardiogram and that the echocardiogram was for a specific purpose, which was later addressed by Dr. Lakhani. However, the echocardiogram also identified an incidental and unexpected issue that was relevant and significant.

Mr. Hembroff noted that the echocardiogram report was sent "STAT" and faxed to Dr. Lakhani's office. However, the radiologist who sent the report did not call Dr. Lakhani's office. Mr. Hembroff explained that when it was faxed, Dr. Lakhani was out of the office for Royal College examinations, and that the echocardiogram report was filed by Dr. Lakhani's office. Mr. Hembroff acknowledged that a physician is ultimately responsible but that he must be able to rely on other medical staff. Dr. Lakhani relies on his staff to bring documents to his attention and he expects a radiologist to contact his office directly. Mr. Hembroff indicated he was not shifting the blame but explaining how other checks and balances did not catch the issue.

Mr. Hembroff advised that this has not happened to Dr. Lakhani in the past and that he has put in additional checks and balances to ensure it does not happen again. He advised Dr. Lakhani took responsibility for his conduct, made an admission, and acknowledge that it rose to the level of unprofessional conduct. He noted Dr. Lakhani was devastated that the incident occurred.

Mr. Boyer observed that Dr. Lakhani's situation was similar to the *Mazeroll* decision as Dr. Mazeroll was also extremely upset and they had a system in place that was defeated by factors. Nonetheless, the ultimate responsibility lay with her, just as it lies with Dr. Lakhani.

VI. FINDINGS

After hearing from the parties and reviewing the evidence compiled in the Exhibit Book and the Agreed Statement of Facts, the Tribunal felt there was sufficient evidence to support Dr. Lakhani's admission of the allegation, and determined that the conduct constitutes "unprofessional conduct" in accordance with s. 1(1)(pp) of the *Health Professions Act* ("HPA").

In particular, the Tribunal found:

The Agreed Statement of Facts establishes that A.B. was referred to Dr. Lakhani by his family physician. A.B. saw Dr. Lakhani on November 7, 2012 and Dr. Lakhani ordered an echocardiogram. The echocardiogram was completed on November 23, 2012 to rule out systolic dysfunction. The results showed an unexpected and incidental, but relevant finding, of pheochromocytoma in the abdomen. Dr. Lakhani met with A.B. on January 10, 2013 and February 8, 2013 in follow-up but Dr. Lakhani did not discuss the results of the echocardiogram at either meeting.

The November 23, 2012 echocardiogram is found at p 46 of the Exhibit Book. It indicates the presence of the right adrenal mass and indicates further assessment is recommended.

The Complaint Reporting Form dated March 18, 2017, Tab 2 of Exhibit 1, states the echocardiogram was not discussed with A.B. until March 2017 by A.B.'s family physician. A.B. learned of the adrenal mass after undergoing another echocardiogram in January 2017. It also indicates indicated that laproscopy was not possible to remove the mass due to its growth. This supported by a January 20, 2017 abdominal ultrasound, found at p 22 of the Exhibit Book, which indicates the presence of the adrenal mass and its growth.

The Letter of Response dated April 21, 2017 from Dr. Lakhani, Tab 3 of Exhibit 1, indicates he was in the United Kingdom examining for the Royal College of Physicians at the time the results of the echocardiogram were sent to his office. The letter states the report was faxed to his office with no preceding phone call. The report, which normally would have been first reviewed by his office staff and then himself, was missed and filed away in his paperwork. He had no explanation for the lapse in protocol. It states Dr. Lakhani did not see or discuss the echo test with A.B. on January 10, 2013 or February 8, 2013. It states Dr. Lakhani may not have considered the need to review the echocardiogram report once he determined A.B.'s cardiac volumes and ejection fraction were normal.

This evidence demonstrates that Dr. Lakhani failed to review the report, dated November 23, 2012, from the echocardiogram, that he did not inform A.B. of the results of the report, and that he did not have discussions with A.B. regarding the options for investigation or treatment of the mass.

Dr. Lakhani's conduct is unprofessional conduct as defined in section 1(1)(pp) of the HPA.

The CPSA Standards of Practice – Preventing Follow-up Care Failures, found at Tab 7, Exhibit 1, which was in force at the time of the conduct states that a physician who orders a diagnostic test or makes a referral to another health profession must have a system in place for review of test results and have a system in place to contact the patient when follow-up care is necessary. It also states that a physician who orders a diagnostic test, and directs a copy of the result to another physician remains responsible for any follow-up care required unless another physician has agreed to accept responsibility.

In the *Mazeroll* case, the Investigation Committee found that Dr. Mazeroll had missed findings of spots on the patient's gallbladder and liver in an ultrasound and that she failed to order an MRI as recommended by the radiologist. It found this constituted a finding of professional misconduct in the context of a breach of the expected standards of practice.

Dr. Lakhani's failure to review the test results and his failure to contact A.B. when follow-up care was necessary is a breach of the CPSA Standards of Practice – Preventing Follow-up Care

Failures. Accordingly, his conduct was contravened a standards of practice and meets the definition of unprofessional conduct found at section 1(1)(pp)(ii) of the HPA.

Dr. Lakhani's conduct was also conduct that harms the integrity of the regulated profession. In *Huang v College of Physicians and Surgeons of Alberta*, 2001 ABCA 230, the Alberta Court of Appeal confirmed a finding of unprofessional conduct and stated:

- "the evidence here supported the finding that Dr. Huang did not make adequate efforts to contact the patient in these circumstances. Even if a patient has a responsibility to attend on a doctor for follow-up care and fails to do so, that does not negate the doctor's duty to ensure that the patient is contacted about important test results" (para 6); and
- "we agree with the College that the determination that Dr. Huang had failed to inform his patient of a pathology report indicating cancer is indicative of conduct inimical to the best interests of the public and the profession, and as such, constitutes unbecoming conduct" (para 8)

The Tribunal concurs with these statements. Dr. Lakhani's failure to review the report, dated November 23, 2012, from the echocardiogram, his failure to inform A.B. of the results of the report, and his failure to have discussions with A.B. regarding the options for investigation or treatment of the mass are all conduct contrary to the best interests of the public and that harms the standing of the profession. Accordingly, his conduct meets the definition of unprofessional conduct found at section 1(1)(pp)(xii) of the HPA.

VII. ORDERS / SANCTIONS

The Tribunal heard submissions from both Mr. Boyer and Mr. Hembroff regarding sanctions for Dr. Lakhani. A Joint Submission and Admission Agreement were entered as Exhibit 3.

The parties jointly-submitted that the following Orders should be imposed:

1. That Dr. Lakhani shall receive a reprimand; and
2. That Dr. Lakhani shall be responsible for the costs of the investigation and the hearing before the Hearing Tribunal, in an amount as determined by the Hearing Tribunal after having heard submissions from legal counsel for the parties.

Mr. Boyer submitted out that the law states that a Joint Submission should be taken seriously by the Tribunal and given deference by the Tribunal. Mr. Boyer submitted that the Tribunal should only reject the joint submission if it is clearly and manifestly unjust. Mr. Boyer submitted that the sanctions were within the range of an appropriate outcome given the agreed facts, as well as the *Huang* and *Mazeroll* decisions as the physicians in these cases also received a reprimand.

Mr. Boyer submitted that the factors referenced in *Jaswal v. Newfoundland Medical Board*, (1996), 42 Admin L.R. (2d) 233, were considered by the Complaints Director in the proposed joint submission. He indicated the sanctions would adequately protect the public and would serve as an appropriate deterrent to Dr. Lakhani and other members of the profession. Mr. Boyer advised a reprimand is a serious sanction and is a mark on a professional's record that is not taken lightly.

Turning to the issue of costs, Mr. Boyer submitted that it is the responsibility for costs of the investigation and hearing lie with the regulated member. He provided the Tribunal with a copy of *Alberta College of Physical Therapists v Fitzpatrick*, 2015 ABCA 95, and indicated the Court of

Appeal found $23,000.00 in costs to be "not unfair" in that decision in a contested hearing situation. He indicated that costs are associated with the independent counsel, per diems for hearing tribunal members, as well as legal counsel for the College.

Mr. Boyer also provided copies of *Hoff v Pharmaceutical Assn.*, [1994] A.J. No. 218, and *Chen v College of Denturists of Ontario*, 2017 ONSC 530, and indicated that these cases state it is the regulated member, and not the profession, that bears responsibility for the overall costs of an investigation and hearing.

Mr. Boyer submitted that the costs of the hearing were reduced by Dr. Lakhani's cooperation and the admission and joint submission, as well as the fact that no witnesses were called. He also indicated that the Tribunal's time was being used efficiently and the Complaints Director was mindful of the costs and took steps to minimize costs. Accordingly, Mr. Boyer submitted Dr. Lakhani should pay the full costs of the investigation and hearing.

Mr. Hembroff stated that the reprimand was a fair and reasonable penalty. He also indicated that the publication of the orders will have a significant impact on Dr. Lakhani as he is a mentor to young physicians and someone physicians look up to.

Mr. Hembroff noted that complaints such as the one against Dr. Lakhani are often resolved earlier without a hearing. In such a case, there are no costs for the member and the costs are absorbed by the membership, of which Dr. Lakhani is a part. He indicated that Dr. Lakhani had made a prompt admission of his error and that the matter could have been resolved prior to the hearing. He submitted this speaks to Dr. Lakhani's responsibility for costs. Further, since the matter was pushed to a hearing, Dr. Lakhani had his own costs as a result. Mr. Hembroff submitted that full costs were not appropriate given the admissions and cooperation of Dr. Lakhani.

Mr. Hembroff submitted that the facts demonstrate there was a systemic issue where there were checks and balances. He indicated that had some other individuals done things differently, the situation would not have occurred. Mr. Hembroff indicated this was not trying to displace the responsibility for the error but that it spoke to the responsibility for costs.

Mr. Hembroff stated that requiring a physician to pay 100% of the costs may be appropriate where it is the physician's purposeful conduct, and denials of that conduct, that lead to the hearing. He submitted this was not the type of case on par with those cases that would require full indemnity costs. Mr. Hembroff also stated that Dr. Lakhani was not aware of the costs and that there is no ability to scrutinize the costs.

Mr. Hembroff also indicated that if the decision is publicized, it would have a significant impact on Dr. Lakhani. He advised Dr. Lakhani has an unblemished record and that the publication would have an adverse effect that he would have to deal with.

Mr. Hembroff submitted that the reprimand and dealing with the publication are fair but the costs sanction was inappropriate and overkill. Mr. Hembroff recognized that asking Dr. Lakhani to pay for some costs was acceptable. He submitted that the Tribunal should order Dr. Lakhani to pay a quarter to one-third of the total costs.

Mr. Boyer responded and stated that publication is not an issue of sanction and that it is about transparency. He also indicated that the Complaints Director could provide a summary of the costs to the Tribunal if the Tribunal wished to reserve on the costs issue.

Mr. Hembroff clarified that he was not asking the Tribunal to rule on publication but that, in making the admission and agreeing to the joint submission, Dr. Lakhani knew that the decision could be published and that this would have a significant and adverse impact.

The Tribunal carefully considered Dr. Lakhani's conduct in this matter, the evidence in the Exhibit Book, Agreed Statement of Facts, and the Joint Submission and Admission Agreement, and submissions from both parties on sanctions. The Tribunal also considered the factors in *Jaswal*, including the seriousness of the conduct, the context in which it occurred, and Dr. Lakhani's cooperation and admission of unprofessional conduct. The Tribunal recognized:

- Dr. Lakhani understood the nature of his conduct and undertook appropriate steps to address it, thus demonstrating the public would be protected in the future.
- The reprimand will have a significant impact on Dr. Lakhani and it will satisfy the requirement for deterrence.
- The reprimand will send a message to other members of the profession that such conduct is not acceptable.
- Dr. Lakhani's cooperation in acknowledging the facts of the case and his unprofessional conduct was a mitigating factor.

The Tribunal recognized that deference should be given to joint submissions. The Tribunal found that the joint submission of a reprimand with respect to sanction was appropriate and it was not clearly and manifestly unjust or contrary to the public interest. Accordingly, the Tribunal accepted the joint submission that a reprimand be ordered.

With respect to costs, the Tribunal was prepared to proceed without a summary of the actual costs. The Tribunal agreed that Dr. Lakhani should be responsible for some of the costs of the investigation and hearing. However, the Tribunal recognized that 100% of the costs would not be appropriate as Dr. Lakhani was responsive with the College throughout the investigation, cooperated in the hearing, and made an early admission. He took responsibility, admitted to the conduct, and negotiated a joint submission. As a result of his cooperation, the level of investigation and the complexity of the allegation were straightforward and no witnesses were called.

For these reasons, the Tribunal made the following orders:

1. Dr. Lakhani shall receive a reprimand; and
2. Dr. Lakhani shall be responsible for 50% of the costs of the investigation and hearing before the Hearing Tribunal.

Signed on behalf of the Hearing Tribunal by the Chair

Dated: June 20, 2018

Dr. Ralph Strother