

SUMMARY

DR. PHILIPPE HAZIZA (CPSO# 64593)

1. Disposition

On January 30, 2018, the Inquiries, Complaints and Reports Committee (the Committee) ordered general practitioner Dr. Haziza to appear before a panel of the Committee to be cautioned with respect to maintaining patient confidentiality, test results management, and inappropriate billing (including asking a patient to pre-pay for medical services and to pay for an appointment to discuss the breach of confidentiality caused by his staff).

The Committee also ordered Dr. Haziza to complete a specified continuing education and remediation program (SCERP). The SCERP requires Dr. Haziza to:

- Review the College's "The Practice Guide" and policies, *Test Results Management* and *Uninsured Services: Billing and Block Fees*, and the Canadian Medical Protective Association (CMPA) Good Practices Guide modules on Communication and Professionalism. The review, to be submitted to the College, will include a written summary of the documents, with reference to current standards of practice, how they are applicable to Dr. Haziza's situation, as well as how Dr. Haziza has made, or plans to make, changes to his practice.
- Practice under the guidance of a Clinical Supervisor, acceptable to the College, for six months with a focus on appropriate stewardship of resources; appropriate billing, including the appropriateness of billing for visits to correct administrative errors; and maintaining confidentiality of health information. The Supervisor is to meet with Dr. Haziza a total of three times; at each visit, the Supervisor will review a minimum of 20 charts and billing to assess for the quality and appropriateness of documentation and billing.
- The Supervisor is to provide reports to the College at three and six months. Reports are to contain a review and report on billing practices and, in particular, procedures put in

place in the office to ensure that no patient is billed for appointments to correct administrative errors.

2. Introduction

Patient A, who was an out-of-province patient, complained to the College about Dr. Haziza's administrative conduct and professionalism. Specifically, Dr. Haziza's office staff e-mailed Patient B's test results to Patient A in error; Dr. Haziza's office staff told Patient A over the telephone that her test results showed a lung lesion, however, it was later recognized that this information was incorrect, and was actually regarding Patient B; and Dr. Haziza would not see Patient A in person free of charge to sort out and correct the medical record. Patient A was also concerned that Dr. Haziza failed to provide her with mammogram results in a timely manner or to ensure appropriate follow-up.

Dr. Haziza responded that he delegates many administrative tasks to his staff. On two occasions, his staff mixed up the results of Patient A and B as they have similar names. Unfortunately, his staff handled the situation in a way that was inconsistent with the clinic's expectations, training and protocols. The clinic's policy is that no patient be billed for a visit to address an administrative issue. It was only when he received Patient A's complaint that he learned his staff had told her she would be billed for a visit with him. He has addressed this issue with his staff and clearly reiterated that no patient should be billed for an administrative visit. His practice is to inform patients of the results of all mammograms, regardless of the outcome, and to do so at a regular appointment, if the results are normal. Had Patient A attended her upcoming appointment, he would have informed her of the normal result and recommended a screening mammogram in one to two years.

3. Committee Process

A General Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. 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 was concerned with several deficiencies in Dr. Haziza's office administration practices. It noted that physicians are always responsible for ensuring their clinic administrative practices do not impact patient care.

The Committee was troubled that Dr. Haziza and/or his staff breached patient confidentiality twice, and furthermore, when Patient A wished to attend to discuss the error and ensure it was corrected, told her she would be charged for this. Had Patient A not questioned the error, in the one instance, she may have been subjected to unnecessary testing. While administrative errors do occur occasionally, to have the same error occur twice with the same patient is troubling, and shows no steps were taken to prevent the error from recurring (such as, verifying using the birthdate that the correct tests have been ordered for the correct patient). These poor administrative practices can lead to unnecessary testing or to patients not receiving appropriate or timely follow-up.

Aside from the staff inappropriately telling Patient A she would have to pay to attend to discuss the results and errors in person, e-mails also support that Dr. Haziza's staff inappropriately requested pre-payment for the visit. The Committee further noticed that even after Dr. Haziza was notified of the complaint, and after Dr. Haziza's office had twice given Patient A incorrect results, staff e-mailed her to provide a copy of her mammogram results, and indicated that if she wanted any other results they would charge additional fees. The Committee questions the professionalism of this, given Dr. Haziza's staff had already made multiple mistakes with respect to Patient A's test results. Furthermore, in reviewing the records, we noted that the documentation of messages from staff notifying patients of test results was poor.

With regard to whether Patient A required a follow-up mammogram within one year, the Committee notes that given her age, lack of known risk factors and normal mammogram results, follow-up in one year was not mandated, in spite of the radiologist's recommendation on the mammogram report, and thus Dr. Haziza's plan was appropriate, and the Committee took no action on this aspect of the complaint.