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. ADIL LADAK

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. Adil Ladak on May 5, 2021. The members of the Hearing Tribunal were:

- Dr. Vonda Bobart, Chair
- Dr. Don Yee (Physician Member)
- Ms. Patricia Matusko (Public Member)
- Ms. Juane Priest (Public Member)

Ms. Mary Marshall 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. Adil Ladak was present with his legal counsel, Ms. Barbara Stratton.

II. PRELIMINARY MATTERS

Neither party objected to the composition of the Hearing Tribunal or its jurisdiction to proceed with the hearing. There were no matters of a preliminary nature. The hearing was open to the public, and there was no application to close the hearing.

III. CHARGES

The allegations to be considered by the Hearing Tribunal (the "Tribunal") were set out in the Notice of Hearing, which were as follows:

1. you did fail to inform, Katerina Robotosh, about the findings on the abdominal CT scan conducted on October 27, 2017, including the finding noted by the radiologist that there was suspect eccentric thickening of the proximal sigmoid colon wall and that a sigmoidoscopy was recommended to exclude an underlying mucosal lesion;
2. you did fail to order any follow up investigation of the abnormal findings reported on the abdomen CT scan report dated October 27, 2017, including failing to order a sigmoidoscopy to exclude an underlying mucosal lesion;

Dr. Ladak admitted that the allegations were true and acknowledged that the conduct amounted to unprofessional conduct.

IV. EVIDENCE

The following Exhibits were entered into evidence by agreement of the parties:

Exhibit 1: Agreed Exhibit Book Containing Tabs 1 to 9

- **Tab 1:** Notice of Hearing dated March 29, 2021
- **Tab 2:** Complaint form from S. Rubinstein dated February 6, 2019
- **Tab 3:** Letter of Response from Dr. A. Ladak dated June 7, 2019 with patient records for K. Robotosh (deceased)
- **Tab 4:** Certificates of Completion for three online courses dated February 6, 2020
- **Tab 5:** Dr. Ladak Office Policy on Radiological Reporting dated February 18, 2020
- **Tab 6:** Memorandum of Understanding signed by Dr. A. Ladak dated April 4, 2020
- **Tab 7:** Letter from Dr. Caffaro to S. Rubinstein dated June 3, 2020
- **Tab 8:** Refusal to consent to resolution from S. Rubinstein dated June 5, 2020
- **Tab 9:** Complaint Review Committee decision dated December 11, 2020

Exhibit 2: Admission and Joint Submission Agreement

The hearing proceeded based on the Exhibit Book and Admission and Joint Submission Agreement 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 Admission and Joint Submission Agreement. Mr. Boyer explained that Dr. Ladak admitted the allegations in the Notice of Hearing, and acknowledged that his conduct constituted unprofessional conduct.

Mr. Boyer explained that Ms. Katerina Robotosh was diagnosed with breast cancer in the fall of 2016. Ms. Robotosh had a mastectomy and was referred to Dr. Ladak for breast reconstruction surgery.

As part of the preparation for the surgery, Dr. Ladak ordered a CT scan. He missed a finding in the report resulting from the CT scan which turned out to be a secondary site of cancer. The patient did not survive.

Mr. Boyer advised that the allegations were the result of unfortunate circumstances but that the conduct amounted to unprofessional conduct. 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 College of Physicians & Surgeons of Alberta's Hearing Tribunal decision regarding the conduct of Dr. Zaheerali Lakhani dated June 20, 2018; 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 Nova Scotia "Summary of Decision of Investigation Committee 'D' – Dr. Courtney Mazeroll" in support of his position.

Ms. Stratton advised that Dr. Ladak confirms that the allegations are true and that they constitute unprofessional conduct.

VI. FINDINGS

After hearing from the parties and reviewing the evidence compiled in the Exhibit Book and the Admission and Joint Submission Agreement, the Tribunal determined that there was sufficient evidence to support Dr. Ladak's admission of the allegations, and determined that the conduct constitutes "unprofessional conduct" in accordance with section 1(1)(pp) of the *Health Professions Act* ("HPA").

The first consultation with Dr. Ladak was in August 2017. Ms. Robotosh elected to proceed with a "TRAM flap" procedure for breast reconstruction surgery. The October 27, 2017 Final Report resulting from the CT scan (October 2017 Report) included a statement in both the body of the report and in the summary referencing a thickening of the proximal sigmoid colon wall and recommending that a sigmoidoscopy be conducted.

The reference to the thickening of the sigmoid colon wall and the recommendation for a sigmoidoscopy are featured prominently in the October 2017 Report provided to Dr. Ladak. The following statement is included in the body of the report (Exhibit #1, Tab 3).

> *"There appears to be eccentric thickening of the proximal sigmoid colon wall and 2 small fecaliths. Surrounding pericolic fat is unremarkable with no pericolic inflammatory stranding/infiltration or mesenteric nodes. Background sigmoid diverticulosis. Sigmoidoscopy is advised to exclude an underlying mucosal lesion."*

The summary in capital letters states as follows:

> *"SUMMARY*
>
> *PATENT BILATERAL INFERIOR EPIGASTRIC ARTERIES WITH 2 MUSCLE PERFORATING BRANCHES ON THE RIGHT AND 3 PERFORATORS ON THE LEFT*
>
> *POST-RADIOTHERAPY LEFT UPPER LOBE SUBPLEURAL FIBROSIS*
>
> *SUSPECTED ECCENTRIC THICKENING OF THE PROXIMAL SIGMOID COLON WALL. SIGMOIDOSCOPY ADVISED TO EXCLUDE AN UNDERLYING MUCOSAL LESION."*

Dr. Ladak failed to notice these references in the October 2017 Report. Dr. Ladak did not arrange a sigmoidoscopy, did not postpone or cancel the TRAM flap procedure pending investigation of this finding, and did not arrange any other follow-up relevant to the finding regarding the colon wall on the CT scan. Dr. Ladak proceeded with a TRAM flap procedure on June 11, 2018 without first addressing the abnormal finding in the October 2017 Report. The tumor site went unnoticed for over one year. Ms. Robotosh died on January 1, 2019.

In summary, the evidence demonstrates that Dr. Ladak failed to notice the references in the October 2017 Report, that he did not inform Ms. Robotosh of the results, and that he did not have discussions with Ms. Robotosh regarding the options for investigation or treatment.

Dr. Ladak's conduct is unprofessional conduct as described in the following sections of the definition of unprofessional conduct in section 1(1)(pp) of the HPA:

- contravention of the HPA, the code of ethics, or standards of practice [section 1(1)(pp)(ii)];
- conduct that harms the integrity of the medical profession [section 1(1)(pp)(xii)].

The CPSA Standards of Practice – Continuity of Care, which was in force at the time of the conduct, state that a physician must have a system in place to review tests results and consultation reports in a timely manner; arrange any necessary follow-up care; and notify a patient of any necessary follow-up care. Dr. Ladak's failure to inform his patient of the results, and his failure to discuss options for investigation or treatment is a breach of the CPSA Standards of Practice.

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. The Investigation Committee found this constituted a finding of professional misconduct in the context of a breach of the expected standards of practice.

In the *Lakhani* case, the Hearing Tribunal found that Dr. Lakhani failed to review test results from an echocardiogram, and failed to contact the patient when follow-up care was necessary. This contravened a standard of practice. The echocardiogram indicated the presence of a right adrenal mass, and further assessment was recommended.

Accordingly, Dr. Ladak's conduct contravened a standard of practice and meets the definition of unprofessional conduct found at section 1(1)(pp)(ii) of the HPA.

Dr. Ladak's conduct was also conduct that harms the integrity of the regulated profession.

In the *Lakhani* case, the Hearing Tribunal also found that Dr. Lakhani's failure to review the report, his failure to inform the patient of the results of the report, and his failure to have discussions with the patient regarding the options for investigation or treatment are all conduct contrary to the best interests of the

public and conduct that harms the standing of the profession. This conduct met the definition of unprofessional conduct in section 1(1)(pp)(xii) of the HPA.

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 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" (paragraph 8).

The Tribunal concurs with these statements, and finds that Dr. Ladak's failure to notice the references in the October 2017 Report, failure to inform Ms. Robotosh of the results, and failure to have discussions with Ms. Robotosh regarding the options for investigation or treatment are all conduct that is contrary to the best interests of the public and harms the integrity 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 Ms. Stratton regarding sanctions for Dr. Ladak. An Admission and Joint Submission Agreement was entered as Exhibit #2.

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

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

Mr. Boyer submitted 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 *Lakhani,* the *Huang,* and the *Mazeroll* decisions, as the physicians in these cases received a reprimand.

Mr. Boyer submitted that the factors referenced in *Jaswal v Newfoundland Medical Board,* (1996), 42 Admin LR (2d) 233, were considered in the proposed joint submission. An appropriate sanction is a balance between deterrence and rehabilitation.

Rehabilitation has already been achieved prior to this hearing. Dr. Ladak revised his office policy, undertook courses on medical records, and wrote an article for The Messenger.

Mr. Boyer indicated that the sanctions that are proposed in the joint submission would serve as an appropriate deterrent to Dr. Ladak and other members of the profession. Dr. Ladak has no history of discipline with the College. A reprimand is a serious sanction and a mark on a professional's record.

Mr. Boyer also addressed costs. The costs of the hearing were reduced by Dr. Ladak's cooperation and the admission and joint submission. Mr. Boyer submitted that Dr. Ladak should pay 50 percent of the costs and that this percentage of costs is in line with the decision in *Lakhani.*

Ms. Stratton stated that the proposed sanctions were fair and reasonable and should be accepted.

The Tribunal carefully considered Dr. Ladak's conduct in this matter, the evidence in the Exhibit Book, the Admission and Joint Submission 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. Ladak's cooperation and admission of unprofessional conduct. The Tribunal recognized that Dr. Ladak understood the nature of his conduct and undertook appropriate steps to address it.

This case, while tragic, highlights the importance of continuity of care and follow-up on test results. Dr. Ladak has taken three CMPA courses on documentation (charting medical records, principles of medical record-keeping) and medical certificates, forms, notes and legal reports. Dr. Ladak has created a policy for the identification of patient investigation results. An article was published in The Messenger outlining the actions taken to address the concerns, and how he has created a "safety net moving forward". All of these steps help to ensure that the public will be protected in the future. The reprimand will have a significant impact on Dr. Ladak, and it will satisfy the requirement for specific and general deterrence. The reprimand will send a clear message to other members of the profession that such conduct is not acceptable.

The Tribunal also recognized that deference should be given to joint submissions on penalty. The joint submission of a reprimand and 50 percent of the costs of the investigation and the hearing before the Hearing Tribunal was appropriate and not clearly and manifestly unjust or contrary to the public interest. Accordingly, the Tribunal accepted the joint submission.

For these reasons, the Tribunal made the following orders:

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

Signed on behalf of the Hearing Tribunal by the Chair

May 21, 2021

Date

Dr. Vonda Bobart