NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Samir Barsoum Aziz, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity or any information that could disclose the identity of the patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45 or 47… is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

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THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. SAMIR BARSOUM AZIZ

PANEL MEMBERS:

DR. W. KING (CHAIR)
M. FORGET
DR. J. WATTS
DR. E. ATTIA (Ph.D.)
DR. C. LEVITT

Hearing Date:	September 17, 2014
Decision Date:	September 17, 2014
Release of Written Reasons:	November 27, 2014

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on September 17, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order, with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Aziz committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1)30 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that he has failed to respond appropriately or within a reasonable time to a written inquiry from the College; and

3. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Aziz is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991* ("the Code").

RESPONSE TO THE ALLEGATIONS

Dr. Aziz admitted the first and third allegations in the Notice of Hearing: (i) that he failed to maintain the standard of practice of the profession; and, (ii) that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the

circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. Counsel for the College withdrew the remaining allegations in the Notice of Hearing.

FACTS AND EVIDENCE

The following facts were set out in an Agreed Statement of Facts that was filed as an exhibit and presented to the Committee:

Background

1. Dr. Samir Barsoum Aziz ("Dr. Aziz") was issued a certificate of registration authorizing independent practice in Ontario on June 24, 2005. He is certified by the College of Family Physicians of Canada with special competence in Emergency Medicine. He practises Emergency Medicine in Burlington and Hamilton, Ontario.

Dr. Aziz's Failure to Maintain the Standard of Practice of the Profession

(a) Patient "A"

2. Patient "A" presented to the Emergency Department of Hospital 1 in September 2010. She complained of retrosternal chest pain that radiated to the back and the left arm, lasting one hour and twenty minutes. The patient's EKG, vital signs and troponin were normal. She was assessed by Dr. Aziz and was discharged home by Dr. Aziz with a final diagnosis of chest pain/anxiety. Prior to discharge, Dr. Aziz arranged for an outpatient stress test.

3. The College retained Dr. X to provide an independent opinion with respect to Dr. Aziz's care and treatment of Patient "A". Dr. X opined:

> *The care provided to Ms [A]. by Dr. Aziz fell below the standard of care for an emergency physician in the Province of Ontario.*
> …
> *In the case of the patient [A], we know that she developed severe retrosternal chest pain that radiated to the left arm that started at*

> *approximately 1400 hours. The pain was defined as a five out of ten by paramedics and was observed to be one out of ten when she presented to the emergency department at 1520 hours. The pain was retrosternal, and radiated to the left arm. Therefore the emergency physician would have to have high suspicion that this patient was having an acute coronary syndrome, in particular, an acute myocardial infarction. The standard of care would be to obtain an initial troponin and initial ECG, and if those were both normal, then to hold the patient in the emergency department for a second set of cardiac markers at least six hours after the first set.…In this particular scenario then, after the initial negative cardiac markers that were done at 1530 hours, this patient should have been held in the emergency department for a repeat troponin at 2130 hours, in association with a repeated electrocardiogram.*

4. Dr. X further opined:

> *Dr. Aziz's care of this particular patient displays a lack of knowledge of the appropriate way to assess patients with chest pain who may have an acute coronary syndrome. In addition, his care displayed a lack of clinical judgment by discharging the patient prematurely without a second set of cardiac enzymes and with a premature diagnosis of anxiety...Dr. Aziz's assessment of this particular patient, who presented with a strong likelihood of having an acute coronary syndrome but had an inadequate assessment, may reflect a clinical practice which is so deficient in clinical judgment that other patients who present with chest pain will also be improperly assessed and treated.*

A copy of the report of Dr. X dated November 24, 2011 is attached at Tab 1 [to the Agreed Statement of Facts].

5. Dr. Aziz retained Dr. Y to provide an opinion in this matter. Dr. Y agreed that Dr. Aziz failed to maintain the standard of practice of the profession by failing to repeat the EKG and troponin prior to discharge. A copy of Dr. Y's report dated August 8, 2012 is attached at Tab 2 [to the Agreed Statement of Facts].

6. Dr. Aziz admits he failed to maintain the standard of practice of the profession in respect of Patient "A".

(b) Patient "B"

7. Patient "B" was an elderly patient who presented to the Emergency Department at Hospital 1 in November 2009 complaining of intermittent blurred vision. There was a history of some blurred vision to the right eye with the onset approximately two hours prior to coming to the Emergency Department that started while the patient was at rest. At Triage, there were no neurological deficits noted. It was noted that the patient was diabetic and had a history of hypertension.

8. The College retained Dr. X to provide an independent opinion. He determined that Dr. Aziz's handwriting was for the most part was illegible and very difficult to decipher. There was no documented visual acuity or complete physical examination. Dr. X was of the opinion that Dr. Aziz failed to maintain the standard of practice of the profession.

9. Dr. Aziz retained Dr. Y to provide an opinion in this matter. Dr. Y disagreed with Dr. X's opinion that Dr. Aziz's care fell below the standard of practice of the profession.

10. Dr. Aziz admits his documentation was deficient in respect of Patient "B" and that he failed to maintain the standard of practice of the profession with respect to his record keeping.

Dr. Aziz's Failure to Co-Operate in the College's s. 75 (1)(a) Investigation

11. On January 12, 2012, the Inquiries, Complaints and Reports Committee approved an Appointment of Investigators under s. 75(1)(a) of the *Health Professions Procedural Code*. The investigation was to inquire into and examine Dr. Aziz's Emergency Medicine practice. The Registrar formed reasonable and probable grounds for the investigation on the basis of the complaints related to Patients "A" and "B" and the opinions provided by Dr. X.

12. Dr. Aziz was notified of the Appointment of Investigators by letter dated January 12, 2012. With the notification, the College Investigator provided Dr. Aziz with a document entitled “Physician Questionnaire”, a document intended to provide the College with detailed information about a member’s practice for the purposes of facilitating the College’s investigation. Dr. Aziz was asked to complete the Physician Questionnaire and return it to the Investigator’s attention within 10 business days of receipt.

13. Dr. Aziz received this letter and the request on January 13, 2012. Dr. Aziz failed to respond at that time.

14. On January 25, 2012, the Investigator wrote to Dr. Aziz noting a reply had not been received and requesting a reply by February 8, 2012. The Investigator’s request was received by Dr. Aziz on January 27, 2012. Dr. Aziz failed to respond at that time.

15. On February 22, 2012, the Investigator again requested a response to his earlier correspondence. The request was received by Dr. Aziz on February 24, 2012. Dr. Aziz failed to respond at that time.

16. On March 22, 2012, the Investigator wrote to Dr. Aziz indicating that he had selected 30 patient records from Hospital 1. The Investigator requested that Dr. Aziz transcribe the entries of the patient records that had been made by him. The Investigator requested that the transcripts be typed and clearly identify the corresponding patient record. The transcriptions were requested on or before April 13, 2012. In the same letter, the College Investigator again requested that Dr. Aziz complete and return the Physician Questionnaire that had been provided in January 2012. The request was received by Dr. Aziz on March 23, 2012. Dr. Aziz failed to respond at that time.

17. The transcriptions were required to facilitate the medical inspector’s assessment

and were required for the section 75(1) (a) investigation. On March 27, 2012, the Investigator contacted Hospital 1 requesting assistance to communicate with Dr. Aziz. In a letter received by the College on April 18, 2012, Hospital 1 informed the College that Dr. Aziz had met with Dr. Z, Chief of Emergency Medicine and Medical Director at Hospital 1. Hospital 1 advised the College that Dr. Aziz declined Dr. Z's request to have a meeting with the College in his presence. Hospital 1 further advised that Dr. Aziz indicated to Dr. Z that he had responded to the College's request by fax. The College did not receive a response from Dr. Aziz as indicated by Hospital 1.

18. On April 24, 2012, the Investigator again requested that Dr. Aziz complete the Physician Questionnaire provided on January 12, 2012 and provide a typed transcription of the 30 emergency medical records. Dr. Aziz was advised that his failure to respond and to provide the transcription of the clinical records was obstructing the investigation, and that he was failing to co-operate contrary to section 76(1) of the *Health Professions Procedural Code*. Dr. Aziz failed to respond.

19. By letters dated June 11, June 19 and July 5, 2012, Dr, Aziz was notified that his failure to co-operate would be reported to the Inquiries, Reports and Complaints Committee. Dr. Aziz provided no response.

20. Dr. Aziz did not provide the transcriptions of the charts or the completed Physician Questionnaire until after the allegations of professional misconduct that are the subject matter of this proceeding were referred to the Discipline Committee on July 25, 2012.

21. Following the referral to the Discipline Committee, the s. 75(1)(a) Investigation was completed and ultimately resolved with Dr. Aziz entering into an undertaking. The undertaking, dated November 21, 2013, requires among other things, that Dr. Aziz engage in clinical supervision, professional education and a

reassessment. A copy of the undertaking dated November 21, 2013 is attached at Tab 3 [to the Agreed Statement of Facts].

22. Dr. Aziz admits the facts set out in paragraphs 11-21 above and admits that the conduct described constitutes disgraceful, dishonourable and unprofessional conduct.

Breach of Undertaking in Lieu of a s. 37 Order

23. Following the referral to the Discipline Committee of specified allegations of professional misconduct and incompetence on July 25, 2012, Dr. Aziz was provided notice that the Inquiries, Complaints and Reports Committee intended to make an Order under s. 37 of the Code.

24. In lieu of making an Order, the College accepted Dr. Aziz's undertaking dated September 12, 2012, a copy of which is attached at Tab 4 [to the Agreed Statement of Facts]. Dr. Aziz undertook to practice under the guidance of a clinical supervisor who was to meet weekly with Dr. Aziz to review a minimum of ten patient charts at each meeting and discuss any issues arising therefrom.

25. Between September 2012 and October 2013, Dr. Aziz breached his undertaking with the College in that he failed to meet his supervisor weekly on 24 occasions.[1]

26. On 15 of these 24 occasions**,** Dr. Aziz and his supervisor reviewed approximately twice the amount of charts required under the undertaking in an attempt to account for the missed weeks of supervision described above. Dr. Aziz made no attempt to seek prior approval of the College to proceed in this manner.

27. Dr. Aziz admits the facts set out in in paragraphs 23 to 26 above and admits that

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1 Week of September 24, 2012; October 1, 2012; October 22, 2012; October 29, 2012; November 12, 2012; December 3, 2012;December 10, 2012;December 17, 2012; December 31, 2012; January 14, 2013; January 21, 2013; January 28, 2013; February 11, 2013; March 11, 2013; March 18, 2013; April 8, 2013; April 22, 2013; April 29, 2013; May 26, 2013;June 3, 2013; June 10, 2013; July 8, 2013;August 12, 2013; and September 2, 2013.

the conduct described constitutes disgraceful, dishonourable and unprofessional conduct.

ADMISSION

28. Dr. Aziz admits the facts set out above and admits that he engaged in professional misconduct:

    (i) under s. 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* in that he failed to maintain the standard of practice of the profession; and

    (ii) under s. 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* in that he engaged in an act or omission that would reasonably be regarded by members as disgraceful, dishonourable and unprofessional conduct.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Aziz's admission and found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession; and that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The jointly proposed penalty included:

(i) a reprimand;

(ii) the suspension of Dr. Aziz's certificate of registration for a period of three months;

(iii) the imposition of the terms of Dr. Aziz's undertaking with the College dated November 21, 2013, as terms, conditions and limitations on his certificate of registration, which terms include a requirement for a period of clinical supervision for eighteen months, the completion of a detailed plan of professional education covering the knowledge and skills of emergency medicine, patient assessment and investigation, and the standards of documentation and record-keeping, an agreement to unannounced inspections of his practice and records and a re-assessment of his clinical practice one year after completion of the supervisory and education period; and,

(iv) payment by Dr. Aziz of costs to the College in the amount of $4,460.00.

In considering the jointly proposed penalty, the Committee was mindful of the standard that a joint submission should be accepted unless the Committee determines that the proposed penalty is so disproportionate that it would be contrary to the public interest and would bring the administration of justice into disrepute. In considering the appropriateness of the jointly proposed penalty, the Committee was also mindful of the principles which underlie the crafting of a suitable penalty. These include: protection of the public; the need to maintain the integrity of the medical profession and public confidence in its capability for self-regulation, specific and general deterrence and, where appropriate, rehabilitation of the member.

Dr. Aziz's conduct in failing to comply with an undertaking given in lieu of a College order involved repeated failures to meet the supervisory requirements to which he had agreed and Dr. Aziz did not seek the College's approval to modify the elements of his supervision. Dr. Aziz repeatedly failed to respond to College requests to provide information, documentation and transcriptions in connection with a s. 75(1)(a) investigation, even after Dr. Aziz was advised that his failure to respond would be reported to the Inquiries, Reports and Complaints Committee. Dr. Aziz did not provide the requested information and documentation until after his case was referred to the Discipline Committee.

The allegations of failing to maintain the standard of practice of the profession involved an occasion on which Dr. Aziz's clinical care had the potential to expose his patient to risk of harm or injury, as well as another occasion in which his record-keeping and charting was clearly deficient. The misconduct was serious enough to demand a period of suspension of Dr. Aziz's certificate of registration and a prolonged period of remediation.

As mitigating factors, the Committee accepted that Dr. Aziz's admission of the allegations and his acceptance of a period of significant levels of supervision, as well as a prolonged educational program, represent insight into his need for both denunciation and deterrence of his conduct and remediation. Moreover, he has no prior history with the College regarding concerns over either his behaviour or standards of care. The Committee was also aware that Dr. Aziz was under significant stress at the time of his misconduct; including that his family in Iraq were in uncertain and dangerous circumstances and he was providing support for his sister who was dealing with a serious illness.

The Committee viewed the jointly submitted penalty as being both appropriate and fair. The administration of a public reprimand expresses the importance of acceptance of governance by his professional body, as well as the profound seriousness with which the profession views his behaviour and his deficiencies. A period of suspension from practice represents both the general and specific deterrence elements of an appropriate penalty. The undertaking to remain under supervision (which includes direct observation of clinical encounters), to engage in remedial education and to be monitored and re-assessed, provides the necessary public protection, as well as remediation and rehabilitation. Finally, the publication of the terms and conditions on Dr. Aziz's certificate of registration means that the information is available to the public, thereby providing a necessary degree of transparency.

The penalty is consistent with penalties imposed in other cases involving breaches of an undertaking, breaches of Committee orders and/or failure to respond to College investigations which were presented to the Committee including *Noriega (Re), Wu (Re),*

Sweet (Re), Tadros (Re) and Gay in which suspensions of between two and six months had been imposed by this Committee.

The requirement to pay costs to the College of $4,460.00, representing the tariff for a single day of hearing costs and partial recovery of the costs of conducting a hearing, is appropriate and consistent with the Committee's previous practice and decisions.

The Committee therefore accepted the joint submission and made the following order.

ORDER

The Committee delivered its finding and penalty and costs order in a written Order at the conclusion of the hearing on September 17, 2014, the terms of which are the following:

1. **THE DISCIPLINE COMMITTEE FINDS** that Dr. Aziz has committed an act of professional misconduct:

> a) under paragraph 1(1) 2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O.Reg. 856/93") in that he has failed to maintain the standard of practice of the profession; and,
>
> b) under paragraph 1(1)33 of O.Reg. 856/93 in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

2. **THE DISCIPLINE COMMITTEE ORDERS** Dr. Aziz to appear before the panel to be reprimanded.

3. **THE DISCIPLINE COMMITTEE DIRECTS** the Registrar to suspend Dr. Aziz's certificate of registration for a period of three (3) months, to commence on October 1, 2014.

4. **THE DISCIPLINE COMMITTEE DIRECTS** that the Registrar impose the terms of Dr. Aziz's undertaking with the College dated November 21, 2013 (attached

hereto as Schedule “A”) as terms, conditions and limitations on Dr. Aziz’s certificate of registration. The Undertaking has been in effect since November 21, 2013. All steps taken by Dr. Aziz between November 21, 2013 and September 17, 2014 in satisfaction of the Undertaking will be deemed to have been made in satisfaction of this Order. The period of Clinical Supervision provided for in paragraph B(3)(a) of the Undertaking will be suspended during the period of suspension referred to in paragraph 3 of this Order.

5. **THE DISCIPLINE COMMITTEE ORDERS** Dr. Aziz to pay costs to the College in the amount of $4,460.00 within 60 days of the date of this Order.

At the conclusion of the hearing, Dr. Aziz waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

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THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
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pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. SAMIR BARSOUM AZIZ

PANEL MEMBERS:

DR. W. KING (CHAIR)
M. FORGET
DR. J. WATTS
DR. E. ATTIA (Ph.D.)
DR. C. LEVITT

Hearing Date:	September 17, 2014
Decision Date:	September 17, 2014
Reprimand Date:	September 17, 2014
Release of Written Reasons:	November 27, 2014

PUBLICATION BAN

TEXT of PUBLIC REPRIMAND
Delivered September 17, 2014
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
Dr. SAMIR BARSOUM AZIZ

Dr. Aziz, the College has been granted the privilege of governing the medical profession by the people of Ontario. It is fundamental to that role that the College can rely on the cooperation of its members, as is indeed their legal responsibility.

It is beyond unfortunate that it should have taken this discipline process to teach you that lesson. You failed repeatedly to respond to a complaint. You breached a signed undertaking, which you ought to have known needed to be followed to the letter.

Your failures were disrespectful, at best. Or, at worst, a flagrant disregard of your responsibility.

A second branch of the College's responsibility is protection of the public. An important part of that role is ensuring that physicians practice to the standard of the profession. The Committee is satisfied that the provisions of your undertaking, now to be an order of this Committee, will assist you in your return to an acceptable standard of practice.

You may be seated, sir.