

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Harmander Singh Gill, this is notice that the Discipline Committee ordered that no person shall publish the names and any information that could disclose the identity of patients who testify, or those referred to orally 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.

**DISCIPLINE COMMITTEE
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**
which is Schedule 2 of the ***Regulated Health Professions Act, 1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. HARMANDER SINGH GILL

PANEL MEMBERS:
DR. W. KING
MS C. TEBBUTT
DR. J. WATTERS
MR. J.P. MALETTE, Q.C.
DR. J. RAPIN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. L. BROWNSTONE
MS. M. KELLYTHORNE

COUNSEL FOR DR. GILL: SELF-REPRESENTED MEMBER, DID NOT ATTEND

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing dates:	April 1, 2, 4, 5 and 8, 2019
Decision Date:	April 16, 2019
Release of Reasons Date:	February 25, 2020

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 April 1 to 2, 4, 5 and 8, 2019. At the conclusion of the hearing, the Committee reserved its decision on finding. On April 16, 2019, the Discipline Committee released its decision on finding, with reasons for decision to follow, that Dr. Gill committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession and has engaged in conduct or 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 Committee also found that Dr. Gill is incompetent. These are the Committee’s reasons for decision.

THE ALLEGATIONS

The Notice of Hearing dated May 18, 2017, alleged that Dr. Harmander Singh Gill committed an act of professional misconduct:

- under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act 1991*, S.O. 1991, c. 30 (“O Reg. 856/93”) in that he has failed to maintain the standard of practice of the profession; and
- under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has engaged in conduct or 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. Gill is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Gill did not attend the hearing, nor did counsel attend on his behalf. The Committee deemed Dr. Gill to have denied the allegations.

PROCEEDING IN THE MEMBER'S ABSENCE

Dr. Gill was not present at the hearing at 9:20 am on April 1, 2019 and no one had appeared on his behalf.

At the outset of the hearing, College counsel advised that they had received information in an unsigned email to the effect that Dr. Gill would not be attending. The Committee adjourned to 1:00 pm to permit College counsel to attempt to obtain further information. At 1:00 pm, College counsel advised that there had been little further information about Dr. Gill's circumstances. Dr. Gill remained absent and unrepresented.

The Committee recognized that it has the jurisdiction to adjourn the proceedings on its own motion, whether or not Dr. Gill was deemed to be making an implied request for adjournment.

The Committee decided to hear submissions from College counsel and the testimony of a College investigator in respect of the question of adjourning in light of Dr. Gill's absence. A number of exhibits were admitted in evidence on this preliminary motion.

College counsel drew the Committee's attention to *Law Society of Upper Canada v Igbinosun*, 2009 ONCA 484 (CanLII), which sets out a non-exhaustive list of factors to be considered in deciding to grant or to refuse an adjournment request:

- Factors that may support the denial of an adjournment are a lack of compliance with prior court orders, previous peremptory hearing dates, the desirability of having the matter decided, and a finding that the applicant is seeking to manipulate the system by orchestrating delay.

- Factors which favour granting an adjournment are the fact that the consequences of the hearing are serious, that the applicant would be prejudiced if the request were not granted, and a finding that the applicant was honestly seeking to exercise his right to counsel.
- Also to be considered are the timeliness of the request, the applicant's reasons for being unable to proceed on the scheduled date and the length of the requested adjournment.

College counsel submitted that it was in the public interest to proceed with the hearing of the allegations, whether Dr. Gill attended or not. Further, the Committee had no medical evidence that Dr. Gill was unable to attend or participate. College counsel acknowledged that their position on proceeding might be different were there such evidence. Dr. Gill, however, had not provided any such evidence and had only sent a last-minute email to the lawyer who had previously represented him, but was no longer retained.

The Committee was informed that the hearing dates had been adjourned twice previously, in April 2018 and November 2018, to allow Dr. Gill time to retain counsel. In addition, Dr. Gill's motion to adjourn, heard March 29, 2019, had been denied. College counsel submitted that Dr. Gill has been seeking to manipulate the system and orchestrate delay.

Notice to Dr. Gill in respect of this hearing

College counsel provided the Committee with documents relating to Dr. Gill's unsuccessful motion to adjourn heard on March 29, 2019; specifically, Dr. Gill's Motion Record and the College's Responding Party Motion Record.

In Dr. Gill's affidavit in the Motion Record (tab 2), he acknowledges that on November 9, 2018 he sought and was granted an adjournment of the previously scheduled dates, that the new dates set for the hearing were April 1-5, April 8-10, April 12, and May 21-

22, 2019, and that the dates were set on a peremptory basis, noting that it is important to the public interest that the hearing proceed without further delay.

History of this matter

College counsel submitted a series of affidavits sworn by Marisa Giokas, legal assistant at the College, setting out a number of events in the history of this matter:

- Affidavit of Marisa Giokas, sworn March 28, 2019, in the Responding Party Motion Record:
 - The matter arose from a Registrar's Investigation begun in 2014, as acknowledged in a letter from Anna Matas, Dr. Gill's counsel at Lerner's.
 - Dr. Gill changed counsel and was represented by Stephen Darroch at McCarthy Tétrault as of April 20, 2017. Mr. Darroch accepted service of the Notice of Hearing, dated May 18, 2017.
 - A case management call was held on November 30, 2017. Mr. Darroch informed the chair that he did not have instructions and asked that the pre-hearing conference be deferred.
 - A scheduled pre-hearing conference proceeded on December 6, 2017. Hearing dates were set in April, May and June 2018.
 - On April 9, 2018, Mr. Darroch advised that his solicitor-client relationship with Dr. Gill had irretrievably broken down, requiring him to withdraw as counsel.
 - On April 11, 2018, Mr. Darroch advised College counsel that Dr. Gill was requesting an adjournment to allow him to arrange for legal representation.
 - McCarthy Tétrault was removed as counsel of record on April 13, 2018. The Committee ordered an adjournment of the hearing on its own motion.
 - A case management call was held on April 19, 2018. Dr. Gill agreed to notify the College about his new counsel by May 25, 2018, six weeks later.

Hearing dates were set in November and December 2018 and January 2019, more than six months later.

- Dr. Gill emailed the chair on May 24, 2018 to advise that he still lacked legal counsel.
- On September 3, 2018, in response to an inquiry from the College's hearings office, Dr. Gill emailed that he was still in the process of obtaining counsel.
- In a case management call on September 12, 2018, Dr. Gill advised that it was taking more time than he thought to find legal counsel and he needed more time still.
- In a case management call on October 1, 2018. Dr. Gill advised that he had spoken with legal counsel and was meeting with him on October 12, 2018.
- In a case management call on October 15, 2018, Dr. Gill advised that he had not yet finalized his retainer with counsel.
- In a case management teleconference on October 19, 2018, Dr. Gill advised that he had retained counsel but this would only be finalized October 23 or 24, 2018.
- In a case management call on October 19, 2018, Dr. Gill identified his counsel as Josh Koziembrocki but advised that Mr. Koziembrocki was not available for the call. In response to the letter reporting on the call, Mr. Koziembrocki advised that he had not yet been retained but that once he was, he intended to seek an adjournment.
- In response to an inquiry from College counsel on October 29, 2018, Mr. Koziembrocki replied that he had not yet been retained.
- On October 30, 2018, Mr. Koziembrocki advised the hearings office that he had not yet been retained.
- In a case management call on October 31, 2018, Dr. Gill advised that he would be unable to confirm the financial arrangements with Mr. Koziembrocki until November 13 or 14, 2018.

- On November 6, 2018, Mr. Koziebrocki advised College counsel that he had been retained to bring an adjournment application and was not available to prepare for and conduct a hearing on the scheduled dates.
 - In a case management call on November 9, 2018, an adjournment request by Dr. Gill, not opposed by the College, was granted and new hearing dates were set for April and May 2019, on a peremptory basis.
 - On December 18, 2018, Mr. Koziebrocki advised that he was no longer retained to represent Dr. Gill in this matter.
 - On December 18, 2018, in response to a reminder from the hearings office, Dr. Gill advised that he was unable to participate in the teleconference scheduled on December 19, 2018.
 - In a case management call on February 22, 2019, Dr. Gill had nothing to disclose about contacting or retaining a lawyer.
 - In various communications, Dr. Gill was notified of the hearing dates, that the College was not prepared to agree to any further adjournments, that Dr. Gill had an obligation to provide reciprocal disclosure, and that the College would seek to proceed were he absent from the hearing.
 - On March 15, 2019, Dr. Gill emailed the hearings coordinator to state that he was providing notice of a motion to request adjournment.
 - On March 26, 2019, College counsel received an email from William Chalmers of Aird & Berlis advising that Dr. Gill had consulted him regarding being retained to seek an adjournment of the hearing.
- Affidavit of Marisa Giokas, dated April 1, 2019:
 - An adjournment motion was heard on March 29, 2019. The motion was dismissed.
 - Mr. Chalmers received an unsigned email sent at 11:40 pm on March 31, 2019 stating that Dr. Gill had asked the writer to let Mr. Chalmers know that Dr. Gill had had to go to the emergency department that night

because of severe chest and back pain and would be unable to attend at the College on the following morning.

- Mr. Chalmers forwarded the email to College counsel at 6:37 am on April 1, 2019, noting that he had been retained by Dr. Gill only in respect of the adjournment motion and not in relation to any further steps in the matter.
- College counsel and the College's Manager of Investigations replied to the address in the unsigned email, requesting more information and asking that Dr. Gill be made aware that the College would seek to proceed in his absence. In a response at 9:14 am, the sender identified herself as Dr. Gill's sister. She stated that Dr. Gill was at the hospital and that she could send all the required information when she went to see Dr. Gill shortly thereafter.

Testimony of Christa Servanez with respect to a current investigation

Christa Servanez, a College investigator, testified about her efforts to arrange observation of Dr. Gill's clinical practice by a medical inspector as part of a current College investigation. She identified her initial letter of April 20, 2018 providing date options for the observation. She received no response from Dr. Gill to the letter or follow up communications. Ms Servanez notified Dr. Gill that October 18, 2018 was the date for the observation. She received no response. On October 18, 2018, Ms Servanez and the medical inspector attended Dr. Gill's office and found it closed. With respect to the next scheduled date, November 15, 2018, Dr. Gill sent an email at 11:50 pm on November 14, 2018 to say he would not be working at the clinic the following day because of a family emergency. He asked that further communication be via counsel but did not provide information identifying counsel. With respect to the most recently scheduled date (March 28, 2019), which was mutually agreed upon, Dr. Gill sent an email at 1:56 am on March 28, 2019 advising that the observation would have to be rescheduled because of an unforeseen medical emergency. Ms Servanez testified that Dr. Gill stated that he had hospital documents to support the significance of the medical emergency and would provide them by April 3, 2019.

Other cases

College counsel identified recent Divisional Court appeals of two tribunal decisions pertaining to motions to adjourn. The allegations were of plagiarism and related to an individual's employment and academic standing.

In *Spence v Ontario College of Teachers*, 2018 ONSC 3335 (CanLII), the court overturned a tribunal's decision to reject the defendant's motion to adjourn, on the basis that the College of Teachers' disclosure had been incomplete and the tribunal had ignored some medical evidence in respect of the member's inability to attend.

In *Spence v University of Toronto*, 2019 ONSC 1085 (CanLII), the court upheld a tribunal's decision to reject an adjournment request, noting that previous adjournments had been granted because of incapability and to enable new counsel to be retained, peremptory hearing dates had been set, and no fresh medical evidence had been presented. The court held that, in light of the history of the case, the notice given that the hearing dates were peremptory, and the absence of current medical evidence, it was well within the discretion of the tribunal to deny the adjournment.

Conclusion

Dr. Gill had ample notice of the hearing dates and was aware that they were set on a peremptory basis following two prior adjournments. The history of the case is lengthy and there is a strong public interest in hearing and deciding the allegations. The allegations include incompetence and have been outstanding for nearly two years. They arise in respect of care provided by Dr. Gill between 2011 and 2015. As well, 11 or 12 witnesses had been prepared and made arrangements to attend the hearing for, now, the third time. The Committee found that the public interest in proceeding was compelling and outweighed the potential seriousness of the consequences and prejudice to Dr. Gill.

The Committee ordered that the hearing commence at 9:00 am on April 2, 2019, in the absence of medical evidence or any other reason before it as to why Dr. Gill may be unable to attend, and that Dr. Gill be notified accordingly.

The hearing proceeded on April 2, 2019. The hearing did not proceed on April 3, 2019, as the College witnesses were not available. On April 4, 2019, the Committee heard about further communications between Dr. Gill and the College. The Committee's view that the hearing should proceed was not altered.

BACKGROUND

Dr. Gill is a family physician. The allegations relate to Dr. Gill's practice at two clinics in Mississauga from 2011 to 2015: These were Star Medical Centre, where he worked with Dr. P. Singh, the clinic owner, and Airport Medical Centre, which Dr. Gill owned.

In April 2014, the Ministry of Health and Long Term Care (MOHLTC) brought concerns about Dr. Gill's billing and medical records to the attention of the College. MOHLTC had identified that Dr. Gill had claimed a particular fee code, G014, payable for conducting a rapid strep test, much more often than his peers. MOHLTC had then reviewed some of the corresponding patient charts. A review of a sample of charts for which he had billed G014, rapid strep test, was done because of the frequency with which he billed this code.

The concerns arose from what was found at the chart review , in respect of both the assessment and treatment of patients and potentially medically unnecessary testing. In response, the College:

- obtained additional OHIP claims data and additional, more complete patient records;
- contacted some of Dr. Gill's patients (including one who had been an employee at the clinics);

- obtained information from Dr. Gill's colleague, Dr. Singh, and medical suppliers about purchases of rapid strep test kits; and
- retained an expert in family medicine, Dr. Eleanor Potter, who reviewed patient records and interviewed Dr. Gill.

As a result of its investigation, the College alleges that Dr. Gill failed to maintain the standard of practice of the profession in his care and record keeping, and is incompetent in his care of patients. The College further alleges that Dr. Gill engaged in disgraceful, dishonourable or unprofessional conduct by inappropriately billing OHIP for rapid strep tests.

ISSUES

The issues for the Committee were

1. Did Dr. Gill fail to maintain the standard of practice of the profession in his record keeping and/or in his care of patients?
2. Is Dr. Gill incompetent in his care of patients?
3. Did Dr. Gill engage in disgraceful, dishonourable or unprofessional conduct in that he billed OHIP inappropriately?

The College did not proceed with the allegation particularised in Schedule A to the Notice of Hearing that Dr. Gill had engaged in disgraceful, dishonourable or unprofessional conduct by misleading a College investigator and providing untruthful or inaccurate information during the College's investigation.

EVIDENCE

The Committee heard testimony called by the College from:

- Dr. Laura Anweiler, a medical advisor at MOHLTC, with responsibility for audit and adjudication of claims submitted by physicians for services rendered;
- Sandy Chapman and George Reed, College investigators;
- Dr. P. Singh, who owned the Star Medical Centre and worked with Dr. Gill there;
- Dr. Eleanor Potter, family physician, retained as a medical inspector by the College;
- Three patients of Dr. Gill: Witness A, Witness B, and Witness C; and
- Representatives of three companies who sold supplies to the clinics: Vasilios Sakellaropoulos, Clifton Coutinho, and Martin Cameron

As well, the Committee admitted 57 exhibits in evidence.

Dr. Laura Anweiler

The Committee heard testimony from Dr. Anweiler about how the matters in question first came to the attention of MOHLTC, the concerns that were conveyed to the College, and the OHIP claims data provided in response to College requests.

Dr. Anweiler testified about the general process of claims review at MOHLTC and the steps commonly taken to better understand a physician's practice and claims for services rendered, including review of patient records. MOHLTC maintains a database of claims paid to physicians in the usual and ordinary course of business. The data are captured at some reasonable point following submission and payment of the claims. This database was the source of the OHIP claims data provided to the College.

Dr. Anweiler identified a letter from MOHLTC to the Registrar of the College dated April 22, 2014 expressing concerns about Dr. Gill's records in respect of claims for the fee code G014 for doing rapid strep tests. MOHLTC's concerns were conveyed to Dr. Gill in a letter in May 2014. In brief, a review of Dr. Gill's billing had shown that he made a high number of G014 claims. MOHLTC reviewed the encounter notes for 17 patients for

dates on which Dr. Gill had billed for rapid strep tests. The documentation of symptoms and findings on examination was almost identical in the 17 notes and the patient's temperature was 98.7 degrees Fahrenheit in each instance. A rapid strep test was documented in every case, all results were negative; yet in patients with similar clinical pictures, some were prescribed antibiotics whereas others were not.

Dr. Anweiler described the steps by which MOHLTC had sought to obtain the patient records for the dates in question from Dr. Gill. She identified five letters sent to Dr. Gill at various addresses between June and October 2013. The patient records were ultimately obtained from Dr. Singh, owner of the Star Medical Centre and health information custodian of the records. Dr. Anweiler identified the patient records received from Dr. Singh which formed the basis for MOHLTC's concerns.

In August 2014, the College requested data on all claims paid to Dr. Gill for services between November 1, 2012 and August 1, 2014. Dr. Anweiler identified the cover letter of September 18, 2014 and the accompanying data sent to the College in response.

The College made further requests in September 2015 for data on all claims paid to Dr. Gill for services in the period January 1, 2011 to June 30, 2015, and for a peer comparison of the number of Dr. Gill's claims for G014 for fiscal years 2012 to 2015 in relation to all general/family practitioners who claimed that code. Dr. Anweiler identified cover letters dated September 28 and September 30, 2015 and the accompanying data which MOHLTC provided in response to the requests.

Sandy Chapman

Ms Chapman has been a College investigator since 2002 and was appointed as an investigator in the present matter in June 2014. Ms Chapman testified about steps taken in the investigation from its commencement in June 2014 until her responsibility was transferred to another investigator in August 2015.

Ms Chapman identified a letter to Dr. Gill dated June 6, 2014, notifying him of the investigation, and a response from his counsel at Lerner's, Anna Matas, in June 2014.

Ms Chapman identified the cover letter and accompanying data received from MOHLTC dated September 18, 2014 in response to the initial request for claims data.

Ms Chapman identified the 17 encounter notes provided to the College by MOHLTC. To broaden the investigation beyond the single service dates reviewed, in November 2014, Ms Chapman sought to obtain the complete medical records of the 17 patients for the period 2010 to present. The records were received in early December 2014 from the Star Medical Centre. They are referred to as patients 1 to 17.

Ms Chapman understood that Dr. Gill had moved his practice to the Airport Medical Centre by late 2014. She wrote in November 2014 to the Manager/Administrator to request eight records of patients of Dr. Gill. She testified that she did not receive a response from Dr. Gill, but in May 2015 she made a similar request to Josh Koziebrocki, Dr. Gill's counsel at Lerner's. Ms Chapman identified a cover letter and eight patient records from Airport Medical Centre, as well as Dr. Gill's "appointment schedule" for May 2013 to December 2014, that she received from Mr. Koziebrocki in June 2015. The eight patients are referred to as patients 18 to 25. The appointment schedule contained the times and dates of shifts Dr. Gill worked, but not a listing of patients he had seen.

In February 2015, the College retained Dr. Eleanor Potter as a medical inspector, providing her with the 17 patient records from Star Medical Centre and a physician questionnaire completed by Dr. Gill. Ms Chapman identified the Star Medical Centre appointment schedule for Dr. Gill for the period March 21, 2011 to April 30, 2013 received from Dr. Singh. She provided Dr. Gill's Star Medical Centre and Airport Medical Centre appointment schedules and the eight charts from the Airport Medical Centre to Dr. Potter at the end of June 2015.

In August 2015, Ms Chapman's role at the College changed and her responsibility for the investigation was transferred to George Reed.

George Reed

Mr. Reed has been a College investigator since 2009, with a focus on investigating billing and administrative matters for several years. He assumed responsibility for the investigation in the fall of 2015. Mr. Reed testified about further steps in the investigation, including obtaining and analyzing additional patient records and OHIP claims data and communication with patients of Dr. Gill and medical suppliers to the clinics.

Additional OHIP claims data

Mr. Reed sought additional OHIP claims data that would be more current and contain additional data elements. He identified the requests to MOHLTC on September 2, 2015 for data on Dr. Gill's claims for January 1, 2011 to June 30, 2015, as well as for a comparative analysis of the frequency with which Dr. Gill had claimed the fee code G014. He identified the cover letters and accompanying data provided by MOHLTC in response.

Purchase of rapid strep test kits

In early September 2015, Mr. Reed requested information from Mr. Koziembrocki relevant to whether Dr. Gill had in fact rendered the services he billed for (i.e., rapid strep tests). Dr. Gill's response, forwarded by Mr. Koziembrocki, states that he was responsible for the purchase of all medical supplies at Airport Medical Centre, that he was not responsible for purchasing supplies at Star Medical Centre but rather he would make requests of Dr. Singh, that he was not in possession of records relating to the purchase of rapid strep tests and that these records should be in the possession of Dr. Singh who arranged all supply purchases at the Star Medical Centre. The Airport Medical Centre appointment

logs and Electronic Medical Record (EMR) audit logs were forwarded to Dr. Potter as she had requested.

Mr. Reed sought clarification as to whether or not Dr. Gill was in possession of records relating to purchase of rapid strep test kits at Airport Medical Centre, and requested a list of all medical suppliers from whom Dr. Gill had purchased rapid strep test kits since 2013. Dr. Gill provided authorizations for three medical suppliers to release business records to the College at an interview with Dr. Potter on October 15, 2015. Mr. Reed contacted the three companies.

Additional medical records

In November 2015, Mr. Reed requested the complete records of 115 patients at the Airport Medical Centre for whom Dr. Gill had billed at least one assessment-based code on a single date, with the expectation that any patient with an assessment-based fee code would have been physically present in the clinic on that date. He received 114 charts from Mr. Koziembrocki shortly afterward. Five of the records, chosen essentially at random and identified as relating to patients 26 to 30, were provided to Dr. Potter to evaluate whether Dr. Gill had changed or otherwise improved his documentation since the start of the investigation.

Mr. Reed also attempted to obtain the complete records of 115 patients whom Dr. Gill had seen on a single service date at the Star Medical Centre. He attended the Star Medical Centre but only 35 charts were produced in the time available as the export function of the EMR proved to be slower than anticipated.

Information from patients of Dr. Gill

To obtain information from patients of Dr. Gill, Mr. Reed identified a sample of patients from among those for whom Dr. Gill had submitted a claim for G014. He sent introductory letters to 20 or 30 patients and ultimately interviewed four.

Mr. Reed identified the medical records and OHIP claims data for Witness A and her dependent child. The claims data show that Dr. Gill had been paid the G014 fee code 11 times for Witness A between June 2012 and January 2015, and 18 times for her daughter between February 2012 and November 2014.

Mr. Reed identified similar materials in respect of Witness B. Dr. Gill had been paid for 11 claims for G014 services to Witness B between June 2013 and July 2014.

Mr. Reed also interviewed Witness C, who was a colleague of Dr. Gill's during the period in question and, as well, a patient of his. A summary of OHIP claims showed that Dr. Gill made 20 G014 fee code claims related to Witness C between September 2011 and October 2013.

Analysis of OHIP claims data

Mr. Reed testified that he had been struck by redundancy of the information documented within patients' records and across the records from patient to patient and that he made efforts to quantify this. He also summarized the highly granular OHIP claims data and the ranking data provided by MOHLTC. He identified the results of his analyses in the brief entitled "Review of OHIP Data and Medical Records" that includes:

- A summary table that shows the number of times Dr. Gill billed specific fee codes by calendar year from 2011 to 2015. The data for 2015 represent a partial year. In total, Dr. Gill billed the fee code A007 (intermediate assessment) 45,594 times in this period. Intermediate assessment is the most commonly billed service in general/family practice. The fee code that Dr. Gill claimed next most frequently was G014, rapid strep test, which he billed on 26,568 occasions.
- A summary table that shows that Dr. Gill billed the fee code G014 for approximately 46% of the patients he saw in 2011, 75% in 2012 and 2013, 69% in 2014, and only 12% in 2015.
- Data that show that Dr. Gill received \$88,968 relating to fee code G014 claimed for services to patients at the Star Medical Centre (March 2011 to May 2013) and \$57,156 at Airport Medical Centre (June 2013 to March 2015), respectively.
- A table that lists the 25 patients who had the greatest number of claims for G014 by Dr. Gill during the 2011-2015 period, ranked by the number of claims. The patient with the greatest number had had 48 claims for rapid strep testing by Dr. Gill from 2011 to 2014. Dr. Gill made at least 31 claims for the G014 fee code for each of the 25 patients. In the case of one patient, Dr. Gill made claims for 20 rapid strep tests in a single year.

- A table and graphic representation of estimates of the number of patients Dr. Gill saw on a daily basis, derived from his claims for assessment-based fee codes (tab 7). In 2011, the estimated median daily number of patients was 46 and the highest number on any single day was 97 patients. From 2012 to 2015, the median ranged from 71.5 to 82.5 patients per day and the highest number in one day from 113 to 143 patients.
- A table and graphic representation of estimates of the number of Dr. Gill's claims for G014 per day, showing that the median number of claims per day in a given year ranged from 10 to 35 between 2011 and 2014. The highest number of claims in any one day of the year ranged from 36 to 89 over the same years. The median and highest number on any day were markedly lower in 2015.

Comparison of Dr. Gill's G014 fee code billing with that of other physicians

Using OHIP comparative data for billing of G014 by general/family physicians, Mr. Reed prepared a summary table. More than 93% of such physicians (5772 physicians) billed the G014 fee code 500 or fewer times in total during the years 2012 to 2015. Five physicians billed G014 more than 10,000 times. Dr. Gill was the sole physician who billed G014 more than 25,000 times, representing 0.02% of the physician population.

Analysis of text in patient records

In manually reviewing Dr. Gill's patient records, Mr. Reed observed that the same or very similar encounter notes appeared repeatedly in a patient's record and from one patient's record to another. He used optical character recognition to capture the text in the patient records for analysis, seeking to determine how frequently certain character strings appeared. In his view, the process might fail to accurately capture a specific character string if the image, i.e. patient record, is of poor quality, but if it did find a match for a specific string, particularly a complex one, then that would be a reliable finding.

Mr. Reed searched for appearances of the following character string in the 35 patient records he obtained in October 2015 from the Star Medical Centre:

“c/o cough and cold x3 days, Sore throat, fever, no vomiting [sic] or diarrhea
Objective 98.7 F. Throat – congested, Chest – clear, CVS/Abd. – WNL”

This precise character string appeared 320 times within 33 of the 35 patient records. In one patient’s record, the phrase appeared 29 times for visits between May 2011 and May 2015.

Mr. Reed did a comparable analysis for the character string “strep”, showing 370 instances in total, present within all 35 patient records. Likewise, “rapid strep neg” appeared in 355 instances and was also found within all patient records. Mr. Reed inferred that, by and large, the results of the rapid strep tests were negative.

Mr. Reed conducted a similar analysis of the 114 patient records he obtained from Airport Medical Centre for appearances of the 246-character string:

“Subjective c/o cough and cold x3 days, Sore throat, fever, no vomiting [sic] or diarrhea
Objective 98.7 F. Throat – congested, Chest – clear, CVS/Abd. – WNL,
Assessment URTI rapid strep neg
Plan Reassured, Symptomatic Rx, F/u in 3 days if not better”

This precise character string appeared 893 times within 111 of the 114 patient records evaluated. In one patient’s record, the phrase appeared 31 times for visits between 2012 and 2014.

The term “strep” appeared in the Airport Medical Centre charts in 1624 instances in total and was found in every one of the 114 patient records. The phrase “rapid strep neg” was found in 113 patient records in 1614 instances in total.

Mr. Reed had noted in his initial reading of the patient records that Dr. Gill had recorded a blood pressure of 130/80 in an “overwhelming” number of instances. Using the same optical character recognition process, he undertook to quantify the number of occurrences of specific blood pressure measurements, e.g. 130/80, and heart rate measurements in the 114 Airport Medical Centre patient records. Mr. Reed acknowledged that not all blood pressures and heart rates were captured for analysis. Approximately 50% of the blood pressures captured were 130/80 and 25% were 110/70. Approximately 92% of recorded heart rates were 76, 80 or 84 beats per minute.

Mr. Reed expressed his understanding that Dr. Gill was the primary physician and practising largely by himself at the Airport Medical Centre, with another primary care physician working there episodically and a specialist attending infrequently. The practice setting at the Star Medical Centre was less exclusive in that Dr. Gill worked with Dr. Singh. As a result, the patient records from Star Medical Centre may have contained entries from providers other than Dr. Gill.

Dr. Parvinder Singh

Dr. Singh has been a family physician in Ontario since 2003. He has owned the Star Medical Centre since 2009 and worked with Dr. Gill there from March 2011 to April 2013. The Committee heard testimony from Dr. Singh about his arrangements with Dr. Gill at Star Medical Centre and the number of rapid strep test kits purchased for the clinic, among other matters. Dr. Singh was familiar with rapid strep tests and would use them on occasion, in selected circumstances, primarily with walk-in patients.

Dr. Singh testified that the Star Medical Centre was a walk-in clinic and that he met Dr. Gill when Dr. Singh advertised for a physician to join him. He made the clinic available for an initial three months at no charge to Dr. Gill in order that Dr. Gill could begin to establish a family practice. Subsequently Dr. Gill was to pay Dr. Singh a flat monthly fee of \$5000 to cover rent, salaries, supplies, computer, electronic medical record software

and other expenses. Dr. Singh paid all clinic expenses. This arrangement was not written down. Dr. Singh had no knowledge of Dr. Gill's OHIP billings, and noted that the monthly fee Dr. Gill paid did not depend on his billings.

Dr. Singh testified that he purchased all of his medical supplies from Nu-Life Medical and Surgical Supplies and had separate accounts for Star Medical Centre and his other clinic, Castlemore Medical Centre. Initially Dr. Gill would let the staff know of any supplies he needed and they would let Dr. Singh know in turn. About six months later he authorized the staff and Dr. Gill to order supplies directly. Dr. Singh testified that he would encounter Dr. Gill at the clinic from time to time and they might talk for 10 or 15 minutes.

Dr. Singh testified that there was never an issue that supply costs at the clinic were too high. He denied that Dr. Gill had ever asked him to order more rapid strep test kits or that he had supplied thousands of kits to Dr. Gill. He denied ever seeing Dr. Gill do a rapid strep test or that Dr. Singh had ever trained the assistants at the clinic to do them. Dr. Singh stated that he may have seen one or two discarded rapid strep test kits in the garbage on any day when he came to the clinic after Dr. Gill had been working. He denied that there could have been 6,000 unused rapid strep test kits at the clinic when Dr. Gill left in April 2013, that Dr. Gill could have taken them with him, or that Dr. Gill was entitled to take them. Dr. Singh stated that he had told Dr. Gill not to take any medical supplies from the clinic when he moved because he (Dr. Singh) had paid for them. Further, he testified that he would have noticed Dr. Gill taking the kits.

With respect to the EMR in use at the clinic, AbelMed, Dr. Singh testified that he had briefed Dr. Gill about it when he started. He had offered to answer any questions that Dr. Gill might have had and did so over the next six months. He showed Dr. Gill the "help" section in the EMR and authorized him to call the AbelMed help line. The clinic used scanners to enter handwritten notes or other documents into the EMR. Dr. Singh showed Dr. Gill the pre-made templates that came with the EMR, templates that he (Dr.

Singh) had made, how Dr. Gill could make his own templates, and how to enter patient-specific information into the templates.

Dr. Singh identified the 17 patient records that he sent to the College in December 2014 (exhibit 23). He also identified a request from OHIP in March 2014 for records of the same patients and an email from Dr. Gill in early December 2014 requesting access to his records at Star Medical Centre. Dr. Singh testified that he was surprised by Dr. Gill's request because Dr. Gill had taken copies of all his patient records with him when he left. Dr. Singh noted that when patients move with a physician from one clinic location to another, they usually request that copies of their records be sent to the new location, but that he had not received a single request that this be done following Dr. Gill's departure.

Dr. Eleanor Potter

Dr. Potter is a family physician who trained in South Africa and trained and practiced in the UK. She began her practice in Pickering in 1997, providing comprehensive care on a fee-for-service basis with four colleagues. From 2008 to 2018, Dr. Potter was a member of a family health team, having been active in its establishment as associate lead physician of a family health organization. Dr. Potter is familiar with human resource and EMR issues arising in group practice settings. She has provided urgent care in the form of shared after-hours coverage for patients of her family health team. She has not worked in a walk-in practice but is familiar with such a practice from the experiences of her patients. Dr. Potter was a preceptor for residents in the family medicine training program at the University of Toronto until recently. She stated that the training of walk-in physicians and family physicians is the same.

The Committee accepted that Dr. Potter is qualified to provide expert evidence on the standard of practice and competency in family medicine in all settings. Dr. Potter expressed her understanding of the Acknowledgement of Expert's Duty that she had signed.

The College retained Dr. Potter in February 2015 to review Dr. Gill's practice and provide an independent opinion on: 1. whether Dr. Gill met the standard of practice in his care of patients; 2. whether his care displayed a lack of knowledge, skill or judgment; and 3. if Dr. Gill did not meet the standard of practice and/or displayed a lack of knowledge, skill, or judgment, did his practice, behaviour or conduct expose or were they likely to expose his patients to harm or injury?

Dr. Potter identified her reports, dated December 19, 2015 and March 6, 2019 which set out the materials she received from the College and upon which she relied in forming her opinion and preparing her reports. The materials included, among others:

- 17 patient records from Star Medical Centre received in December 2014 (exhibit 23), referred to as patients 1 to 17;
- 8 patient records from Airport Medical Centre received by the College in June 2015, referred to as patients 18 to 25;
- Transcripts of her (Dr. Potter's) interviews with Dr. Gill on September 2 and October 15, 2015;
- 5 patient records from Airport Medical Centre received by the College in November 2015, referred to as patients 26 to 30;
- Summary of OHIP claims for rapid strep testing (fee code G014) by Dr. Gill from November 2012 to August 2014
- College Policy Statement #4-12, Medical Records.

Dr. Potter testified at the outset that her overall opinion was that Dr. Gill had failed to meet the standard of practice in family medicine and that his care displayed a lack of knowledge, skill and judgment.

Significance of proper patient records for patient care

Dr. Potter described the importance of the patient record in general/family practice. The record documents what took place during patient encounters and incorporates test results, referral letters and consultant reports. Notes are most often structured in a way

that helps a physician organize their thoughts about the patient's issues and the encounter. There are also medico-legal, insurance and other purposes for the patient record. The patient record is integral to what physicians do and it is imperative that physicians keep good records.

Dr. Potter also spoke about the cumulative patient profile (CPP). The CPP serves to remind the physician of the patient's past medical history, current medical issues, family history, allergies, medications and tools to assist in screening and other forms of preventive care. The CPP, if kept up to date, provides a quick reference to key information during patient encounters and orientates the physician to the patient's situation overall. The CPP is also very helpful in settings where other physicians and providers are seeing the patient, i.e. sharing knowledge of the patient with a larger team. The medication list is an important component of the CPP and needs to be kept up to date with current medications.

Dr. Potter described templates in an EMR as standardized forms for particular conditions or situations, such as diabetes care. They contain relevant questions and prompts which assist the physician to be thorough in their evaluation. When well done and used appropriately, templates allow the physician to move effectively through the proper steps, and they can save time. In many EMRs, physicians can create their own templates for common conditions or scenarios they encounter. Dr. Potter emphasized the need for physicians to enter information into the template, describing what makes the patient and the encounter unique. In some instances, templates have default pre-filled answers to the standardized questions, in which case the physician must be sure to change the answers if they are not accurate for that specific patient or have not been assessed during that encounter.

Strep throat symptoms and the rapid strep test

Dr. Potter described strep throat as an infection with group A strep bacteria that results in pharyngitis and tonsillitis. It is commonest in patients aged 5 to 10 years. It typically

lasts 5 to 7 days but there can be complications such as ear infection, sinusitis, tonsillar abscess, rheumatic fever and glomerulonephritis (kidney inflammation). The last two, while serious, are nowadays very unusual.

Strep throat most typically presents with sore throat, fever, pus on the tonsils and swollen lymph nodes in the neck. Cough is typically absent. Physicians can use the presenting symptoms to calculate a clinical score (Centor score) to help in deciding how likely it is that a patient has strep throat. A point is given for swollen, tender lymph nodes, pus on the tonsils, fever, the absence of cough and age between 3 and 14 years. A point is subtracted from the score when the patient's age is more than 45 years. A score of 4 or more indicates the chance of strep throat being the cause of the patient's symptoms as 50%; a score of 1 means the chance is only 5-10%. Dr. Potter emphasized that the presence of a cough and the patient being an adult both reduced the likelihood that the patient had strep throat.

Making a judgment about the likelihood that a patient has strep throat is significant because if the likelihood is high, then the physician will probably prescribe antibiotics whereas, if the likelihood is low, they may well not.

Dr. Potter uses the rapid strep test in perhaps three patients during a three-hour urgent care clinic with 20 patients. The test is completed in the clinic and takes perhaps ten minutes in total. It requires a throat swab, mixing of reagent drops in a tube, and then watching a test strip for any colour change for as long as five minutes if there is no change, i.e., the test is negative. An alternative to the rapid strep test is to obtain a throat swab and send it to a laboratory for testing. This is much quicker for the physician but the result takes 3 to 4 days to become available.

Rapid strep tests in Dr. Gill's practice

Dr. Potter testified that almost every one of Dr. Gill's patient who presented with "cough and cold x 3 days" had a rapid strep test done and opined that this was excessive. She testified that Dr. Gill stated in his interview that he used the rapid strep tests to educate

patients, specifically that a negative test helps convince them that they do not need antibiotics. While she acknowledged that patients may want to receive antibiotics for minor complaints, Dr. Potter did not accept Dr. Gill's rationale for using rapid strep tests. In her view, the likelihood of the numerous patients with "cough and cold" presentations having strep throat was low and a rapid strep test was the wrong test to evaluate those patients. If a patient presented instead with a sore throat and absence of cough, then the likelihood that the cause was a strep infection might be higher, and a rapid strep test would have a place.

Dr. Potter noted that Dr. Gill appeared to have done more than 80 rapid strep tests on some clinic days and testified that Dr. Gill told her in their interview that he did 90% of them himself. Dr. Potter opined that the logistics of performing the tests made it impossible to complete this number in a day. She described the need for the physician to obtain a history, do a throat swab, open the kit and complete the test as outlined above. The colour change that indicates a positive result may occur in less than five minutes, but the test strip must be watched for or checked at five minutes to ensure that a result is negative. She estimated that completing a negative rapid strep test would take at least seven minutes. Dr. Potter observed no positive rapid strep test results in the records she reviewed.

Hypertension and the measurement of blood pressure, heart rate and temperature

Dr. Potter described how blood pressure is measured and how a diagnosis of hypertension (high blood pressure) is made. When a patient is in the physician's office or clinic, it is usual to take multiple measurements of blood pressure, sometimes as many as four, as their initial reading may be unreliably high because of anxiety or rushing to their appointment. This is more easily done with an automatic, electronic blood pressure device compared to the traditional method of taking blood pressure using a stethoscope. A blood pressure reading of 140/90 or less when done in the office, or 135/90 or less when taken at home, is normal. The target blood pressure in a patient with diabetes is 130/90 or less.

Dr. Potter testified that in general, a given patient's blood pressure readings vary quite a lot from visit to visit, and typically vary when measured repeatedly during a visit. Further, there is a great deal of variation from one patient to the next. Blood pressure is measured in single digit increments, not in intervals of five.

The first time a patient has a high blood pressure reading, the usual approach is to obtain additional measurements over time when the patient is comfortable and not stressed. Medications are not usually started immediately unless the blood pressure is very high. The diagnosis of hypertension, once made, usually means that the patient will be on medication permanently, so it is important to be certain of the diagnosis.

When a patient with hypertension is found to have a high reading, i.e., their blood pressure is not well controlled, the physician is expected to review relevant lifestyle factors, stress, and current medications, and consider alternative or additional blood pressure medications.

Dr. Potter testified that measuring a patient's temperature is not routine and specifically not routine in a visit for hypertension. Temperature should be measured when it is relevant to the patient's presentation. Accordingly, it is relatively common to measure temperature in children but not in adults unless pneumonia or other infection were suspected.

Blood pressure measurements documented in Dr. Gill's patient records

Dr. Potter observed that a blood pressure of 130/80 was recorded in many patient charts, even when the patient was being seen for hypertension. She described these values as "completely unreliable" and opined that it is unrealistic to think that all of these patients have the same, normal blood pressure. Dr. Potter testified that when she asked about this in their interview, Dr. Gill stated that his usual practice was to write notes that he would later use to adjust the information in the encounter note templates, and that he

had not got around to entering the measurements for the 25 patient records Dr. Potter reviewed initially.

Overall concerns with Dr. Gill's records

In both her testimony and written reports, Dr. Potter expressed serious concerns about the quality of the documentation in Dr. Gill's patient records, from both the Star and Airport Medical Centres.

In Dr. Potter's opinion:

- the vast majority of encounter notes were in the form of templates, identical from encounter to encounter and patient to patient. Original information, unique to a patient, was rarely entered, in particular:
 - recorded blood pressures, heart rates and temperatures were almost always identical;
 - the frequency with which Dr. Gill recorded "cough and cold x 3 days" among his patients overall and with individual patients defied belief: Dr. Gill saw patient 1, for example, for 27 such visits in 16 months and on each occasion noted "cough and cold x 3 days";
 - the encounter notes provided no support for the rapid strep tests that were documented in a high proportion of patients with "cough and cold x 3 days".
- when there was mention of a serious condition in a consultant's letter, for example, there was minimal reference to the condition in Dr. Gill's notes, or indication that Dr. Gill was aware of the information;
- the unreliable record of blood pressure and the absence of regular documentation of important clinical and lab parameters contributed to Dr. Gill's failure to meet the standard of practice in respect of diabetes and hypertension;
- Dr. Potter found no CPPs with the initial 25 charts from the Star and Airport Medical Centres. She stated that Dr. Gill told her in their interview that he used

CPPs, yet in the 5 patient records sent to her following the interview, she found only empty CPP templates, that is, blank forms with no patient information entered into them.

Dr. Potter testified that, in her opinion, Dr. Gill's record keeping fell below the standard of practice and exposed his patients to the risk of harm or injury. She described the deficiencies in his records as severe and deserving of a score of "10 percent". With patients presenting so frequently with the same apparent complaints and the same information recorded for so many visits, she concluded that the records were unreliable and untrustworthy. There was no indication in his encounter notes that Dr. Gill was aware of the patient's status in terms of chronic conditions, test results or consultant reports, nor was there any indication as to what his thought process might have been. Further, the absence of credible notes would adversely affect his care of patients. Dr. Gill would have no basis for knowing whether to modify treatment for, say, high blood pressure, at an encounter as he would have no reliable record of previous blood pressure measurements. In addition, with wholly inadequate records, there is the risk that genuine, serious conditions would be neglected or forgotten, as appeared to be the case in at least one patient with diabetes.

Dr. Potter's opinion of individual patient records

Dr. Potter testified that she reviewed each patient record in detail and, in her opinion, none of the 30 records met the standard of practice. In her written report, she provided a clinical summary for each patient record and an analysis of whether Dr. Gill's care met the standard of practice, whether his care displayed a lack of knowledge, skill or judgment, and whether his practice, behaviour or conduct exposed or was likely to have exposed his patient to harm or injury. Her written analysis is set out separately for patients 1 to 7. For the remaining patients, Dr. Potter grouped the analyses together as there were consistent themes.

In her testimony, Dr. Potter referred to the records for patients 1, 3, 5, 6 and 15:

Patient 1

- Dr. Gill saw this male patient aged in his mid-60s on 57 occasions between January 2012 and April 2013. Twenty-seven visits were documented as for “cough and cold x 3 days”, hypertension 10 times with a blood pressure of 130/80, “dyspepsia” eight times, and “feeling tired with leg pains on and off for six weeks” four times, among other presentations.
- No clear reason was given for almost weekly visits.
- For each instance of a given presentation, an identical or nearly identical note was recorded.
- Rapid strep test was documented on 16 occasions between August 2012 and March 2013.
- Dr. Gill saw the patient on January 30, 2012 for dyspepsia and made a diagnosis of gastroesophageal reflux. The medication history report, but not the encounter note, shows that Prevacid, a proton pump inhibitor, was prescribed. Dr. Potter testified that the symptoms of heart disease overlap with dyspepsia and that the presentation of dyspepsia in a patient with hypertension would raise concern, at least in retrospect, about the possibility of heart disease as the cause.
- Dr. Gill saw the patient again for hypertension on February 6, 2012. Much of the note is identical to the January 24, 2012 note. Dr. Gill did an ECG although one was also done or ordered on January 24 and February 3, 2012. The “assessment” section of the note mentions chest pain without any elaboration. Much more information is required according to Dr. Potter. Echocardiogram and Holter monitor testing were to be done for “chest pain, syncope, palpitation, SOB, HTN.” It is unclear what Dr. Gill’s thoughts were and whether he felt that the patient’s dyspepsia and/or chest pain might in fact represent angina.

- On June 4, 2012, Dr. Gill documented an annual health exam. An annual health exam was also recorded on February 3, 2012 with an identical note. There is no reason to repeat such an assessment.
- Lab results from June 6, 2012 show a HbA1c level 0.063 mmol/mol, indicating pre-diabetes. Dr. Potter would have expected this result to be noted somewhere by Dr. Gill but there is no indication that Dr. Gill was aware of it.
- The patient had a coronary angiogram on June 8, 2012 that showed new coronary artery narrowing and noted the patient's history of coronary artery disease including multiple previous coronary angioplasties and stent placements. Dr. Gill saw him on June 14, 2012. There is no mention of the coronary angiogram result in his note, only the same "tired with leg pains, off and on x 6 weeks" template. Dr. Gill should have been concerned that the patient's fatigue was a result of diminished heart function. He prescribed a stool softener.
- The patient underwent quadruple coronary bypass surgery on July 23, 2012. Dr. Potter described being "shocked" when she saw this report given the lack of relevant information elsewhere in the record.
- The hospital discharge summary on July 29, 2010 notes the patient's history of myocardial infarction in 2010. Dr. Potter would have expected this information in the patient's CPP. The information is relevant to the patient's presentations with "dyspepsia" and to his pre-diabetes, as diabetes is a risk factor for accelerated atherosclerosis and heart disease, and thus there would be value in steps that might prevent the pre-diabetes from becoming diabetes proper. There is no indication that the medications prescribed at discharge from hospital were updated in Dr. Gill's patient record.
- Dr. Gill's note on August 4, 2012 records that the patient had had cardiac surgery on July 23, 2012 and, as part of his assessment records: "cardiologist referral urgent for postsurgery followup." This phrase appears, without elaboration, in seven further encounter notes up until

October 9, 2012. The patient was prescribed an antibiotic (amoxicillin) with no indication recorded or information to support the decision.

- On August 20, 2012, the patient presented with “cough and cold x 3 days”. The note states “fever” but the recorded temperature is 98.7 degrees Fahrenheit. This temperature is not a fever. A rapid strep test was done but was not warranted, as was typical of many other visits. Dr. Potter opined that given the number of such presentations by this patient, it would be important to conduct a thorough evaluation, including detailed history and examination, to address why the symptoms were recurring or persisting. There is no indication that this was considered or done.
- On August 28, 2012, the patient was seen for hypertension. Recorded blood pressure was again 130/80. In the assessment section is “hypotension from patch” but 130/80 is normal. Dr. Potter presumed that the “patch” was a nitroglycerine patch as prescribed on discharge from hospital, which can lower blood pressure. There is no indication that Dr. Gill evaluated the question of hypotension further or considered discussing the patient’s medication with his cardiologist.
- Bloodwork on August 29, 2012 shows a fasting blood sugar of 6.9, indicating diabetes, and HbA1c 0.064, just below the 0.065 at which diabetes would be diagnosed. Dr. Potter would have discussed starting diabetes medication (metformin) with the patient and referred the patient for diet and exercise counselling. There is no indication that Dr. Gill was aware of these results.
- Dr. Gill saw the patient on October 13, 2012 for “cough and cold x 3 days”. The note was almost identical to that of September 29, 2012 with the addition of “d/ced patch and betablockers, altace changed to pm”. It is not clear whether these changes were made at this visit or previously. Input from the patient’s cardiologist about this decision would be important before proceeding with these changes, but there was no indication that this had been done.

- Bloodwork on November 15, 2012 shows HbA1c at 0.068, i.e. in the frankly diabetic range. There is nothing in the record to suggest that Dr. Gill was aware of these results or took any relevant steps.
- The patient is recorded as presenting with “cough and cold x 3 days” on November 22, November 29, December 2, December 3, December 15, and December 22, 2012, and January 5 and January 7, 2013, in consecutive visits to Dr. Gill. The notes are identical for four of the visits and there are minor additions to the basic template in the others. The medication history report, but not the encounter note, shows that Dr. Gill prescribed an antibiotic (amoxicillin) on November 29, 2012. Dr. Potter would not have expected such a prescription in these circumstances. On December 2, 2012, Dr. Gill prescribed another antibiotic (Biaxin). His note for that day is identical to those for November 29 and November 22, 2012 and offers no rationale for this prescription. The assessment or diagnosis for the December 3 and December 15 visits is “HTN” (hypertension) yet the presentation is “cough and cold x 3 days” on both days, the notes are identical and say nothing else about hypertension.
- The note for the visit of January 5, 2013 records “letter for flight unable to fly Jan 8th 2013 indefinitely.” There is nothing in the note to help understand this letter or why domperidone (to help stomach emptying) was prescribed. The letter is in the patient record and is a medical certificate for trip cancellation insurance. The diagnosis listed as resulting in the claim is “cardiac post-surgery”. The date symptoms first appeared, the date of first medical consultation, the date investigative testing began and the date the condition was diagnosed are all documented as January 5, 2012. Dr. Potter noted that the cardiac surgery occurred in July 2012 and that she would have expected that the patient was continued on Altace, yet it was not listed as a medication on the certificate.
- The patient returned on January 7, 2013 with “cough and cold x 3 days”. The note is identical to that on a number of prior visits. There is no mention of cardiac surgery or related investigations or problems.

- The patient saw Dr. Gill on January 26, 2013 with “cough and cold x 3 days.” The note is almost identical to that of January 7, 2013 and other dates and offers no support for the diagnosis of sinusitis that is recorded. The medication history report shows that Dr. Gill prescribe antibiotic eardrops (Garamycin). This would not be expected for a diagnosis of sinusitis.
- The patient record contains a consultation letter from a cardiologist, dated January 31, 2013. The cardiologist describes the patient’s chest pain, which the cardiologist thinks is likely related to anxiety. He records that the patient has no history of diabetes or hypertension but does have dyslipidemia (e.g. elevated cholesterol). He notes that the patient ran out of Altace some time previously and did not have it renewed. The cardiologist re-prescribed it and asked that Dr. Gill titrate the dose upwards according to the patient’s blood pressure. He mentioned further that the patient’s statin (Lipitor) dose would need to be adjusted periodically depending on the blood lipid levels. Dr. Potter opined that there was no documentation in the patient record to that point or in the next several visits to suggest that Dr. Gill was aware of the patient’s dyslipidemia or diabetes or the recommendation that he be taking a statin as was prescribed when he was discharged after coronary bypass surgery.
- Dr. Potter opined that Dr. Gill failed to maintain the standard of practice and displayed a lack of knowledge, skill and judgment in his care of patient 1. With a failure to notice and treat the patient’s diabetes, he exposed the patient to the risks of worsened heart disease and complications such as stroke, neuropathy (nerve damage), retinopathy (retinal damage), and kidney disease. The absence of reliable records was especially concerning to Dr. Potter in respect of the period following the patient’s coronary bypass surgery when the patient could have been having serious problems that were not recognized.

Patient 3

- This male patient of about 60 years of age was enrolled with another physician but saw Dr. Gill on seven occasions between March 2011 and March 2013. Dr. Potter noted that the fact a patient is enrolled with another physician does not relieve the physician of the obligation to follow up on test results that they order or see.
- Blood tests ordered by Dr. Gill were done May 30, 2011 and show a fasting blood sugar of 7 mmol/L and HbA1c 0.075, indicating that the patient had overt diabetes. Dr. Gill saw the patient next on September 19, 2011. The diagnosis of diabetes is acknowledged. The recorded plan includes “continue same meds”, yet the medication history report shows no prescribed medications. The plan also includes “advised re diet, exercise and diet, maintain healthier body weight.” There is no record of the patient’s weight in the patient record. Monitoring weight is important because weight and diabetes are strongly associated.
- Dr. Gill obtained bloodwork again on March 20, 2013, showing a fasting blood sugar 7.8 and HbA1c increased to 0.088. Dr. Potter opined that these results demonstrate that the patient’s diabetes was not adequately controlled and his diabetes not adequately monitored between May 2011 and March 2013. Monitoring blood results every three months is the expected standard in diabetic patients, and perhaps more often in the early period following diagnosis. On March 30, 2013, Dr. Gill prescribed metformin, an appropriate drug, at a low but perhaps reasonable dose. Dr. Potter expected that metformin would have been prescribed when the diagnosis of diabetes was first made in 2011 or soon after a trial of diet and exercise for three months was unsuccessful in controlling the patient’s diabetes. The patient’s lipid levels were elevated and diabetes guidelines would have supported the prescribing of a statin, yet none was prescribed.
- Dr. Potter does not give credence to the recorded blood pressure of 130/80 and concludes that the record contains no reliable record of blood

pressure. Diabetic patients often have hypertension, and hypertension is an additional risk factor for atherosclerosis and cardiovascular disease.

- In Dr. Potter's opinion, Dr. Gill's record keeping and care of this patient failed to meet the standard of practice, displayed a lack of knowledge, skills or judgment and exposed the patient to the risks of inadequately managed diabetes.

Patient 5

- Dr. Gill saw this diabetic male patient who is around 60 years of age at 19 visits between July 2011 and April 2013
- There are blood test results for diabetes on only two occasions, July 2011 and December 2012. The results demonstrate poor control of the patient's diabetes and represent wholly inadequate monitoring of his condition.
- The patient had been prescribed Diamicron at the maximum dose but this was not adequate to control his diabetes. Dr. Gill prescribed metformin on August 8, 2011 at a relatively low but reasonable dose, one that would require monitoring with a view to being increased in one month. Metformin was prescribed for one month only.
- The patient returned on August 22, 2011. There is no mention of diabetes in the encounter note, but "sleeping aids" is recorded in the assessment section with no other information.
- Dr. Gill saw the patient on September 19, 2011. The patient would have run out of metformin by this time, but Dr. Gill renewed only the Diamicron prescription and medications for hypertension and lipids.
- Dr. Gill saw the patient on October 25, 2011 for "cough and cold x 3 days." There is no mention of diabetes, hypertension or dyslipidemia or any medication in the encounter note. The medication history report shows that Dr. Gill prescribed amitryptiline on that day, presumably for sleep difficulties, Flovent, which would presumably be for asthma, and Zithromax, an antibiotic. Dr. Potter concluded that the Flovent and

Zithromax would have been prescribed for a wheezy cough. A rapid strep test was done, with no clinical indication.

- The encounter note for November 14, 2011, as in prior notes, lacks any of the expected three-monthly monitoring of the patient's diabetes with blood work, weight, and meaningful blood pressure measurements, to ensure that the diabetes is coming under appropriate control. Self blood glucose monitoring is recorded: "SBGM – 6 to 8, no new concerns", text that appears identically in several other encounter notes and that Dr. Potter found inconsistent with the patient's bloodwork.
- Dr. Gill prescribed Pennsaid drops, a topical anti-inflammatory medication, for mechanical backache on January 14, 2012. Dr. Potter described Pennsaid as little used now with inexpensive over-the-counter alternatives readily available.
- Dr. Gill saw the patient for painful urination (as well as cough and cold x 3 days) on September 16, 2012. Urinalysis was positive and his diagnosis was urinary tract infection. The plan was reassurance and symptomatic treatment, with no mention of medication. Dr. Potter opined that she would have prescribed an antibiotic but Dr. Gill did not do so. The medication history report shows that Dr. Gill prescribed Lamisil cream, an antifungal agent, and Betaderm cream, a corticosteroid. In Dr. Potter's view, the question of a fungal or yeast infection in a diabetic patient should immediately have raised concern about uncontrolled diabetes, yet there is no sign that Dr. Gill considered this.
- On November 3, 2012, the patient saw Dr. Gill again. The encounter note is solely the "cough and cold x 3 days" and "rapid strep neg" template seen in many other notes. The medication history report shows that Dr. Gill prescribed Lamisil cream again and Lyderm cream, another corticosteroid. These bear no relation to the content of the note.
- Dr. Gill prescribed amoxicillin at the patient's November 26, 2012 visit according to the medication history report. There is no suggestion in the encounter note as to why or even that the prescription was written.

- Dr. Gill obtained bloodwork on December 1, 2012 showing that the patient's diabetes was not controlled: fasting blood sugar 8.4 and HbA1c 0.08. Dr. Gill saw the patient on March 25, 2013. The encounter note for that date is the "cough and cold x 3 days" and "rapid strep neg" template, with no indication that Dr. Gill was aware of or had turned his attention to the December bloodwork at any point.
- Dr. Gill saw the patient again on April 7, 2013. The medication history report shows that he prescribed three medications for diabetes: metformin, Januvia and Diamicon. Dr. Potter characterized the combination as not unreasonable but the dose of metformin inadequate.
- Dr. Potter opined that Dr. Gill had failed to meet the standard of practice in his care of this patient, displayed a lack of knowledge, skill and judgment, and exposed the patient to the risks of uncontrolled diabetes. She references in particular Dr. Gill's lack of knowledge of the management of diabetes, the recording of inaccurate information in the patient chart, and the inadequate documentation of original information about the patient's problems and his own thought processes.

Patient 6

- Dr. Gill saw this female patient of around 60 years of age on 27 occasions between June 2011 and April 2013.
- Thirteen visits were for "cough and cold x 3 days" with identical or nearly identical encounter notes.
- Seven visits were identified as for hypertension. The patient was on no medication for hypertension. In six of the encounter notes, the blood pressure is recorded as 130/80 and in one note, on July 13, 2011, 140/85. In Dr. Potter's view, the blood pressures were unreliable and, should the patient in fact have had inadequately controlled hypertension, then she would have been exposed to an increased risk of complications such as heart disease, stroke, kidney disease and peripheral vascular disease.

- In the record of the patient's annual physical examination done by Dr. Singh on September 19, 2012, the blood pressure is recorded as 100/85. Dr. Gill saw the patient on December 16, 2012 for "cough and cold x 3 days" and painful and frequent urination for 3 days. There is no blood pressure recorded or mention of hypertension at that visit or at earlier visits to Dr. Gill on October 11, 19, 22, and 26 or November 17, 2012. The medication history report shows that Dr. Gill prescribed Atacand (anti-hypertensive medication) for the first time, as well as Tylenol #3. There is no rationale given for prescribing an anti-hypertensive medication, particularly when the patient's blood pressure is somewhat low. There is no reason given for prescribing a narcotic, Tylenol #3, nor is there any discussion of why an antibiotic was not prescribed for the documented diagnosis of urinary tract infection.
- Dr. Potter opined that Dr. Gill's record keeping and care of this patient failed to meet the standard of practice. She concludes that the information in the patient record is unreliable and untrustworthy and provides no indication of what Dr. Gill was thinking about the patient's problems and whether he had noticed test results or not. She expressed concern that serious conditions were likely being ignored, mismanaged and/or forgotten about.

Patient 15

- Dr. Gill saw this male in his mid-50s at eight visits between April 2011 and March 2013.
- Dr. Gill recorded patient-specific information in his encounter note for the visit of March 26, 2011 when the patient presented with upper extremity weakness.
- At the visit of April 5, 2011, Dr. Gill prescribed meloxicam, an anti-inflammatory medication, apparently for medial epicondylitis (tennis elbow) and hand sprain.

- Dr. Gill saw the patient on May 7, 2011 for dyspepsia. The medication history report shows that he prescribed Prevacid, a proton pump inhibitor. There is no indication that Dr. Gill considered the possibility that meloxicam might have contributed to the patient's symptoms, or re-assessed the problem for which it was prescribed. Zithromax was prescribed with no reason or supporting information in the encounter note. Dr. Gill recorded diabetes in the patient's past medical history, yet bloodwork he ordered on March 30 and again April 16, 2011 shows that blood glucose and HbA1c are normal, i.e., the patient does not have diabetes.
- The patient saw Dr. Gill on February 18 and 23 and March 26, 2013 for "cough and cold x 3 days". Rapid strep test was negative on each occasion. There is no information from which to judge whether the patient has a chronic condition underlying these presentations or whether this was considered.
- Dr. Gill records that the patient has hypertension in his encounter notes for April 6, May 7, and June 16, 2012. There is nothing else in the record to support the diagnosis of hypertension, as the only blood pressure recorded anywhere is 130/80 and there is no record of anti-hypertensive medication.
- Dr. Potter opined that Dr. Gill's care of this patient failed to meet the standard of practice and displayed a lack of knowledge, skill and judgment

Dr. Potter identified hypertension, diabetes, dyslipidemias, and sore throats as extremely common conditions that a family physician is called upon to manage. She described Dr. Gill's deficiencies in his care and treatment of patients as egregious and very severe. She would absolutely not accept, and indeed would be horrified if one of her family medicine trainees provided such care and treatment. .

Further, Dr. Potter opined that Dr. Gill's record keeping deficiencies are severe and put patients at risk. She described such poor notes that, particularly in a busy practice, it is

not surprising that Dr. Gill would not remember a diagnosis or the specifics of a previous encounter and thus compromise his care.

The Committee heard testimony from three patients of Dr. Gill at the Star and Airport Medical Centres, particularly about whether they had had rapid strep tests done.

Witness B

Witness B has been a patient of Dr. Gill for some years. She has not made a complaint about Dr. Gill and was contacted by the College in respect of the investigation of this matter.

When asked if she had ever had a swab for possible throat infection, Witness B responded that she may have had one once, and certainly not more than twice. She was unsure whether the swab or swabs had been sent away to a lab or she had gotten the results during the visit.

Witness B delivered a baby by caesarean section on November 24, 2013 at Credit Valley Hospital and was discharged on November 26 or 27, 2013. Witness B recalled seeing Dr. Gill in his office perhaps a week after delivery, possibly on November 28, 2013. She was quite clear that the purpose of the visit was for her baby to be checked and certain that she had not had a throat swab on that day. The OHIP billing record indicated that Dr. Gill claimed G014 on November 28, 2013. for this patient. The chart entry for this patient for November 28, 2013 includes “rapid strep neg”.

College counsel drew Witness B's attention to a copy of her patient record from the Airport Medical Centre that showed that she had seen Dr. Gill for cough and cold on March 28 and April 2 and 8, 2013. She testified that this was not correct information, that she had not had a sore throat at that time in her pregnancy. She experienced vomiting throughout her pregnancy.

Witness B was then shown a series of encounter notes from July 2013 to May 2014, which recorded a total of 11 rapid strep tests, all negative. Witness B denied the possibility that these had been done.

Witness C

Witness C was employed at both Star and Airport Medical Centres. She was also a patient of Dr. Gill during that time. She had made no complaint about Dr. Gill and did not know what the issues were when a College investigator contacted her.

Witness C testified that she worked with Dr. Gill at Star Medical Centre and at Airport Medical Centre. At the Star Medical Centre, Dr. Gill worked evenings starting at 3 pm. Dr. Singh worked from 9 am to 3 pm. Witness C had a good working relationship with Dr. Gill.

Witness C's duties at the Star Medical Centre did not include ordering supplies. Her duties at the Airport Medical Centre included ordering supplies and doing billing for visits at which the patient did not see the physician, e.g. for bloodwork or an injection. Witness C described Dr. Gill's practice as very busy, particularly at the Airport Medical Centre where she estimated he saw perhaps 100 patients and sometimes 150 patients in a day. Dr. Gill worked similar hours to Witness C, and also 9 am to 3 pm on Sundays when there would be another staff member there.

Witness C testified that Dr. Gill was always "really behind" in his billing, sometimes as much as three or four months. She could tell this because patients' charts would change colour in the EMR when the billing was finished. Witness C helped with his billing only once, for a week or so before he moved from the Star Medical Centre to the Airport Medical Centre. She billed using the encounter notes in the EMR. Witness C never saw any handwritten notes from patient encounters.

Witness C testified that Dr. Gill would do throat swabs and send them to the lab. She stated she was familiar with the supply room at both the Star and Airport clinics. She did not order any "starter" supplies when they moved to the Airport clinic, but Dr. Gill did. She did not know who was the supplier.

Witness C was familiar with rapid strep tests from working previously at another clinic. She testified that she never saw Dr. Gill do a rapid strep test at either the Star or the Airport Medical Centre, that no rapid strep test kits were stored at either clinic, and that she never saw packaging or material from rapid strep tests at either clinic.

Witness C did not remember Dr. Gill ever having done a throat swab on her. Shown a document summarizing Dr. Gill's OHIP claims for services rendered to her, Witness C agreed that the service dates matched her recollection of the period when she had worked for Dr. Gill. The claims for 20 rapid strep tests, however, did not fit with her recollection, and she testified that she had never had a rapid strep test done at the clinic.

Witness A

Witness A is a registered practical nurse. She was a patient of Dr. Gill at the Airport Medical Centre but stopped seeing him around 2014 because the clinic was very busy. She stated that she had nothing against Dr. Gill and had not contacted the College.

Witness A testified that she had been seeing Dr. Gill about diabetes and medication, and that she did not usually go to a doctor for cough and cold treatment. She did not know what a rapid strep test was until it was explained to her by a College investigator.

Witness A denied that Dr. Gill had ever done a rapid strep test on her. Further, when referred to a copy of Dr. Gill's encounter notes, she testified that she did not see Dr. Gill for three visits in five days in June 2012, for a sore throat, and further that she never had the three rapid strep tests documented in the notes. Likewise, Witness A described the encounter notes for two dates in April and one in June 2013, each for "cough and cold x 3 days" and "rapid strep neg", as not accurate and reiterated that she had never had that test done. Witness A did recall having given a urine sample at the clinic in the past and that it was sent out for analysis. She also recalled occasions when she had

blood drawn for testing, but this was always at LifeLabs, and identified its location, which had changed when one site closed.

College counsel showed Witness A copy of Dr. Gill's patient record and OHIP billings for her daughter. Witness A acknowledged that she accompanied her daughter on some visits and her husband did so on others, but firmly denied that her daughter had had any of the 18 rapid strep tests that Dr. Gill recorded doing.

The Committee heard testimony from representatives of three companies identified as suppliers to the Star and Airport Medical Centres.

Medical Supply Companies

George Reed testified that he has asked Dr. Gill's counsel to provide an exhaustive list of all medical supplies companies where purchases for rapid strep tests may have been made by Dr. Gill. Dr. Gill then brought consent forms to his interview with Dr. Potter, identifying three places that had supplied rapid stress tests: (1) Universal Data Supplied; (2) Nu-Life Medical; and (3) Cardinal Health.

(i) Vasilios Sakellaropoulos

Mr. Sakellaropoulos is co-owner of Universal Data Supplies. He testified that they wholesale and retail technical and office supplies and have sold technical and office products to Dr. Gill. They do not sell medical supplies. In particular, they do not sell rapid strep test kits.

(ii) Clifton Coutinho

Mr. Coutinho is a sales consultant with Nu-Life Medical. The company sells medical equipment and medical supplies. He identified Dr. Singh as a longstanding client. Dr. Gill has not been a client.

Mr. Coutinho testified that Dr. Singh had purchased eight or nine boxes of rapid strep test kits, with 25 tests per box, probably in 2012. This would represent 200 or 225 rapid strep tests in total. He believed that there had not been any other purchases between 2011 and 2013.

(iii) Martin Cameron

Mr. Cameron is an employee of Cardinal Health, a medical supplier. He sells to physicians' offices, dealers and home health stores. Cardinal Health purchased FutureMed a number of years ago, possibly 2012.

Dr. Gill was a customer of Mr. Cameron when he (Dr. Gill) was at Airport Medical Centre around 2013. In response to a College request, Mr. Cameron searched his company's sales records and printed out the information requested. Mr. Cameron identified an invoice for three boxes of rapid strep test kits sold to the Airport Medical Centre dated August 21, 2015. He also identified a sales report showing that Dr. Gill purchased three boxes of 25 rapid strep test kits in the current fiscal year, as of April 30, 2016. Mr. Cameron indicated that the fiscal year ran from July to June. Thus, the invoice in August 2015 corresponded to the sales report for the fiscal year from July 2015 to June 2016. Mr. Cameron could find no record of purchases in 2013, 2014 or other years. He acknowledged that these years may have been a period of transition following the purchase of FutureMed, but expressed reasonable confidence that he would have identified any other sales that had taken place.

FINDINGS AND ANALYSIS

For the reasons set out below, the Committee finds, that Dr. Gill committed acts of professional misconduct, in that he:

- failed to maintain the standard of practice of the profession; and
- engaged in conduct or an act or omission relevant to the practice of medicine that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

In addition, the Committee finds that Dr. Gill is incompetent in family medicine.

Legal Issues

Proceeding in Dr. Gill's absence.

The Committee ordered the hearing to proceed after considering whether to adjourn in light of Dr. Gill's absence, and having heard evidence on communications between Dr. Gill and College counsel. Section 6 of the *Statutory Powers Procedure Act* (the "SPPA") states that parties must be given reasonable notice of the hearing and sets out the required elements of that notice, including a statement that if the party does not attend at the hearing, the tribunal may proceed in the party's absence and the party will not be entitled to any further notice in the proceeding. Subsection 7(1) provides that where a party has been given proper notice of an oral hearing and the party does not attend at the hearing, the tribunal may proceed in the absence of the party and the party is not entitled to any further notice of the proceeding.

There is ample evidence that Dr. Gill was provided reasonable and proper notice of the hearing that met the relevant statutory requirements. The Committee heard no medical evidence or other reason why Dr. Gill did not attend. The Committee determined that, on balance, the public interest weighed in favour of proceeding with the hearing in Dr.

Gill's absence. The public interest in deciding these very serious and long outstanding allegations against Dr. Gill outweighed any prejudice to him from proceeding in his absence given the history of this matter and the fact that Dr. Gill did not, at the time, provide any reasonable explanation for his non-attendance.

Burden of proof

The Committee recognizes that the burden is on the College to prove the allegations. Non-attendance by Dr. Gill and/or his counsel does not relieve the College of this burden. The standard of proof is on the balance of probabilities, based on evidence in the hearing which is clear, cogent, and convincing. There is no onus on Dr. Gill to disprove the allegations.

Credibility and reliability

The Committee recognizes the importance of assessing credibility and reliability and that they are different (*R. v HC*, 2009 ONCA 56 (CanLII), para 41). Credibility refers to the witness's sincerity and willingness to speak the truth as he or she believes the truth to be. Reliability relates to the witness's ability to accurately observe, recall and recount the events at issue. An honest witness can still be mistaken and, consequently, his or her evidence while sincerely given, may be unreliable. As well, the Committee may find a witness' evidence to be credible and reliable on one point, while, at the same time, finding that the same witness is unreliable or not credible on another point.

In assessing credibility and reliability, the Committee considers the totality of the evidence and assesses the impact of any inconsistencies. Inconsistencies in the witness's evidence on minor matters of detail are normal and to be expected.

Inconsistencies of a material nature, about which an honest witness is unlikely to be mistaken, may demonstrate carelessness with the truth.

Assessing credibility is ultimately a matter of judgment, based on a number of factors.

Did the witness seem honest? Did the witness have an interest in the outcome? Did the

witness seem to make accurate and complete observations? What were the circumstances of the observations? Did the witness seem to have good memory? Was the testimony reasonable or consistent? Did they say something different on an earlier occasion? Did any inconsistencies make the evidence more or less reliable and believable? Is there an explanation for the inconsistency? The Committee is aware that appearance and demeanor can be highly unreliable in assessing the credibility of a witness.

The Committee is aware that additional considerations apply when assessing the evidence of expert witnesses. How qualified is the expert? Has the expert approached the issue in a neutral and objective fashion? How reliable was the evidence used by the expert? Was the testimony plausible, reasonable and consistent with the knowledge and understanding of the Committee? Did the expert's testimony stray beyond the scope of his or her proven expertise?

The Committee found the witnesses to be credible and reliable in their evidence, as outlined below.

Issue 1. Did Dr. Gill fail to meet the standard of practice in his care of patients?

What is meant by "standard of practice"?

A failure to maintain the standard of practice is an act of professional misconduct under paragraph 1(1)2 of O. Reg. 856/93, the professional misconduct regulation, made under the *Medicine Act, 1991*. The standard of practice is defined as the standard which is reasonably expected of the ordinary, competent practitioner in the member's field of practice. It is not necessary to find that harm has been done in order to find that there has been a failure to maintain the standard of practice.

As a general principle, the Committee recognizes that the standard of practice may be established on the basis of the evidence of experts, advisory notices published by the

College or pertinent regulations that apply to the member. In some circumstances, there may be guidelines published in particular areas of practice.

The Committee notes that a failure to maintain the standard of practice may be found where an individual act does not of itself constitute a violation of the standard of practice, but where the cumulative effect of a number of acts amounts to conduct which falls below the standard of practice of the profession.

What evidence does the College rely on?

The College relies primarily on the uncontested expert opinion evidence of Dr. Potter.

Dr. Potter's approach to the review appeared objective and detailed. For example, in respect of Dr. Gill's care of one patient, she recognized and took into account that the patient was enrolled in the practice of another physician at the time. Dr. Potter's testimony was reasonable and was consistent with her written reports. Her conclusions were consistent with the patient records, the clinical summaries in her reports, and statements by Dr. Gill in their interviews.

The Committee found Dr. Potter well qualified to evaluate Dr. Gill's care in relation to the expected standard of practice on the basis of her own experience as a family physician, her role as a teacher of physicians training in family medicine, her experience in group practice with other family physicians, and her experience with electronic medical records in family practice. The Committee found her evidence to be very helpful and based on her medical expertise and the facts and information before her.

Dr. Potter formed her opinions on the basis of her review of, among other materials, 30 patient records obtained from the Star and Airport Medical Centres and her two interviews with Dr. Gill. Dr. Potter also relied on the College policy statement on Medical Records as evidence of the standard of practice.

The initial 17 patient records, for patients at the Star Medical Centre, were obtained by the College from Dr. Singh, their custodian at the clinic, who identified them in his testimony. Eight patient records from the Airport Medical Centre were provided to the College investigator, Ms Chapman, by Dr. Gill's counsel, Mr. Koziembrocki, and were identified by Ms Chapman during her testimony. A further five patient records, also from the Airport Medical Centre, were provided to Dr. Potter for her review after her interviews with Dr. Gill. These were drawn from 114 patient records provided by Mr. Koziembrocki to the College investigator, Mr. Reed, who identified them in his testimony. The Committee is satisfied that the patient records reviewed by Dr. Potter were authentic and complete.

With respect to the interview transcripts, the Committee recognizes that out of court statements by Dr. Gill are, in general, not admissible for the truth of their contents but may be admissible for the fact that they were made.

The Committee accepts the OHIP claims data in evidence as business records, pursuant to section 35 of the *Evidence Act*, on the basis that they represent records made in the usual and ordinary course of business, and it was in the usual and ordinary course of business for MOHLTC to make such records at the time or within a reasonable time after the events recorded therein. Proper notice of the College's intention to introduce such records was given to Dr. Gill in the Notice of Hearing.

Dr. Gill's record keeping

Dr. Potter opined that Dr. Gill's patient records were severely deficient, represented a failure to maintain the standard of practice, and exposed his patients to risk. Most fundamentally, she found the content of Dr. Gill's chart notes not to be credible, in that he used identical or nearly identical pre-filled templates repeatedly within individual patients' records and from one patient's record to another's. This repetition included numerous passages of text, and blood pressure and temperature readings that were identical.

In effect, Dr. Gill kept no reliable or meaningful record of many patient encounters and had no documentary basis upon which to make proper judgments about a patient's problems or decisions about their care. Dr. Potter testified that, for most patient records, Dr. Gill's notes contained almost no original, patient-specific information that would have given her an idea of what was happening with the patients or why they were seeing Dr. Gill at a given visit. She "had to be like a detective" searching for clues in consultant reports and test results, for example. As a consequence of this poor record-keeping, Dr. Gill exposed his patients to the risks that a serious condition would not be recognized and properly managed or that chronic conditions such as diabetes and hypertension would not be properly monitored and treated.

Among a great many examples, Dr. Potter expressed particular concern about patient 1, a patient in his mid-60s whom Dr. Gill saw 57 times in 15 months. These visits included 27 for "cough and cold x 3 days", with encounter notes that were identical or nearly so. There was no indication that Dr. Gill was aware of the patient's blood work which showed overt diabetes. At one visit, ostensibly for high blood pressure, the patient's blood pressure was recorded as normal, and Dr. Gill's assessment was low blood pressure. Dr. Gill did not ensure that the patient remained on a particular medication following heart surgery, and there was little meaningful reference to the heart surgery in his notes. There was no indication that Dr. Gill was aware of or acted on recommendations of the patient's cardiologist.

Dr. Gill failed to adequately monitor patient 5's diabetes. He appeared to have been unaware for as long as 18 months that he had not renewed a prescription for metformin and that he needed to follow up on control of the patient's diabetes. There is no indication that he was aware of blood results that indicated the patient's diabetes was poorly controlled until several months after the blood tests were done, or that he recognized that a fungal infection he treated should have raised a concern about whether diabetes was controlled.

Dr. Gill saw patient 15 on eight occasions. The encounter notes for three of those visits documented that the patient was hypertensive, yet there was no other indication that this was a correct diagnosis: the only blood pressure measurements anywhere in the patient record were 130/80, which is a normal blood pressure, and there was no record of anti-hypertensive medication. Dr. Gill also recorded that the patient has diabetes, yet bloodwork he ordered on two separate occasions demonstrated this was not the case.

The College's analysis of text strings in Dr. Gill's patient records is consistent with Dr. Potter's observations about the repeated appearance of similar or identical notes. In particular, the 246-character string:

“Subjective c/o cough and cold x3 days, Sore throat, fever, no vomiting [sic] or diarrhea

Objective 98.7 F. Throat – congested, Chest – clear, CVS/Abd. – WNL,

Assessment URTI rapid strep neg

Plan Reassured, Symptomatic Rx, F/u in 3 days if not better”

appeared identically, i.e., with identical spacing, punctuation, spelling and misspelling, 893 times in 111 of 114 patient records from the Airport Medical Centre. In one patient's record, the text appeared 31 times. Analysis of patient records from the Star Medical Centre yielded similar findings.

Dr. Potter observed that in many instances Dr. Gill's encounter notes provided no basis for tests he ordered or medications he prescribed. Perhaps the most frequent example is again the “cough and cold x 3 days” template which offers no support for Dr. Gill's decision to do rapid strep tests. In numerous instances, Dr. Gill's medication lists (medication history reports) showed that he had prescribed medications that bore no relation to his encounter note for the same day, or his notes referenced medications that did not appear in the medication list. Among many examples is that of patient 2. At visits for hypertension, Dr. Gill's plan included “continue same meds” yet the patient was on

no medication for hypertension. As well, Dr. Gill prescribed a series of eyedrops with no rationale documented. For patient 6, Dr. Gill prescribed Tylenol #3 with no reason given.

In her written report, Dr. Potter referenced the College's Medical Records policy. The purpose of the policy is to set out physicians' professional and legal obligations with regard to medical records. Dr. Potter cited several passages from the policy:

- Clinical notes must capture all relevant information from a patient encounter
- Templates ...may be helpful tools ... but may not, on their own, meet the requirements for a complete clinical note
- Physicians must avoid over-reliance on pre-populated templates
- Where patient information is entered into templates in advance, physicians must verify that the entries accurately reflect the nature of the encounter and provide all pertinent details about the patient's health status

Dr. Potter's evidence makes clear that Dr. Gill's records do not "capture all relevant information from a patient encounter" or "provide all pertinent details"; they do not meet the requirements for complete clinical notes, and they rely to a great extent on pre-populated templates without verification.

The College policy further sets out the requirement that a CPP be maintained in each family medicine patient's chart. The CPP provides a brief summary of essential information and allows a physician or other provider to quickly get an overall picture or reminder of the patient's health and medical issues. Notwithstanding this requirement, Dr. Potter found no CPPs in the 25 patient records she first reviewed. Dr. Potter understood Dr. Gill to have said in their interview that he did use CPPs. However, in five records provided following the interview, she found only blank CPPs with no patient information in them.

Dr. Gill appears to have acknowledged, to some extent, the deficiencies in his record keeping. In his first interview, in reference to the template blood pressure 130/80 and

temperature 98.7, he stated “I probably failed to adjust it”, “I failed to document it, probably”, and “I think the proper way would probably have been to scan in my notes”. During the second interview, Dr. Gill acknowledged that “on reflection, there was a deficiency of my note taking. I agree 100%, yes”. The Committee accepts these statements for their truth of their contents as statements by Dr. Gill against his own interest.

The purpose of patient records is to promote consistency and quality in patient care, assist in continuity of care, allow assessment of care, and serve as evidence of what care was provided. It is evident that Dr. Gill’s patient records fulfill none of these purposes adequately.

The Committee accepts and agrees with Dr. Potter’s opinion that Dr. Gill failed to meet the standard of practice in his record keeping and exposed his patients to the risk of harm or injury.

Based on the uncontested evidence before it, as discussed above,. the Committee finds that Dr. Gill failed to maintain the standard of practice of the profession in his record-keeping.

Dr. Gill’s care of his patients

- i. Visits for “cough and cold x 3 days” and use of rapid strep tests.

Dr. Potter identified several problems with the care of patients with this presentation. She described the frequency with which Dr. Gill recorded the diagnosis of “cough and cold x 3 days” as being “beyond credibility”. She noted numerous patients who had had repeated visits for this diagnosis. Patient 1, for example, had 27 such visits in a period of 16 months. On 16 of those visits, a rapid stress test was done, invariably negative.

Further, Dr. Potter opined that, if Dr. Gill's notes were accepted at face value, a patient's recurring visits for the same problem should have led Dr. Gill to consider why the problem persisted and to conduct a thorough evaluation, including a careful history and examination, for an underlying cause. There was no evidence in the patient records that this was ever done.

Dr. Potter noted that Dr. Gill did a rapid strep test in a high proportion of patients with this presentation and opined that that his use of rapid strep test was excessive. The College's allegation that Dr. Gill did not do all or most of the rapid stress tests for which he billed OHIP is addressed below. Regardless, Dr. Gill's encounter notes do not support his decisions to do rapid strep tests. Indeed, they suggest that his patients were most often at relatively low risk: for example, the presence of cough, absence of fever, and adult age of the patient all reflect a diminished likelihood that a strep infection is present. Further, it is particularly unlikely that repeated rapid strep tests in a short period of time in the same patient will be useful.

Dr. Potter understood Dr. Gill's rationale for doing rapid strep tests to be to educate patients, i.e., to be able to show them a test result that would persuade them they did not need an antibiotic prescription. Dr. Potter rejected this rationale as illogical. She opined that a rapid strep test is not an appropriate test in circumstances where it is very unlikely to be helpful in making a clinical decision, i.e., does the patient have a strep infection or not? Further, she stated that it is the wrong test when a patient's symptoms point to an alternative diagnosis. Dr. Potter noted that Dr. Gill's educational efforts were not very successful either with patient 1, for example, who had 16 rapid strep tests in a relatively short period of time, or in general.

Based on the uncontested evidence before it, the Committee finds that Dr. Gill failed to meet the standard of practice in his care of patients presenting with "cough and cold x 3 days" and in his use of rapid strep tests.

ii. Diabetes, hypertension and dyslipidemia

Dr. Potter opined that Dr. Gill's care of patients with chronic conditions such as diabetes, hypertension and dyslipidemia was poor, notwithstanding her challenges in understanding his care from patient records which she characterized as unreliable, untrustworthy and containing little unique information.

Dr. Potter found no evidence in Dr. Gill's notes that Dr. Gill conducted the proper, expected monitoring of patients with diabetes, which would typically be done at three-month intervals. Indeed, in patient 1, for example, Dr. Potter found no evidence that Dr. Gill was aware of the patient's diabetes or dyslipidemia, despite the results of blood tests he had ordered. The proper control of these conditions is particularly important in patients with heart disease. Dr. Gill ordered blood tests for patient 3 in May 2011 that were consistent with overt diabetes and dyslipidemia. Patient 3 was enrolled in another physician's practice but Dr. Gill saw him at seven visits in two years. Dr. Gill recorded the diagnosis when he next saw him, in September 2011. However, in that note Dr. Gill stated that the patient was "compliant with meds" and his plan included "continue same meds", yet did not document what the medications were, and the medication history report shows that the patient was on no medication. Dr. Gill did not document, or provide treatment for, the patient's dyslipidemia. In patient 5, Dr. Gill failed to adequately monitor the patient's bloodwork. Further, it appeared likely that Dr. Gill had forgotten for some months that he had prescribed metformin for inadequately controlled diabetes.

As well as concluding that Dr. Gill's follow up was inadequate for patients with diabetes, Dr. Potter expressed concern about the excessive frequency with which Dr. Gill would see some patients. Most often the visits were for "cough and cold x 3 days", and beyond this template Dr. Potter could identify no rationale for the visits in the patient records.

With respect to diabetes medication, Dr. Potter opined that the starting dose of metformin that Dr. Gill usually prescribed was inappropriately low or perhaps

reasonable. In any event, she notes that he failed to properly follow up to evaluate its effectiveness and to adjust the dose to achieve adequate diabetes control.

Dr. Potter also observed generally that information about serious conditions, in consultants' letters and lab results, for example, was not reflected in Dr. Gill's notes, nor was there evidence that he was consistently aware of the information or acted upon it. Examples in respect of patients with diabetes are noted above. Dr. Potter was also quite concerned by the example of patient 1. There was no indication that Dr. Gill was aware of or acted on the recommendations of patient 1's cardiologist six months following coronary bypass surgery.

Lastly, Dr. Potter concluded that much of the information in Dr. Gill's notes was unreliable in accurately recording the pertinent details and reflecting the substance of his patient encounters. As a consequence, lacking a meaningful record of prior blood pressure measurements, Dr. Gill had little or no basis upon which to determine whether a patient's hypertension was properly controlled, whether to alter management, and even whether the diagnosis was well founded. Dr. Gill saw patient 2, for example, twice for hypertension. He recorded normal blood pressure measurements. The "plan" on both occasions was to "continue same meds", yet the patient was not on anti-hypertensive medication. There was no documentation of discussion of hypertension, or of blood pressure measurements, at subsequent visits. For patient 6, Dr. Gill initiated blood pressure medication without recording a blood pressure measurement and failed to document either a diagnosis of high blood pressure or prescription of blood pressure medication in his note at the time.

The Committee accepts and agrees with Dr. Potter's opinion that the deficiencies in Dr. Gill's care of his patients are severe, represent a failure to meet the standard of practice and exposed his patients to risk.

On the basis of the uncontested evidence before it, the Committee finds that Dr. Gill failed to meet the standard of practice of the profession in his care of patients.

Issue 2. Is Dr. Gill incompetent in his care of patients?

The basis for finding that a member is incompetent is set out in section 52(1) of the Health Professions Procedural Code, Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18:

A panel shall find a member to be incompetent if the member's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the member is unfit to continue to practise or that the member's practice should be restricted.

Did Dr. Gill's care display a lack of knowledge, skill or judgment?

In Dr. Potter's testimony, she opined that Dr. Gill had demonstrated widespread, very severe and basic deficiencies in his care of patients with conditions that are commonly seen by family physicians. College Counsel had Dr. Potter go through the details of Dr. Gill's care of five patients, patients 1, 3, 5, 6, and 15. She noted the observations in each patient's record that had led her to form her opinions about care, and opined that Dr. Gill's care failed to meet the standard of practice in each instance. Further, Dr. Potter testified in respect of patients 1, 3, 5, and 15 individually that Dr. Gill's care displayed a lack of knowledge, skill and judgment. She was not asked and did not make an explicit statement in respect of patient 6, but did express concern that genuine conditions were being ignored, mismanaged or forgotten about in her care. In her written report on patient 6, she states that Dr. Gill's over-reliance on templates displayed a lack of skill and judgment. Considering all of the evidence before it, the Committee is satisfied that Dr. Gill displayed a lack of knowledge, skill or judgment in his care of patient 6.

In her written reports, with respect to knowledge, skill and judgment displayed in Dr. Gill's care of the 30 patients whose records she reviewed, Dr. Potter opined:

- Dr. Gill displayed a lack of judgment in using the same templates repeatedly (patients 1, 2, 5, 7);
- Dr. Gill displayed a lack of skill and judgment in his over-reliance on templates (patient 6 and summary of patients 8 to 25)
- Dr. Gill showed no apparent use of medical knowledge or skill (patient 1)
- Dr. Gill's minimal knowledge is revealed in the patient records (patient 2)
- Dr. Gill's skill is only in the use of electronic stamps (patient 2)
- Dr. Gill displayed a lack of knowledge of the standard of care of diabetes (patient 5)
- No skill is evident (patient 5)
- It is hard to see whether Dr. Gill has any knowledge of his patient's condition (patient 6, summary of patients 8 to 25)
- Patient record does not show any useful medical knowledge or skill (patient 7)
- There is no evidence for knowledge, skill or judgment in any of these patient records as there is no reliable record (summary of patients 26 to 30)

Dr. Potter concludes in her report on the initial 25 patient records that Dr. Gill displayed a severe lack of judgment in that his patient records were wholly inadequate, but also that she was unable to judge his knowledge or skill from the records. The Committee accepts College counsel's submission that in her initial report, Dr. Potter had available only the first set of patient records from which to form her opinion, and that the opinions she expressed in her testimony were significantly informed by her subsequent interviews with Dr. Gill and review of additional records. The Committee is satisfied from the examples in her testimony and in the details of her written patient summaries that Dr. Potter was able to evaluate essential aspects of the care provided by Dr. Gill and the ways in which Dr. Gill's care displayed a lack of knowledge, skill and judgment, despite and separate from the marked deficiencies in his record keeping.

Based on the uncontested evidence before it, the Committee finds that Dr. Gill's professional care of patients displayed a lack of knowledge, skill or judgment.

“Incompetence” as described in section 52(1) of the Code requires the Committee to consider current circumstances (i.e., at the time of the hearing). The Committee heard no evidence to the effect that Dr. Gill’s care no longer (currently) displays such a lack or that it no longer exposes his patients to risk.

Nature and extent

Based on the details of Dr. Gill’s care as reflected in his patient records, and on Dr. Potter’s observations and opinions as set out above, the Committee finds that Dr. Gill’s care displayed a lack of knowledge, skills or judgment that is severe. Dr. Gill failed to properly evaluate, follow up, and document the health problems of his patients and the care he provided. By these failings, he exposed his patients to the risk of harm or injury arising from failure to recognize significant health conditions, neglect or inadequate or inappropriate management of both acute and chronic conditions, and complicating the work of consultants and others sharing in his patients’ care. Dr. Gill’s patients are markedly disadvantaged in respect of both their current and future health care by his grossly deficient record keeping.

The deficiencies in Dr. Gill’s care were not narrow or limited in clinical scope, rather they were apparent across a range of conditions that are commonly seen by family physicians and they were present in every patient whose care was reviewed. Additionally, the deficiencies were not limited to a particular period of time: they occurred throughout the period in question. Further, they persisted when Dr. Gill moved from the Star Medical Centre, where he worked with the owner, Dr. Singh, to the Airport Medical Centre which he himself managed and where he worked largely on his own.

During Dr. Gill’s second interview with Dr. Potter, Dr. Gill’s counsel reported that Dr. Gill had enrolled in the University of Toronto record keeping course and that he intended to complete it. The Committee accepts that Dr. Gill’s counsel made the statement, but heard no other evidence on the matter.

In conclusion, based on the totality of the evidence before it, the Committee finds that Dr. Gill is incompetent in that his professional care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrate that he is unfit to continue to practise or that his practice should be restricted.

Issue 3. Did Dr. Gill engage in disgraceful, dishonourable or unprofessional conduct in that he billed OHIP inappropriately?

The College alleges that Dr. Gill did not perform all or even a majority of the rapid strep tests for which he billed OHIP and that his conduct in billing OHIP was inappropriate and constituted disgraceful, dishonourable or unprofessional conduct.

In the alternative, were the Committee to find that Dr. Gill did perform the rapid strep tests, the College alleges that the tests were unnecessary and unjustified, and that Dr. Gill's billing for them was inappropriate and constituted disgraceful, dishonourable or unprofessional conduct.

What is meant by disgraceful, dishonourable or unprofessional conduct?

The professional misconduct regulation under the *Medicine Act, 1991*, includes a “catch-all” provision intended to capture serious or persistent disregard for professional values and/or obligations:

an act or omission relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

It is not intended that it be the values of the general population that are reflected, but rather the values of the profession itself.

The catch-all provision, on the one hand, is not intended to capture the legitimate exercise of professional discretion or mere errors of judgment. Conduct need not harm the physician’s patients or staff to be unprofessional. A serious or persistent disregard for one’s professional obligations is sufficient. Both disgraceful and dishonourable conduct carry an element of moral failure, whereas conduct need not involve dishonest or immoral elements to be considered unprofessional.

Did Dr. Gill perform the rapid strep tests for which he billed OHIP?

- i. The frequency and overall volume of claims for rapid strep tests was high

The Committee heard evidence that, during the period in question, the overall number of Dr. Gill’s claims for doing rapid strep tests (fee code G014), the overall frequency of G014 claims relative to other services he claimed, the median and maximum number of G014 claims he made on clinic days, and the number of G014 claims he made in individual patients were all unusually high. The overall pattern of claims continued when Dr. Gill moved his practice from the Star Medical Centre to the Airport Medical Centre.

The issues in this hearing first came to light when claims analysis at OHIP identified that the number of Dr. Gill's G014 claims was very high, a statistical outlier in relation to his peers. OHIP provided claims data to the College showing that Dr. Gill made more than 25,000 G014 claims, the highest number of claims made by any of the 6174 family/general practitioners in 2012-15 who made claims for this service. More than 93% of Dr. Gill's peers claimed G014 just 500 or fewer times in that period. Dr. Gill made multiple G014 claims in many patients. In one patient, he made 48 G014 claims from 2011-15, and in another, 20 claims in one year. Among the 25 patients for whom Dr. Gill made the highest total numbers of G014 claims, he made at least 31 such claims for each patient.

Intermediate assessment (fee code A007) is the service most commonly billed by family/general practitioners, as it was for Dr. Gill during the period in question. However, among the more than 250 different fee codes he billed, the second most common was G014 for rapid strep tests. Analysis of claim codes further suggests that, in 2012 and 2013, Dr. Gill claimed G014 fee codes for more than 75% of the patients he saw.

The Committee finds that Dr. Gill is an extreme statistical outlier in terms of his claims for doing rapid strep tests.

- ii. Was it physically possible for Dr. Gill to have done the number of rapid strep tests he claimed?

Analysis of OHIP claims data suggest that, in the individual years 2012 to 2015, Dr. Gill saw a median number of patients per day ranging from 71 to 82, and a maximum number on the busiest day each year between 113 and 143 patients. These estimates are consistent with the testimony of Witness C that Dr. Gill was very busy and would see perhaps 100 patients per day, and sometimes as many 150 patients. Dr. Potter understood from her interview with Dr. Gill that he saw about 500 patients per week, or 80 per day on average, and would spend five to seven minutes with each patient.

Dr. Gill claimed the G014 fee code a median of 10 to 35 times per clinic day in 2011 to 2014. In 2011, the maximum number of G014 claims Dr. Gill made in any one day was 36. In 2012, the maximum number of claims was 89 in one day, 77 in one day in 2013 and 77 in one day in 2014. Dr. Potter understood from Dr. Gill that he would perform 90% of the rapid strep tests himself. Dr. Potter stated in her report that, in a three-hour urgent care clinic with 20 patients, she might conduct an average of three rapid strep tests, representing three G014 claims.

Dr. Singh estimated that a rapid strep test takes about five minutes in total. Dr. Potter's estimate was seven to ten minutes from beginning to end, as a throat swab must be taken, reagents mixed, and a test strip introduced and observed for colour change. The colour change may not occur for up to five minutes. Specifically, if the result is negative – as was invariably in so in Dr. Gill's records - the test strip needs to be observed after five minutes to be sure the colour has not changed. In Dr. Potter's interview with Dr. Gill, she acknowledged that a physician might do other tasks during the five-minute waiting period. As well, Dr. Gill told her he would do rapid strep tests on family members who came in together, e.g. a mother and child. Presumably the waiting periods would coincide or overlap in that circumstance.

Allowing as little as five minutes for each test, completing 35 tests one after another would occupy three hours in a clinic day, and 89 tests would occupy more than seven hours. College counsel submitted that it would not have been possible, or at least that it would have been highly improbable, that Dr. Gill could perform all or even a majority of the rapid strep tests for which he made G014 claims, on the basis of the time that would have required to perform the tests and the context of needing to report the results back to the patients and maintain a high-volume practice. Dr. Potter expressed a similar view.

The Committee accepts College counsel's submission and Dr. Potter's opinion and finds on balance that it is highly improbable that Dr. Gill would have been able to complete during his clinic days the number of rapid strep tests that he claimed.

iii. Evidence of three patients.

Witness B was clear and straightforward in her testimony. She had nothing against Dr. Gill. She was able to ground her recollection of certain dates and visits with Dr. Gill in relation to her pregnancy, caesarean section, and care of her newborn. She was unequivocal in stating that she had not had a throat swab or rapid strep test on a date in November 2013 that corresponded to when she would have seen Dr. Gill for a well-baby check-up (although she was not certain about the date she attended). Further, she testified that the information recorded for three visits in the early part of her pregnancy was not accurate and denied that she had 11 rapid strep tests at a series of visits beginning in July 2013.

Witness C was a patient of Dr. Gill and worked with him at both clinics. She was familiar with rapid strep tests from her work at another clinic. She was unaware of the issues respecting Dr. Gill when contacted by the College, described having had a good working relationship with Dr. Gill and had no complaint about him. She was straightforward in giving her evidence. Shown an OHIP claims summary with 20 claims for rapid strep test by Dr. Gill between August 2011 and October 2013, Witness C was very clear in stating that she had never had a rapid strep test done at the clinic.

Witness A is a registered practical nurse. She had nothing against Dr. Gill and only stopped seeing him in 2014 because his clinic was very busy. She was not familiar with rapid strep tests until a College investigator explained these to her. She denied that Dr. Gill had ever done a rapid strep test on her. She testified that she had not seen Dr. Gill or had rapid strep tests done as he had recorded in his encounter notes for three dates in April 2012. Similarly, she testified that the notes for three dates in the spring of 2013, recording "cough and cold x 3 days", were not accurate and reiterated that she had never had a rapid strep test. Further, she firmly denied that her daughter had had 18 rapid strep tests for which Dr. Gill submitted OHIP claims, although she acknowledged that she had not accompanied her daughter on all her visits. Witness A was straightforward in giving her evidence and was able to recall instances when other tests had been done, and where. Although Witness A was very clear that her daughter had

never had a rapid strep test, the Committee heard no details of why she could be fully confident when she was not always present at the visits.

The Committee finds clear, cogent and convincing the evidence of the three patients that they did not have the rapid strep tests claimed by Dr. Gill and recorded in his clinical notes.

- iv. Did others at the clinics observe Dr. Gill doing rapid strep tests or was there other evidence in the clinics that they were done?

Witness C worked at the Star Medical Centre at the same time as Dr. Gill started his shifts. She then worked full-time with Dr. Gill at the Airport Medical Centre. She was familiar with the supply rooms at the clinics and was responsible for putting away supplies at the Airport Medical Centre. Witness C testified that she never saw Dr. Gill do a rapid strep test at either clinic, that no rapid strep test kits were stored at either clinic, and that she never saw discarded packaging or material from rapid strep tests at either clinic. Witness C was straightforward in her testimony and had knowledge of rapid strep tests. The Committee found her evidence credible and reliable.

Dr. Singh testified that he would do rapid strep tests on patients at the Star Medical Centre on occasion, typically on walk-in patients. According to Witness C's testimony, Dr. Singh typically started his shift at 9 am and ended at 3 pm. Dr. Singh testified that he would encounter Dr. Gill at the clinic from time to time. Dr. Gill would let the clinic staff know if he needed supplies and they would pass on the request to Dr. Singh who was responsible for ordering supplies. Dr. Singh denied that Dr. Gill had ever asked him to order more rapid strep test kits, or that he had ever supplied Dr. Gill with thousands of test kits. Dr. Singh testified that he had never seen Dr. Gill do a rapid strep test, but that he may have seen one or two discarded test kits in the garbage on occasion when he came to the clinic after Dr. Gill had been working.

Dr. Singh's testimony suggests that he did at least some rapid strep tests at the Star Medical Centre. It is perhaps not surprising that Witness C did not observe Dr. Singh doing them as she was working part-time and on shifts that did not overlap significantly with those of Dr. Singh. As well, Dr. Singh stated that he did rapid strep tests only occasionally. Dr. Singh's testimony that he occasionally saw discarded rapid strep test materials in the garbage suggests that Dr. Gill also did a small number of rapid strep tests at the Star Medical Centre.

Witness C's testimony about the dates of employment at the clinics, and particularly when she moved to the Airport Medical Centre, is not consistent with other evidence, but the Committee finds this to be a minor inconsistency that did not affect her credibility.

Witness C testified that she did observe Dr. Gill do throat swabs that were sent to an outside lab. The Committee concludes that Witness C would have observed Dr. Gill doing rapid strep tests if he had done more than a small number at either clinic, and accepts her testimony that she did not. That she also did not see rapid strep test kits in the supply rooms is consistent with the clinics having only a small number of such kits, and that they were very infrequently restocked during the period in question, if at all.

v. How were the kits for thousands of rapid strep tests acquired?

In Dr. Gill's submission to the College dated September 30, 2015, he stated that

- he (Dr. Gill) was not responsible for purchasing supplies at the Star Medical Centre
- Dr. Singh provided all supplies at the Star Medical Centre, and when he (Dr. Gill) needed additional supplies, he would make a request of Dr. Singh
- he (Dr. Gill) was responsible for purchase of all medical supplies at Airport Medical Centre
- he (Dr. Gill) was not currently in possession of records relating to the purchase of rapid strep tests.

The Committee heard evidence from Dr. Singh and representatives of the three companies that Dr. Singh and Dr. Gill identified as suppliers to the Star and Airport Medical Centres.

With respect to the Star Medical Centre, Dr. Singh testified that he purchased all medical supplies from Nu-Life Medical and Surgical Supplies, that high supply costs had never been an issue, that Dr. Gill had never asked him to order more rapid strep test kits, and that he had never supplied thousands of such kits to Dr. Gill. Further, before Dr. Gill moved from the Star Medical Centre in April 2013, Dr. Singh told Dr. Gill not to take any medical supplies from the clinic. Dr. Singh stated that there could not have been kits for 6000 rapid strep tests at the clinic, that Dr. Gill was not entitled to take any medical supplies as he (Dr. Singh) had paid for them, and that he (Dr. Singh) would have noticed Dr. Gill taking them.

In his second interview with Dr. Potter, Dr. Gill stated that he had taken the kits for approximately 6000 rapid strep tests along with other supplies from Star Medical Centre when he left, and stored them in his condominium.

The evidence of Mr. Coutinho in respect of Nu-Life Medical and Surgical Supplies was that Dr. Singh had purchased eight or nine boxes of rapid strep test kits, probably in 2012. With 25 tests per box, this would represent 200 or 225 rapid strep tests in total. He didn't believe that there had been any other purchases between 2011 and 2013. Dr. Gill was not a client of Nu-Life.

With respect to the Airport Medical Centre, one of the three companies identified by Dr. Gill (Universal Data Supplies) was a supplier of office and technical supplies, but not medical supplies such as rapid strep test kits. Another of the companies (Cardinal Health Canada) had acquired the third company (FutureMed) some years ago. Mr. Cameron of Cardinal Health searched his company's sales records. He identified a single invoice dated August 21, 2015 for three boxes of rapid strep test kits, 25 tests per box or 75 tests in total, sold to the Airport Medical Centre. This corresponded to a sales

report for the fiscal year July 2015 to June 2016. Mr. Cameron found no record of any sales in 2013 or 2014.

Considering all of the evidence before it, the Committee finds that there were supplies at the Star Medical Centre for a maximum of 225 rapid strep tests during the period in question (January 1, 2011 to June 30, 2015), and that there were not the supplies needed for thousands of such tests that Dr. Gill might have taken to the Airport Medical Centre. Further, the Committee heard no evidence that Dr. Gill purchased rapid strep test kits for use at the Airport Medical Centre during the period in question and finds that there were few, if any, kits available for conducting rapid strep tests there.

vi. Dr. Gill's encounter notes record that rapid strep tests were done.

As detailed above, Dr. Gill's notes were severely deficient and unreliable in representing his clinical encounters.

In determining whether or not he actually conducted the rapid strep tests for which he made claims to OHIP, the Committee puts no weight on Dr. Gill's having recorded "rapid strep neg" in his encounter notes.

Insofar as Dr. Gill may have conducted any rapid strep tests, Dr. Gill's notes fail to provide meaningful support that they were clinically indicated or medically necessary.

Analysis

The Committee finds, on a balance of probabilities, that Dr. Gill did not conduct any or, at most, conducted only a small number of the rapid strep tests for which he submitted claims to OHIP, on the basis of:

- the exceptionally high number of claims Dr. Gill made for conducting rapid strep tests;

- the improbability that he would have had the time to complete the tests during his clinic days;
- the evidence that only a vastly smaller number of test kits was available at the clinics;
- the evidence of other staff at the clinics that indicated that Dr. Gill did few or no rapid strep tests; and
- the evidence of three patients that Dr. Gill did not do the rapid strep tests on them that he documented and for which he made claims.

Was Dr. Gill responsible for submitting the claims for rapid strep tests?

The Committee accepts the evidence of Witness C that, with the exception of the week prior to his leaving Star Medical Centre, Dr. Gill prepared his own OHIP claims. Dr. Singh had no knowledge of or interest in Dr. Gill's OHIP billing as Dr. Gill was paying him a flat fee for the use of the Star Medical Centre. In any event, regardless of who submitted them, Dr. Gill is responsible for claims made to OHIP using his billing number.

If Dr. Gill conducted any rapid strep tests, the Committee heard no evidence that the tests were justified and finds that any done were not medically necessary. Dr. Gill knew or should have known, and was reminded in a letter from OHIP on May 12, 2014, that a requirement to claim an insured service to OHIP is that the service is medically necessary.

Conclusion

Based on the totality of the evidence before it, the Committee finds that Dr. Gill did not perform any or, at most, performed only a small number of the rapid strep tests for which he billed OHIP, and that this constitutes conduct that would reasonably be regarded by the profession as disgraceful, dishonourable or unprofessional.

Dr. Gill submitted claims to OHIP and was paid more than \$146,000 over a period of years for thousands of services that he did not provide. In doing so, he abused the trust which the public gives him and the profession, to be honest and careful in dealings with the taxpayer-funded system upon which the provision of essential health services in the province relies. Moreover, Dr. Gill has diminished the public funding that could otherwise have been directed to appropriate health care services. Thus, Dr. Gill has failed in his stewardship of limited health care resources and in his responsibilities to the profession and to society at large. This conduct is disgraceful, dishonourable and unprofessional.

SUMMARY OF FINDINGS

The Committee finds that the allegation that Dr. Gill failed to maintain the standard of practice of the profession is proven. Dr. Gill failed to maintain the standard of practice in that his records were unreliable as a reflection of the nature and details of patient encounters and patients' overall health status, and they were wholly inadequate to the provision of good quality patient care. Moreover, Dr. Gill's care of patients with common, sometimes serious acute and chronic conditions was poor. He failed to meet the standard of practice in that he did not adequately assess, monitor, and document those conditions, did not respond to important information in patient records from other sources, and exposed his patients to the risk of significant harm and injury.

Further, the Committee finds that Dr. Gill is incompetent in that his professional care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

Lastly, the Committee finds the allegation that Dr. Gill engaged in conduct or an act or omission that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional to be proven. Dr. Gill submitted thousands of claims to OHIP for rapid

strep tests that he did not perform. As well, of any rapid strep tests he may have conducted, many or all were without justification.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made, at the earliest opportunity.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Harmander Singh Gill, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names and any information that could disclose the identity of patients who testify, or those 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.

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

Citation: *College of Physicians and Surgeons of Ontario v. Gill*, 2021 ONCPSD 16

Date: April 13, 2021

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Harmander Singh Gill

PENALTY ORDER AND REASONS

Panel: Dr. William King (chair)
Ms. Christine Tebbutt
Dr. James Watters
Mr. J. Paul Malette, Q.C.
Dr. John Rapin

Heard: December 14, 2020, by videoconference

Appearances:

Ms. Lisa Brownstone and Ms. Morgana Kellythorne, for the College
Dr. Harmander Singh Gill, self-represented
Ms. Jennifer McAleer, Independent Legal Counsel to the Discipline Committee

Introduction

- [1] On February 25, 2020, we released our decision in Ontario (*College of Physicians and Surgeons of Ontario*) v. *Gill*, 2020 ONCPSD 8, finding that Dr. Gill committed an act of professional misconduct and is incompetent.
- [2] On December 14, 2020, we heard submissions from both parties on penalty and costs. Our decision is to direct immediate revocation of Dr. Gill's certificate of registration and to order him to attend for a reprimand and pay costs of \$124,440 to the College.

Positions on penalty

The College

- [3] The College submitted that only revocation of Dr. Gill's certificate of registration and a public reprimand would satisfy the penalty principles of protecting the public, maintaining public confidence in the integrity of the profession, regulating in the public interest and deterring others in the profession from similar misconduct.

Dr. Gill

- [4] Dr. Gill submitted that, without the benefit of legal counsel, he could not effectively defend himself. His request to adjourn the penalty hearing on this basis, however, had previously been denied by the Committee.
- [5] Dr. Gill submitted that revocation is not warranted and that the appropriate penalty is a suspension of his certificate of registration and remediation. He suggested that remediation could include course work and a period of supervision. He submitted that he had had no guidance early in his career and had made a one-off mistake, specifically, choosing to practice in a walk-in clinic, and not hiring the right people.
- [6] Dr. Gill stated that he has been working with a coach in professional ethics, conduct and communication and is willing to continue with this. Dr. Gill also said that he had taken a record-keeping course some time ago. He did not provide details or other information about coaching, coursework or other remedial activities.

- [7] Dr. Gill pointed out that he has not been permitted to practise for a considerable period already as his certificate was suspended in May 2019. We note that the suspension was a condition of granting Dr. Gill's request for an adjournment at that time and was intended to protect the public and not as a penalty. The Committee subsequently granted Dr. Gill's motion to vary the suspension, in its order released on September 14, 2020.

Analysis and reasons

Possible orders

- [8] Having found that Dr. Gill committed an act of professional misconduct, we may order any one or more of the orders set-out under section 51(2) of the Code.
- [9] Specifically, we may direct any one or more of: revocation of the member's certificate of registration, suspension of the certificate for a specified period, imposition of specific terms, conditions and limitations on the certificate, requiring the physician to attend for a reprimand and/or imposing a fine. None of these orders is mandatory.
- [10] Similarly, having found Dr. Gill to be incompetent, under section 52(2) of the Code, we may direct one or more of: revocation of his certificate of registration, suspension of the certificate and/or imposition of specified terms, conditions and limitations on the certificate.
- [11] The Committee wrote in *College of Physicians and Surgeons of Ontario v. Minnes*, 2015 ONCPSD 3:
- There will be some cases where the factual findings will compel revocation in order to do justice to one or more of the driving [penalty] principles.
- [12] Revocation is the most severe penalty which we can impose, yet may be an appropriate penalty even when the conduct has not been among the most serious misconduct.

- [13] In *College of Physicians and Surgeons of Ontario v. McIntyre*, 2017 ONSC 116, the Divisional Court upheld the penalty of revocation, relying in part on *Adams v. Law Society of Alberta*, 2000 ABCA 240. In *Adams*, the court wrote:

[11] It is therefore erroneous to suggest that in professional disciplinary matters, the range of sanctions may be compared to penal sentences and to suggest that only the most serious misconduct by the most serious offenders warrants disbarment. Indeed, that proposition has been rejected in criminal cases for the same reasons it should be rejected here. It will always be possible to find someone whose circumstances and conduct are more egregious than the case under consideration. Disbarment is but one disciplinary option available from a range of sanctions and as such, it is not reserved for only the very worst conduct engaged in by the very worst lawyers.

Penalty principles

- [14] The paramount consideration in determining the appropriate penalty for professional misconduct is ensuring protection of the public. Other important principles are: maintaining public confidence in the integrity of the profession and in the College's ability to regulate the profession in the public interest, denouncing wrongful conduct, proportionality, specific deterrence as it applies to the member, general deterrence in relation to the membership as a whole and, where appropriate, the member's potential for remediation.
- [15] These principles are weighed in light of the specific facts and circumstances of the case in order to arrive at a penalty that is fair and reasonable. The nature of the misconduct and aggravating and mitigating factors are also considered. In general, the penalty should be proportionate to the misconduct and like cases should be treated alike. However, while we make a conscious comparison with prior similar cases, each case is unique and we are not bound by our prior decisions.

Nature of misconduct

- [16] The findings of professional misconduct we made against Dr. Gill are very serious and include both failure to maintain the standard of practice of the profession and disgraceful,

dishonourable or unprofessional conduct. In addition, we found Dr. Gill to be incompetent.

- [17] First, Dr. Gill failed to maintain an acceptable standard of practice in that his care of patients with common acute and chronic conditions, including serious conditions, was poor. He did not adequately assess, monitor, and document those conditions and did not respond to important information in patient records from other sources. Dr. Gill's clinical records were unreliable in reflecting patient encounters and patients' overall health status and were wholly inadequate for the provision of good quality patient care. Dr. Gill's misconduct exposed his patients to the risk of harm from his failure to recognize significant health conditions, his neglect or inadequate or inappropriate management and from complicating the work of consultants and others sharing in his patients' care. Dr. Gill's patients are markedly disadvantaged in respect of both their current and future health care by his grossly deficient record-keeping.

- [18] Second, Dr. Gill engaged in disgraceful, dishonourable or unprofessional conduct in that he submitted thousands of claims to OHIP over a period of four years and OHIP paid him more than \$146,000 for rapid strep tests that he did not perform. As well, of any rapid strep tests he may have performed, many or all were without justification.

- [19] We are particularly troubled that Dr. Gill's misconduct encompassed both grossly inadequate clinical care that put his patients at risk and dishonest actions by which he placed his own interests ahead of those of his patients and the public. Dr. Gill persisted in his misconduct when he moved from one clinic to establish his own clinic. The deficiencies in his clinical care were profound, pervasive and ongoing. Deficiencies were present in every patient whose care was examined. Further, through his dishonest actions, Dr. Gill abused the trust that the public placed in him and the profession to be honest and careful in dealings with the taxpayer-funded system that pays for essential health services in Ontario. As well, Dr. Gill has diminished the public funding that could otherwise have been directed to appropriate health care services.

Aggravating factors

[20] We find the breadth, severity and persistence of Dr. Gill's misconduct to be aggravating factors.

Mitigating factors

[21] Dr. Gill has no prior discipline history. We give limited weight to this as Dr. Gill's misconduct began relatively early in his career and continued over a period of years. As well, it is generally expected that physicians will not become involved in discipline matters.

[22] A physician's insight into their misconduct, and/or remorse for their actions, can be mitigating factors. We have no basis to find that Dr. Gill has shown either. We reject Dr. Gill's submission that his present circumstances are the result of a one-off mistake he made early in his career. To the contrary, we find that Dr. Gill's misconduct has been both widespread and persistent, as described above.

[23] We also have very little information about efforts at rehabilitation by Dr. Gill. More than five years ago, in October 2015, at Dr. Gill's second interview with Dr. Potter (the expert retained by the College), Dr. Gill's (then) counsel reported that Dr. Gill had enrolled in the University of Toronto record-keeping course and intended to complete it. Dr. Gill also informed us that he has engaged more recently in work with a coach in professional ethics, conduct and communication. However, we have no meaningful detail of these activities – which at best might begin to address only limited aspects of Dr. Gill's professional misconduct and incompetence - and no knowledge of any others. We are not persuaded that Dr. Gill recognizes the scope and severity of his misconduct and his incompetence, that he accepts responsibility or that he is remorseful.

Prior decision

[24] In the following four prior cases, physicians engaged in dishonest billing. Some additionally had deficiencies in clinical care, others did not.

College of Physicians and Surgeons of Ontario v. Taylor, 2017 ONCPSD 17; *Taylor v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 4562 (Divisional Court)

- [25] Dr. Taylor improperly and deliberately billed patients who had chosen the more expensive of two ophthalmologic procedures, when he had actually performed the less expensive one. He directed his staff to alter patient records to show that the more expensive procedure had been done. As well, he attempted to obstruct the College investigation by having his staff falsely report the theft of a safe containing medical records. Dr. Taylor made restitution and had no discipline history.
- [26] The Committee characterized Dr. Taylor's misconduct as premeditated, exploitative, and dishonest. It concluded that in respect of such misconduct individual deterrence and rehabilitation were of less importance than protection of the public, maintaining public confidence in the profession and in the regulation of the profession in the public interest, denunciation of the misconduct and general deterrence.
- [27] The Committee directed revocation and a reprimand. In its reasons, the Committee wrote:
- Ultimately, all dishonest billing is a betrayal of the honesty and integrity expected of the physician in the patient-physician relationship. The public must be confident not only in the clinical skills of a practitioner, but in the honesty of a practitioner to bill correctly for services rendered.
- [28] The decision was upheld on appeal. The Divisional Court noted (at para. 95) that the penalty of revocation fell within the appropriate range for such misconduct.
- [29] Dr. Gill's misconduct was similar to Dr. Taylor's in his deliberate, dishonest billing over a period of time, although Dr. Gill did not involve his staff as Dr. Taylor had, nor did he attempt to interfere with the College's investigation. The scope of Dr. Gill's misconduct was much more extensive than the issues of billing in *Taylor*, however, in his serious and extensive failure to maintain the standard of practice of the profession.

College of Physicians and Surgeons of Ontario v. Savic, 2019 ONCPSD 40

- [30] Dr. Savic failed to meet the standard of practice in his prescribing, ordering unnecessary clinical tests, overall management of patients and record keeping. The expert retained by the College opined that Dr. Savic showed a “marked and consistent lack of thoroughness in his case management, with frequent evidence of insufficient history, physical exam, inappropriate investigation, and incomplete follow-up.” Dr. Savic’s misconduct put his patients at significant risk. In addition, Dr. Savic breached an undertaking to the College that prohibited him from prescribing narcotics and other drugs, and he engaged in disgraceful, dishonourable or unprofessional conduct by ordering unjustified tests and billing OHIP for related services.
- [31] Dr. Savic had had significant prior involvement with the Inquiries, Complaints and Reports Committee and the Discipline Committee. The Committee’s finding that Dr. Savic was ungovernable was an additional aggravating factor. The Committee concluded that only revocation would achieve the goals of public protection and maintaining public confidence.
- [32] Dr. Savic’s misconduct is similar to Dr. Gill’s in that it included very serious failure to maintain the standard of practice, dishonest billing and clear risk to patients. However, Dr. Gill did not breach an undertaking and there has not been a finding that he is ungovernable. As well, Dr. Gill has had no prior involvement with the College.

College of Physicians and Surgeons of Ontario v. Kumra, 2019 ONCPSD 32

- [33] Dr. Kumra directed his staff to register family members of individual patients attending his office as patients and to bill OHIP using their health card information. In addition, he improperly accepted cash payments from patients for completing special diet program forms without adequately assessing them against the program’s eligibility requirements. Dr. Kumra attempted to obstruct the College’s investigation. In addition, the Committee found he had failed to meet the standard of practice of the profession in several regards, including: no documentation to justify ordering medical imaging studies, multiple versions

of the documentation for specific visits and/or identical templated documentation in other patient charts, OHIP claims with no documentation or insufficient documentation and no documentation to support the conditions identified on special diet forms or contradictory documentation.

- [34] Dr. Kumra had appeared before the Committee previously on another matter involving dishonesty.
- [35] The Committee wrote that it would have revoked Dr. Kumra's certificate of registration had he not already resigned and undertaken never to reapply to practise in any jurisdiction.
- [36] Although *Kumra* was resolved by way of an agreed statement of facts, plea of no contest and a joint submission on penalty, the facts appear similar to the present matter in that the misconduct included serious failure to meet the standard of practice and dishonest billing. However, unlike Dr. Kumra, Dr. Gill has no prior discipline history.

College of Physicians and Surgeons of Ontario v. Patel, 2015 ONCPSD 22

- [37] Dr. Patel engaged in a number of improper billing practices including billing for more than \$34,000 during a period in 2011 when he was on vacation. Further, Dr. Patel failed to meet the standard of practice in his care of patients, was incompetent and breached an undertaking to the College in respect of delegating controlled acts to his staff and following the recommendations of his clinical supervisor. Dr. Patel made unsubstantiated diagnoses, ordered inappropriate and unnecessary tests based on templates and routine, failed to address patients' presenting concerns, treated respiratory infections inappropriately, failed to ensure that information in patients' charts was informative, failed to adequately supervise staff and improperly delegated controlled acts. The Committee made a finding that Dr. Patel was ungovernable. The Committee had twice previously, in 1991 and 1999, found that Dr. Patel failed to meet the standard of practice. The Committee directed revocation and a reprimand.

- [38] The extensive nature of Dr. Patel's clinical deficiencies and his dishonest billing are broadly similar to the present matter. However, Dr. Gill did not involve his staff in his misconduct, has not breached an undertaking, and has not been found to be ungovernable.
- [39] We find these decisions useful in respect of the range of misconduct for which the Committee has found revocation to be an appropriate penalty. They speak to the seriousness of misconduct that involves dishonest billing on its own or in conjunction with serious deficiencies in clinical care.
- [40] Of note, in *Taylor*, the physician's certificate was revoked for misconduct that centred on dishonest billing - albeit with overt involvement of clinic staff and an attempt to hamper the College's investigation - but absent any finding of failure to meet the standard of practice. *Savic*, *Kumra* and *Patel* each had findings in respect of standard of practice and dishonest billing that are roughly similar to those in the present matter. However, the cases are distinguishable in that those physicians also had a history of prior discipline findings and, in *Savic* and *Patel*, had breached an undertaking to the College.

Application of penalty principles

- [41] We are concerned first with the protection of the public and with maintaining the public's confidence in the integrity of the profession and the ability of the College to regulate the profession in the public interest.
- [42] The significant impact of misconduct on public confidence in the profession at large and in its regulation, was set out in *Adams*, where the court wrote:

[6] ... A professional misconduct hearing involves not only the individual and all the factors that relate to that individual, both favourably and unfavourably, but also the effect of the individual's misconduct on both the individual client and generally on the profession in question. This public dimension is of critical significance to the mandate of professional disciplinary bodies.

- [43] As well, we agree with the approach in *Taylor* where general deterrence was identified as a critical penalty consideration in cases of deceptive billing, a view upheld on appeal by the Divisional Court.
- [44] We recognize that we must be careful not to punish Dr. Gill for any perceived lack of insight or remorse or for defending himself against the College's allegations. However, Dr. Gill's prospects for rehabilitation are relevant to the determination of penalty. For example, in *Houghton v. Association of Ontario Land Surveyors*, 2020 ONSC 863, in dismissing the surveyor's appeal, the Divisional Court held that a discipline committee is entitled to consider the member's lack of recognition and accountability for his actions as factors that weigh on the risk of repetition, the need to protect the public and deterrence.
- [45] In respect of rehabilitation, we find that Dr. Gill has demonstrated limited understanding of his misconduct and incompetence. He has presented no meaningful plan for change. Nor do we have any information to suggest that Dr. Gill is a suitable candidate for rehabilitation or that rehabilitation has any reasonable prospect of allowing Dr. Gill to return safely to practice. As the Committee wrote in *Minnes*, it "cannot make decisions crucial to the protection of the public based on speculation."

Conclusion

- [46] Dr. Gill's egregious deficiencies in clinical care and deliberate and ongoing dishonesty have put his patients at serious risk and undermined the trust that is fundamental to the relationships between physicians and their patients and the reliance that society places on the integrity of physicians and the profession.
- [47] We conclude that revocation of Dr. Gill's certificate of registration is the appropriate penalty for his professional misconduct and is necessary in respect of his incompetence. Revocation is the only order that will adequately protect the public and assist in maintaining public confidence. Revocation is proportionate to Dr. Gill's very serious misconduct and incompetence and is consistent with prior decisions.

[48] Revocation of Dr. Gill's certificate of registration will, as well, serve notice to the profession at large that dishonest and deceitful behaviour such as his will simply not be tolerated.

[49] A reprimand will allow us to express denunciation of Dr. Gill's misconduct in a public forum, assist in general deterrence, and promote public confidence in the integrity of the profession and the College's ability to regulate in the public interest.

Costs

[50] Section 53.1 of the Code gives us discretion to order Dr. Gill to pay costs to the College, as we have found that he engaged in professional misconduct and is incompetent.

[51] We considered the written submissions of the College and the advice of independent legal counsel. Dr. Gill took no position on the question of costs.

[52] We find that this is an appropriate case in which to award costs of \$124,440. This amount represents 12 days on which the Committee sat in hearing the allegations against Dr. Gill, hearing various motions, and in the penalty hearing. It is calculated at the tariff rate of \$10,370 per day. It does not reflect hearing days lost because of late adjournment requests or scheduled hearing days that were not required.

Order

[53] The Discipline Committee orders and directs:

1. Dr. Gill to attend before the panel to be reprimanded
2. The Registrar to revoke Dr. Gill's certificate of registration effective immediately
3. Dr. Gill to pay costs to the College in the amount of \$124,440 within 30 days of the date of this Order.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Tribunal File No.: 17-001-I

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Harmander Singh Gill

The Tribunal delivered the following Reprimand
in writing on Friday, February 24, 2023.

Dr. Gill, we are deeply disturbed by your egregious failure to meet the standard of practice of the profession, your engaging in disgraceful, dishonourable or unprofessional conduct and the finding that you are incompetent.

You kept no meaningful record of many patient encounters. Your records were wholly inadequate to making proper judgments about your patients' health problems and decisions about their care. Your care of patients with common - at times serious - acute and chronic conditions was poor. You did not adequately assess, document, or follow-up these conditions and did not respond to important information in patient records from other sources. As a result, you exposed your patients to the risk of substantial harm.

In addition, you submitted thousands of claims to OHIP for rapid strep tests that you did not perform. Of any rapid strep tests you may have conducted, many or all were without justification.

Dr. Gill, your misconduct is extremely serious. It reflects pervasive and repeated acts and choices on your part. You have violated the public's trust that physicians will act with competence and in their patients' best interests, and will be honest in their dealings with the taxpayer-funded health care system. In the absence of any acknowledgement or apparent understanding of your deficiencies, we can only conclude that the public interest is served by your losing the privilege of practising medicine.