Indexed as: Jain (Re)

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

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

BETWEEN:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. ARUN KUMAR JAIN

PANEL MEMBERS: DR. A. BIENENSTOCK (CHAIR)
DR. R. MACKENZIE
L. SAMIS
H. MAEOTS

HEARING DATE: MARCH 11-12, 1999

DECISION/RELEASED DATE: AUGUST 19, 1999

DECISION AND REASONS FOR DECISION

This matter came on for a hearing before the Discipline Committee at the College of Physicians and Surgeons of Ontario at Toronto on March 11 and 12, 1999.

ALLEGATIONS

It is alleged in the Notice of Hearing that Dr. Jain is guilty of professional misconduct in that he:

1. failed to maintain the standard of practice of the profession contrary to clause.(1)1 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*;

2. contravened subsection 2(5) of Ontario Regulation 865/93 made under the Medicine *Act, 1991* (registration) and Part V of Ontario Regulation 241/94 made under the Medicine *Act, 1991* (records), contrary to clause 1.(1)27 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*;

3. engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional contrary to clause 1(1) 33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*;

4. permitted, counselled or assisted a person who is not a member of the College to perform acts which should be performed by a member contrary to clause 1.(1) 29 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*; and

5. contravened a federal law, specifically the *Narcotic Control Act* and the regulations made thereunder, the purpose of which is to protect public health and the contravention of which is relevant to Dr. Jain s suitability to practise contrary to clause 1.(1) 28 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*.

It is also alleged that Dr. Jain is incompetent as defined in section 52 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 in that:

> ... his professional care of patients named in the appendices and schedules to this notice displays a lack of knowledge, skill or judgment or disregard for the welfare of the patients of a nature or to an extent that demonstrates that Dr. Jain is unfit to continue to practise or that his practice should be restricted.

PLEA

Dr. Jain pleaded guilty to allegations 1, 2, 3 and 5 contained in the notice of hearing. The College withdrew the allegation contained in paragraph 4 at the commencement of the hearing.

Dr. Jain also pleaded guilty to the allegation of incompetence contained in the Notice of Hearing.

THE EVIDENCE

The facts were not substantially in dispute, and were established before the Committee through an Agreed Statement of facts, a Joint Book of Documents, and the testimony of Dr. G. Morris, an expert witness called on behalf of the College, and Dr. Jain himself.

In the Agreed Statement of Facts, Dr. Jain admitted the following facts in Appendix B to be substantially correct:

1. On or about June 11, 1995, Dr. Jain performed a surgical procedure, a massive incisional hernia repair, on his patient, L.C., which it was inappropriate to perform in a clinic setting.

3. On more than one occasion, Dr. Jain exposed the patient to an unnecessary and unacceptable risk of harm by administering an anaesthetic to her when he knew or ought to have known that her complex medical history, respiratory and cardiac conditions, and medication regime rendered her an inappropriate candidate.

4. Dr. Jain exposed the patient to an unnecessary and unacceptable risk of harm by performing surgery on her when he knew or ought to have known that her complex medical history, respiratory and cardiac conditions and medication regime rendered her an inappropriate candidate.

5. On more than one occasion, Dr. Jain exposed the patient to an unnecessary and unacceptable risk of harm by administering an anaesthetic to her in a clinic which was an inappropriate facility given her medical history, respiratory and cardiac conditions, and medication regime.

6. Dr. Jain exposed the patient to an unnecessary and unacceptable risk of harm by performing surgery on her in a clinic which was an inappropriate facility given her medical history, respiratory and cardiac conditions, and medication regime.

7. Dr. Jain failed to prescribe an appropriate analgesic to the patient post-operatively.

8. Dr. Jain performed a surgical procedure on the patient when he knew or out to have known that he was unable to prescribe an appropriate analgesic for the relief of the patient s pain post-operatively

Dr. Jain also admitted to the following facts in Appendix C to be substantially correct:

1. On about March 16, 1995, Dr. Jain administered a toxic dose of anaesthetic to his patient, S.J.

2. Dr. Jain exposed the patient to an unnecessary and unacceptable risk of harm or injury by administering the anaesthetic he administered in a clinic which was an inappropriate setting.

3. On about March 16, 1995, Dr. Jain exposed the patient to an unnecessary and unacceptable risk of harm or injury by performing a surgical procedure, a lipectomy, in a clinic which was an inappropriate setting.

4. Dr. Jain administered an epidural to the patient when he knew or ought to have known that he did not have the requisite knowledge, skill, and/or experience to do so.

5. Dr. Jain failed to monitor the patient adequately both during the surgery mentioned in paragraph 3 above and post-operatively.

6. Dr. Jain failed to keep adequate records for the patient both during the surgery and post-operatively.

7. Dr. Jain administered a narcotic to the patient during the surgery when he knew that he had resigned his privileges to prescribe or order narcotics.

8. Dr. Jain administered an anaesthetic to the patient during the surgery when he knew or ought to have known that he did not have available the requisite equipment, drugs, and other supplies including emergency equipment for resuscitation.

9. Dr. Jain performed the surgery when he knew or ought to have known that he did not have available the requisite equipment and supplies including those for transfusion of the patient.

10. Dr. Jain administered an anaesthetic to the patient when he knew or ought to have known that he did not have available the requisite staff.

12. Dr. Jain failed to take the measures required to ensure that the anaesthetic and ancillary equipment he used to perform the surgery remained sterilized.

14. Dr. Jain performed the surgery when he knew or ought to have known that he was unable to prescribe an appropriate analgesic for the relief of the patient s pain post-operatively.

Dr. Jain also admitted the following facts in Appendix D to be substantially correct:

11. On about December 16, 1994, Dr. Jain administered a near toxic dose of anaesthetic to his patient, L.L.

12. Dr. Jain twice performed a surgical procedure, an axillary dissection (the surgery), which it was inappropriate to perform on the patient in a clinic setting.

13. On about December 16, 1995, Dr. Jain performed the surgery even though he knew, or ought to have known, that the patient had a prior malignancy.

14. Dr. Jain performed the surgery on about December 16, 1995 without checking the original pathology reports.

15. On about February 23, 1995, Dr. Jain performed the surgery again which was inappropriate.

16. Dr. Jain performed the surgery on about February 23, 1995 without arranging for a radiotherapy consultation.

17. Dr. Jain performed the surgery under a local anaesthetic when he knew or ought to have known that exposure to the axilla can be better achieved under a general anaesthetic.

18. Dr. Jain performed the surgery without the assistance of an anaesthetist when he knew or ought to have known that to do so could compromise the surgery and/or the patient.

19. Dr. Jain performed the surgery when he knew or ought to have known that he did not have available the requisite equipment, drugs, and other supplies including emergency equipment for resuscitation.

The following facts are also established through the Agreed Statement of Facts:

C Dr. Jain is 43 years old. He obtained his medical degree at the University of Ottawa in 1977. After completing a year of internship at various McGill University hospitals, he

passed the L.M.C.C. examination and obtained a general license in Ontario in 1978. Between 1977 and 1982, Dr. Jain successfully completed a residency program in general surgery at Royal Victoria Hospital in Montreal. From 1982 to 1984, he took a further two years of training in C.V.T. surgery at the McGill University Teaching Hospitals. Dr. Jain passed the written fellowship examinations in C.V.T. surgery. He passed the oral exams in vascular and thoracic surgery but was unable to pass the oral examinations in cardiac surgery.

C From 1984 to 1992, Dr. Jain worked as a general, vascular and thoracic surgeon in Edmundston, New Brunswick. He was the Director of the Intensive Care Unit and had privileges in general surgery, vascular surgery, thoracic surgery, pacemaker surgery, angiography, endoscopy and laparoscopic surgery.

C From June 10, 1992 until February 2, 1993, Dr. Jain resided in India. While there, he started a private surgical centre with in-patient facilities to perform laparoscopic surgery.

C From April to September of 1993, Dr. Jain worked as a general practitioner for M.C.I. Clinics in Ontario. In October of 1993, he opened his own private practice as a general practitioner. Dr. Jain was out of Canada from December 10, 1993 until April of 1994.

C On June 1, 1994, Dr. Jain opened a family practice in Geraldton, Ontario and remained there until October 1, 1994. At that point in time, Dr. Jain returned to Toronto and opened a clinic in the Richmond Heights Plaza. The intent was to have a clinic with examining rooms, a small laboratory, an E.C.G. room, an endoscopy room and an operating room. It took some time to outfit and equip that clinic so in the meantime he opened a smaller, temporary site on November 18, 1994 in the same plaza. The full medical-surgical clinic opened in May of 1995. It was in these two clinics where the patient difficulties documented in the various College reports occurred.

C For a number of years, Dr. Jain had been intermittently providing narcotics to his wife for her personal use. In 1993 and 1994, the Bureau of Dangerous Drugs became concerned at the amount of Demerol Dr. Jain was purchasing, allegedly for office use.

Dr. Jain admitted to the Bureau that most of the Demerol was being administered to his wife for the treatment of recurrent dislocation of her shoulders and multiple wounds in her legs. On May 9, 1994, Dr. Jain met with officials of the C.P.S.O. and freely admitted that the provision of Demerol to his wife was inappropriate. To eliminate the temptation of continuing to provide this medication to her, he volunteered to the College that he would terminate his privileges to prescribe all narcotics except verbal prescription narcotics. Tab 2 of the Joint Book of Documents is a copy of the letter to the Bureau of Dangerous Drugs dated May 9, 1994 signed by Dr. Jain. Tab 3 is a copy of a Circular Letter No. 285 notifying Ontario pharmacists of the restriction.

C In January of 1995, Mrs. Jain experienced additional emotional problems and, when this resulted in her shoulder dislocating, she requested narcotics again. Dr. Jain ordered 4 ampoules of Demerol 50 mg. from Richpoint Pharmacy by telephone. He then persuaded another physician to write a prescription to cover that order. Dr. Jain obtained a second telephone order of Demerol for his wife but this time the other physician refused to write a prescription to cover it. Dr. Jain then wrote a prescription on his own office pad to cover the order. Thereafter, as his wife's need for Demerol grew, he wrote further prescriptions for her use, and to a lesser extent for use in the clinic.

C This matter originally came to the College's attention as a result of a letter of complaint dated April 25, 1995 from a surgical patient, S.J.. An inspector was appointed and he attended at Dr. Jain's clinic to review the complaint with Dr. Jain. As a result of the concerns raised by that inspection, an investigation was ordered pursuant to s. 75 of the *R.H.P.A. Code*. A total of 17 surgical charts were selected for review. In addition, a further 54 charts were selected from a list provided by the Bureau of Dangerous Drugs relating to Dr. Jain's prescription of narcotic and controlled drugs.

C As a result of the investigation, the Executive Committee, by Order dated March 8, 1996, suspended Dr. Jain's license under section 37 of the Code. Dr. Jain has been unable to practice medicine since that date.

C The College had the 71 patient charts reviewed by Dr. Geoffrey Morris, a general

practitioner. Dr. Morris identified problems in 37 of the 71 charts. Dr. Morris' report is found at Tab 4 of the Joint Book of Documents. Dr. Jain accepts as substantially correct the criticisms of his practice detailed in Dr. Morris' report.

- Dr. R., a staff anaesthetist at a major city hospital, was asked to review a number of charts with regard to anaesthetic management. A copy of Dr. R. s report, dated November 26, 1995, is found at Tab 5 of the Joint Book of Documents. Dr. Jain accepts as substantially correct the criticisms of his practice contained in Dr. R. s report.

- Dr. C., Surgeon-in-Chief at a major city hospital, was asked to review three specific surgical cases. A copy of his report dated December 11, 1995 is found at Tab 6 of the Joint Book of Documents. Dr. Jain accepts as substantially correct the criticisms contained in Dr. C. s report.

- At the request of the College, and with the consent of Dr. Jain and his wife, Dr. and Mrs. Jain were assessed by Dr. A., a specialist in alcoholism, drug dependencies and addiction medicine. Dr. A. s two reports dated September 23, 1996 are found at Tab 7 of the Joint Book of Documents. On the recommendation of Dr. A., Mrs. Jain enrolled in a program at an addiction rehabilitation institution in the spring of 1997 and, over the course of the last year, has successfully completed that program. She has been drug free since June of 1995.

- Dr. Jain also had himself voluntarily assessed by Dr. N., a Professor in the Department of Psychiatry at a major city university. Dr. N. s report dated November 6, 1997 is found at Tab 8 of the Joint Book of Documents.

EXPERT TESTIMONY

Dr. Geoffrey Morris is a Family Practitioner in Brampton, Ontario, member of the College of Family Physicians of Canada, and member of the Ontario Guidelines Implementation Network (CFPC) was accepted as an expert witness and testified at the hearing.

He gave evidence, supplementing his written report, and providing further detail regarding his

review of Dr. Jain s charts. He identified problems in 37 of the 71 charts he was given to review. His criticisms were significant, and are accepted by Dr. Jain as substantially correct. Excerpts are set out below:

With regard to L.C. (Appendix B of the Notice of Hearing), Dr. Morris written summary and assessment of the case is as follows: (tab 4, pp 32 & 33)

Name: *L.C.*
Sex: *Female*
Age: *43*

This patient's chart is remarkable in many respects.

The patient had a repair of a recurrent incisional hernia, which the doctor indicates was massive, apparently performed in his office in Richmond Hill. This procedure was performed under intravenous anaesthesia with Diazepam. Demerol and subcutaneous 2% Xylocaine with Epinephrine were also used. The operative report reveals that four fascial defects were identified in the linea alba, the largest of which measured approximately 10 centimeters in diameter. This does appear to justify the description of a massive hernia. The patient's initial visit to Dr. Jain took place on April 25, 1995 at which time the record indicates the patient had been recently diagnosed with a cardiomyopathy and was being treated with anticoagulants. The patient in fact had brought her records with her from _____ and a discharge summary from the _____ indicates that she had had this diagnosis, possibly related to ethanol intake, and showing evidence from an echocardiogram study of cardiac dysfunction. The patient's medications included the following:

Nitroglycerin
Isordil
Vasotec
Ativan
Digoxin
Coumadin
Lasix
Tylenol #3

Trental
Losec
Beclovent Inhaler
Ventolin Inhaler

The record of old notes in this chart also shows that the patient had had barium studies of the upper gastrointestinal and lower gastrointestinal tracts in the recent past prior to moving to Toronto.

Despite this history, over the next six weeks the patient had the following investigations done at Dr. Jain's office: esophagogastroduodenoscopy (EGD), pulmonary function tests, colonoscopy and biopsy, bronchoscopy, a doppler study of the vasculature of the legs and a ventral hernia repair. The patient also had a ganglion removed from her right foot.

It is my opinion that the large majority of these investigations were unwarranted. It is also my opinion that several of them placed the patient at unnecessary risk because of her past medical history, her complicated drug regimen, and the fact that they were performed in a primary care physician's office. In my opinion, the management of this patient falls significantly below the standard expected of a physician in this kind of practice in Ontario .

With regard to S.J. (Appendix C in the Notice of Hearing), Dr. Morris written summary and assessment of the case is as follows: (tab 4, p. 38)

Name: *S.J.*
Sex: *Female*
Age: *34*

This chart is remarkable for two reasons. Firstly, the patient had an esophagogastro-duodenoscopy (EGD) done for relatively minor indications and without any other attempt at treatment first. Secondly and most notably, this patient underwent an abdominal lipectomy in the doctor's office. This was done under epidural and local anaesthesia. The operation time is recorded as 2 hours 39 minutes. The notes record that the patient remained in the clinic for 24 hours for postoperative monitoring, that is the patient was an inpatient. I note also that the

patient appeared to develop a wound infection and was placed on antibiotics by the doctor. It is also evident from copies of correspondence in the chart that the patient was markedly unhappy with the results of the procedure performed by Dr. Jain.

In my opinion, the performance of this surgery in the doctor's office showed a marked discrepancy from the normal practice of a primary care physician. I believe that it shows a serious lack of judgement on the part of the doctor and in my opinion he demonstrated a disregard for the well being of his patient

Dr. Morris, on examination, stated that he believed that to keep a patient in a doctor s office over night as completely out of line and put the patient at considerable risk .

With regard to B.O., Dr. Morris summary of this man s chart and his opinion were as follows: (tab 4, p. 43)

Name: *B.O.*
Sex: *Male*
Age: *27*

There are a number of remarkable aspects to this patient's chart.

1) In the course of an annual health examination, the patient had an ECG and pulmonary function tests done for no obvious reason that I can discern.
2) The patient had an EGD done based upon flimsy indications.
3) The patient had a colonoscopy done for very flimsy indications.
4) The patient apparently had a repeat EGD done four months after the first one.

I note in passing that following the first EGD when the diagnosis of helicobacter pylori was made the patient was treated with triple therapy of Flagyl, Tetracycline and Pepto-Bismol. This treatment was offered in January 1995. This is noteworthy because by that date triple therapy for suspicion of helicobacter pylori had become fairly commonplace therapy in Ontario. In my opinion, the large majority of patients that Dr. Jain scoped should in fact have first been treated either with maximal ulcer therapy or with triple therapy such as this.

I note again that the procedures done in the doctor's office were done under intravenous sedation.

Dr. Morris stated in examination that Dr. Jain demonstrated that he was aware of triple therapy but did not always offer it, and Dr. Jain performed unnecessary investigations in his office under intravenous sedation .

With regard to M.S., Dr. Morris summary of this man s chart and his opinion were as follows: (tab 4 p 47-48)

Name: *M.S.*
Sex: *Male*
Age: *21*

The course of investigation and treatment provided to this patient by Dr. Jain is very difficult to understand. The patient's initial presentation was on December 1, 1994 at which time he appears to have had a general examination and had been given a prescription for Betnovate ointment and Atarax. There was also a plan that he would have blood work done the following day. The patient did indeed return the following day and had blood work done which is recorded as showing a haemoglobin of 9.2 milligrams % which was checked twice. This is equivalent to 92 grams per litre. The patient was then brought back the following day, December 3, 1994, and at that time had an esophagogastroduodenoscopy done under intravenous sedation. The justification for this investigation appears to be a history of abdominal pain four months previously and occasional dark stools. It appears that this was also done because of the low haemoglobin result. The patient was then seen again at the office on December 6, 1994 at which time the laboratory haemoglobin result had come back at 155 grams per litre. The repeat haemoglobin done in the office is recorded as showing 17 milligrams % on this occasion. The notes record signs and symptoms of reflux on and off and the patient was prescribed Zantac and Maxeran. The patient was seen again on December 9, 1994. The office notes indicate the patient having had side effects with Zantac, specifically decreased appetite and drowsiness. The patient is also said to have had slight shaking with Maxeran. The Zantac was discontinued and Losec was prescribed in its place. In my opinion, it

is most improbable that a decrease in appetite and drowsiness would result from Zantac.

The patient is seen again several times and on February 7, 1995 was once more seen with a clinical history of reflex esophagitis. The notes indicate that Zantac helps. The notes also indicate that food sticks in the esophagus and this apparently is the reason for recommending to the patient that another EGD should be performed. This is done again on February 8, 1995 and once again the pathology results are essentially negative. In may opinion, the first EGD is hard to justify and the second EGD is completely unjustified. The patient is seen again on February 25, 1995 when the results of the EGD and biopsy are reported to him and the notes indicate that the patient has lost weight during fasting. The doctor's note further recommends that the weight be checked in two weeks, however, three days later the patient is seen again.

The note says discussed weight loss, suggested colonoscopy, booked. This colonoscopy is indeed performed on March 4, 1995 and it is normal. In summary, this patient is subjected to two esophagogastroduodenoscopies and one colonoscopy in the space of three months. These investigations are done on the flimsiest of grounds in a 21 year old male. In each case the procedure is done under intravenous sedation in the doctor's office. It is my opinion that this management of the patient's problems is widely at variance from the expected management by a primary care physician. I believe that the doctor's judgement with regard to the patient's problems is markedly deficient and that the doctor demonstrates a disregard for the patient's well being in subjecting him to these investigations given the evidence available in the patient record.

Dr. Morris stated in examination that in his opinion the management of this case demonstrated careless management of a simple problem with a lack of thought about what was appropriate .

With regard to J.F., Dr. Morris summary of this man s chart and his opinion were as follows: (tab 4 p 58)

Name: *J.F.*
Sex: *Male*
Age: *64*

This unfortunate patient had a malignant tumor of the liver diagnosed at _____ Hospital

with a confirmatory biopsy done at that hospital on September 22, 1994, The report of this biopsy is in the patient's chart and it appears to have been obtained with the notes from the previous physician of this patient. The date of the patient's first visit to Dr. Jain is November 24, 1994 and the first note of that visit indicates results of CT scan, brain scan and the liver aspirate referred to above. This is in fact an extensive note and records in more than one place the diagnosis of sarcoma or spindle cell cholangio carcinoma with references to Dr. C. at _____as well as the pathology report from _____. There is also a reference to the patient having had a colonoscopy done at _____.

Although this patient clearly has had extensive workup, for his malignancy Dr. Jain performed a colonoscopy under intravenous sedation on November 26, 1994. On November 29, 1994 he then performed a gastroscopy. On December 24, 1994 Dr. Jain performed a needle biopsy of the liver.

It is my opinion that the actions of Dr. Jain in providing care to this patient are unreasonable, unethical and show remarkably poor judgement. Clearly this patient had had already an extensive workup, done at_____ and was attending a Dr. F. for oncology treatments. He was also being seen by other oncologists and specialists. It is my opinion that the role of a primary care physician in providing care to this patient is to explain to him his situation, the results of the tests that he has had and to counsel him where necessary on the advisability of further treatment or investigations. It is not the role of the primary-care physician to repeat investigations which have already been done. Nor is it his role to do investigations whose yield will not after the course of treatment or illness in the patient. I am unwilling to speculate as to what Dr. Jain's motives may have been for performing these invasive procedures in a seriously ill man. I do not believe however that any of them would have yielded information which would alter the course of treatment or disease in this patient. Subjecting this terminally ill man to these invasive procedures, in my opinion, demonstrates a disregard for the patient's well being .

Dr. Morris stated in examination that in his opinion no one should have performed the investigations done by Dr. Jain on a terminally ill patient who had already been worked up and to do so showed disregard for the patient s well being.

Finally, Dr. Morris gave evidence of his opinion with regard to L.L., Appendix D of the Notice

of Hearing. Dr. Morris summary of this man s chart and his opinions were as follows: (tab 4 p 78 & 79)

Name: *L.L.*
Sex: *Male*
Age: *88*

This 88-year-old man presented to Dr. Jain's office on December 14, 1994 for the first time. He presented with a mass in his right axilla which had previously been subjected to a needle biopsy. The first note indicates that the pathology was suggestive of malignancy showing a squamous cell carcinoma. There was a history of a previous excision of a malignant lesion on the right forearm 1 hears before. Dr. Jain did an esophagogastroduodenoscopy (EGD) on this visit. I am uncertain as to why this was done. There appears to be no indication for this investigation. Two days later on December 16, 1994 Dr. Jain did an excision of the axillary mass under local anaesthesia plus intravenous anaesthesia. The patient subsequently developed a seroma secondary to this surgery with ongoing drainage from the incision and requiring this to be drained by the doctor on several occasions. On January 4, 1995, the patient had three lesions excised from his forehead and scalp by Dr. Jain, query malignancy. The notes subsequently indicate that this was diagnosed as Bowen's disease. The patient's postoperative course was complicated by purulent discharge from the scalp wounds and by a erysipelas or cellulitis on the chest. These infections were treated initially with Cloxacillin and subsequently with Cipro. An opinion from a dermatologist regarding the rash on the chest was sought. His opinion was that the rash was ecchymosis or bruising.

On February 23, 1995, radical right axillary lymphadenectomy was done by Dr. Jain under local anaesthesia in his office. The patient once again developed a serous discharge or ooze from the incision. On April 18, 1995, the patent was diagnosed as having six new lesions in the axillary skin, 3 to 4 millimetre nodules and was referred for radiotherapy. On August 16, 1995, the patient had a lesion on his right forearm excised by Dr. Jain under local anaesthetic.

<u>Comment:</u>
In my opinion, Dr. Jain's management of this patient is entirely outside the normal bounds for a primary care physician. This unfortunate man clearly had a significant problem with metastatic

squamous cell carcinoma. He had already had a pathological diagnosis made at the time of initial presentation. He clearly required an early referral for systemic treatment, probably radiotherapy. Instead he was subjected to multiple investigations and surgical procedures, including an excision of the mass on the right axilla, a radical lymphadenectomy in the right axilla, an esophagogastroduodenoscopy, an excision biopsy of a lesion on the right forearm, and management of the multiple complications which ensued from the surgeries. It is my opinion, that this patient was done considerable disservice by this approach to his disease, I believe that Dr, Jain demonstrated disregard for his patient and showed a deficiency in his judgement such that I would have concerns about his continuing to practice without restriction .

Dr. Morris stated in examination that this form of treatment and management showed disregard for patient care.

In Dr. Morris opinion the information from the reviewed charts demonstrates poor judgement, lack of regard for patient welfare and lack of proper referral.

Criticisms of Dr. Jain s surgical practice by Dr. C. were also accepted as substantially correct by Dr. Jain, and are set out below.

1. L.C.

This woman underwent what is described as a massive incisional hernia repair under a local anaesthetic. This was an open abdominal procedure with entry into the peritoneal cavity. If the incision was as large as Dr. Jain described, then the treatment would be to drain the subcutaneous dead space, and to decompress the abdomen with a nasogastric tube to minimize abdominal distension and minimize any possibility of dehiscence and eventually evisceration. This case was done as an open procedure under local anaesthetic in a clinic setting with no hospital back up. There was no anaesthesia back up. It is definitely not the standard to perform this type of operation as described by Dr. Jain in a clinic setting under local anaesthesia. In addition and importantly, this patient had a complex medical history with multiple comorbid conditions. The patient was taking the following medications:

Nitroglycerin, Isordil, Vasotec, Ativan, Digoxin, Coumadin, Lasix, Tylenol, Losec, and Ventolin.

This patient obviously had cardiac and respiratory comorbid conditions. There was nothing in the history to suggest any type of medical consultation prior to undertaking surgery even though this was being done under local anaesthetic. The procedure as described and the setting in which it was performed definitely put the patient at an unneccessary risk of potential harm. I will not comment on the qualifications of Dr. Jain to carry out endoscopic procedures such as colonoscopy and bronchoscopy.

C *S.J.*

Again I will not comment on Dr. Jain's qualifications to do this type of cosmetic surgery. However, it was a lengthy operative procedure done under local anaesthetic and again with no anaesthetic back up. I have observed through my reading of the file that Dr. Jain also administered the epidural. Was he monitoring the epidural catheter while the surgery was being performed? Dr. Jain carried out this procedure removing what was described as four pounds of fat from an individual with an obvious obesity problem. Her problem is really dietary, psychiatric and possibly surgical either gastric stapling or a gastrojejunal bypass procedure for obesity. It would be completely unrealistic to assume that the underlying problem of this patient would be helped with removal of fat from the abdominal wall. In addition, there is no evidence that proper counselling was given to this patient. I would certainly like to know what qualifies Dr. Jain to give proper counselling to a patient such as this. In addition, this patient was undergoing medical treatment for Peptic Ulcer Disease presumed to be due to Helicobacter. Was it necessary to undertake this type of cosmetic procedure while the patient was undergoing treatment for another organic problem? Again I would reiterate that this procedure was not going to fulfill the patient's expectations and the doctor should have realized this. Once again, I would question the ethical nature of performing this type of procedure in, not only a clinic setting, but a clinic setting which is not well equipped with regards to lighting and emergency equipment.

C *3. L.L.*

In this particular case the patient initially presented approximately one and one-half years prior to the initiation of surgical procedures by Dr. Jain, with a lesion in the right arm. Lesions were

found in the axilla and a description of an excision of the lesion and an axillary dissection were outlined. It is not the standard of practice to carry out a proper axillary dissection under a local anaesthetic in a clinic setting. This person had a malignancy originally and one could have predicted that this was a malignancy once again. Exposure to the axilla can be much better achieved with a general anaesthetic than with a local anaesthetic. The original pathology from a year and a half ago should have been checked prior to proceeding with this particular surgery. In addition when the problem did recur, another attempt at a radical axillary dissection was undertaken. I would ask what the purpose of this would be if an adequate radical axillary dissection was undertaken with the first procedure. Thus, was anything left to remove? In addition, with this type of early recurrence there would be no point in further surgery. I therefore question the judgement in this particular case. A radiotherapy consultation should have been arranged immediately for this patient on learning of the recurrence following the initial surgery by Dr. Jain.

Even if this procedure were carried out under local anaesthetic, Dr. Jain should have had the presence of mind to have an anaesthetist present in case he was not able to gain adequate exposure in order to carry out the axillary dissection. This was not arranged as far as I can tell from the notes. Once again, I would question the adequacy of the facility and lack of emergency resuscitative equipment.

Overall I believe that none of these three cases should have been performed in the outpatient ambulatory setting without better back up, human and physical resource. I believe that in all three cases, Dr. Jain fell below the standard of practice in the ways that I have described above .

The anesthetic management by Dr. Jain of his practice was the subject to a report by Dr. R.. His criticisms of Dr. Jain s practice were also accepted by Dr. Jain as substantially correct. In his report he states as follows:

My first concern on reviewing the charts was Dr. Jain's method of intravenous sedation for colonoscopy and gastroscopy. it is customary to sedate most patients for these uncomfortable procedures. The following patients all received Demoral (Meperidine) 100 mg and Diazemul (Diazepam injectable emulsion) 10 mg intravenously.

S.S. 17/3/95
M.S. 8/2/95 & 4/3/95
B.O. 10/5/95

The use of Diazemul is very common in this situations but the addition of Demoral in this dose could lead to severe respiratory depression, lack of oxygen, and low blood pressure. The dose and route of these drugs in this quantity for these apparently young and healthy patients would be clinically safe if the monitoring of breathing, oxygen saturation and blood pressure was done. There is no record of this in the chart. It would also be necessary to give these drugs in divided doses as there is great patient variability in response. This was not done as all received the same dose.

The next two patients,_____ and _____ had surgical procedures on 30/5/95 and 3/4/95. These operations were also done under intravenous sedation of Demoral 100 mg and Diazemul 10 mg. The same problems as with colonoscopy and gastroscopy occur. Again these two patients had no monitoring done. The Canadian Anaesthetist Society minimum standards of practice dictate the use of electrocardiography, blood pressure, respiratory monitoring, oxygen saturation and temperature. There is no evidence of this being done.

The next patient _____ is a special case. On May 8, 1995 she had a colonscopy and May 9 bronchoscopy and June 11 1995 massive recurrent incisional hernia repair. On all these occasions she received intravenously Demoral 100 mg and Diazemul 10 mg. There is no evidence of any monitoring being done and no evidence of incremental doses. The major problems is that unlike the previous patients this lady in spite of being only 43 was suffering from cardiomyopathy (inflammation of the heart muscle) and chronic obstructive lung disease. She was receiving 11 different drugs. I believe that the anaesthetic drugs given on three separate occasions were dangerous. The absence of monitoring during the procedures put her under unnecessary risk. In my opinion this sort of sedation and anaesthesia on this patient should not be done in a doctor's office due to her far from ideal clinical condition.

The final patient is _____. She is a 34 year old who had an abdominal lipectomy on 1 6/3/95. The anaesthetic management obtained from her chart was epidural and local. There is

no documentation of the epidural but the dose of local was 125 mg of 0.5 % xylocaine (lidocaine). This equals 625 micrograms, the upper limit of a patient weighing 218 lb. The dose of the anaesthetic given in the epidural space would have put her into the high toxic range where convulsions and low blood pressure are likely to occur. This anaesthetic management is especially dangerous in a doctor's office aswell the dose of local anaesthetic put this patient under greater risk.

Unlike all other patients there is slight mention of monitoring in the operation note of blood pressure, oxygen saturation and temperature. I find it very worrisome that there is absence of charting of these parameters the standard of practice of anaesthesia is for these to be recorded every 5 minutes during an operation. I think that Dr. Jain did the epidural and then was unable to monitor the patient properly afterward as he was operating. There was no evidence of any other person charting the patients condition during the operation. This is unacceptable anaesthetic practice.

If there is any other documentation relating to these cases that could clarify Dr. Jain's practice I would be pleased to examine it but based on the patients' charts I believe the use of drugs, absence of monitoring and very poor documentation lead me to believe that these patients were put under unnecessary risk. This type of anaesthetic practice does not meet normal Canadian standards .

THE TESTIMONY OF DR. JAIN

Dr. Jain gave evidence regarding his medical career which was essentially as described in the Statement of Agreed Facts. He also gave evidence regarding stressors in his life often at crucial points in his medical career.

At the time of his final examinations, which he failed, his sister had been killed in India and his wife suffered repeated shoulder dislocations. She insisted that he manage this and he did, using intravenous Demerol. Thereafter, he supplied his wife with Demerol on a fairly regular basis until in 1994, the Bureau of Dangerous Drugs became involved. He then attended at the College of Physicians and Surgeons of Ontario and voluntarily gave up his privileges to prescribe narcotics. In 1995, his wife again demanded Demerol and he obtained it for her until July 1995 when she became pregnant. Since then she has been drug free.

Dr. Jain also gave evidence regarding his financial difficulties. Four years after he began independent practice as a surgeon in New Brunswick, he suffered a major financial setback related to real estate speculations. Three years later, after leaving New Brunswick and not finding a place to work in Ontario, he went with his wife to India, intending to liquidate his Indian assets and bring them back to Canada. It was at this point he opened in India a surgical clinic under his wife s name, since she was a registered physician in India and he was not. This was a very successful venture but came to an abrupt end when he and his wife were kidnapped and she was tortured until she signed over all her assets. She received multiple injuries, which did not heal well and caused severe pain for which Dr. Jain says he also supplied her with Demerol.

On return to Canada, Dr. Jain worked in walk-in-clinics and was unable to obtain hospital privileges since he did not have specialist certification. He opened in 1993, a practice in Richmond Hill and shortly thereafter returned to India with his wife. Once again, Dr. Jain testified that they were captured, their money taken and in April 1994 returned again to Canada to find the Richmond Hill office closed.

Dr. Jain testified that this was the reason why he moved to Geraldton where he worked long hours in a hospital setting. Once again, because of his wife s difficulties, they returned to Toronto at the end of 1994 and in November 1994 opened a small medical/surgical clinic and in May 1995 a full medical/surgical clinic. Dr. Jain stated that he meant to apply for this to be a registered as an independent health facility but did not do so. In April 1995, a complaint was made to the College and as a result of this, after inspection, his certificate of registration was suspended under Section 37 of the Code on March 31, 1996.

He and his wife were assessed by Dr. A. at the request of the CPSO. Dr. A. recommended Mrs. Jain attend the addiction rehabilitation institution although she had been and still is, drug free since June 1995. Dr. A. found no evidence of psychiatric illness or chemical dependency in Dr. Jain but made no statements regarding his return to practice. Dr. Jain also had himself assessed by Dr. N. and his report is dated November 6, 1997. This stated that at the time, Dr. Jain suffered no mental or physical disorder. Dr. N. stated that Dr. Jain s lack of awareness of the dynamics of his personality (passive dependent with a repressed anger) and its impact on

critical situations were major factors in creating his difficulties. He recommended psychotherapy. Furthermore, Dr. N. expressed his opinion that if Dr. Jain worked under strict supervision for one year while in therapy, this would ensure the safety of the public. Dr. N. does not comment on Dr. Jain s actual practice of medicine.

Dr. Jain also stated in examination that since the suspension of his certificate of registration, after two years of trying to find employment in medically related work, he returned to real estate in which he has had an active interest since the age of 13. He obtained his real estate licence in 1998 and has been very successful in employment.

Since 1996, he has not entered into psychotherapy, has not attended any CME courses but stated that he continued to read *CMAJ, Members Dialogue* and take Internet courses.

He stated also that in his practise of medicine, his normally good judgement was totally lacking due to financial, emotional and marital pressures. He apologized to his colleagues and requested a second chance.

In cross-examination, Dr. Jain stated that he learned to do endoscopies in the residency program when he was supervised and that he had experience in EGD s in a hospital but never in a clinic setting. He agreed that the majority of his activity in the_____ clinic was performed without the presence of an anaesthetist. He also stated that 50 percent of his revenue of his OHIP billing was sent directly to Revenue Canada and that there was strong pressure on him to earn money. Since being in real estate, these financial difficulties have been essentially resolved.

Dr. Jain agreed retrospectively that some of his procedures put his patient at risk but did not remember thinking this at that time.

When asked specifically about the cases described in the Statement of Agreed Facts, he agreed that he should have done some things differently. He agreed that he was aware he could have made referrals to other facilities, but stated that this was difficult since he did not have privileges at the _____hospital. He thought that with some effort he could have done this and in fact did eventually refer L.L. to a dermatologist.

Also in regards to L.L., Dr. Jain stated that he treated this patient in his clinic since L.L. did not want to go to hospital. He also stated that this patient was offered a referral to _____hospital, but refused it. However, there is no note of any of this in the patient s chart. Prosecution counsel also noted that none of the 31 patients reviewed were referred to other consultants and Dr. Jain stated that he did not recollect this but repeated that he had referred L.L. to a dermatologist.

DECISION

The Committee accepted the criticisms of Dr. Jain s practice in the expert evidence of the College. Taking into account the factual admissions in the Agreed Statement of Facts and the plea of guilt, the Committee found Dr. Jain guilty of professional misconduct and incompetence as alleged in the Notice of Hearing.

SUBMISSIONS AND ARGUMENT REGARDING PENALTY

Prosecution counsel argued that the nature, seriousness and scope of misconduct overcame the very extensive mitigating circumstances and that the circumstances were not sufficient to allow a lesser penalty than revocation. Prosecution counsel also submitted that Dr. Jain had extensive training and ample provision of knowledge yet still put his patients at very real risk . Furthermore, Dr. Jain s breach of prescribing restrictions in ordering narcotics after he had voluntarily given up his privileges indicated that he may not be trusted to abide by restrictions.

Counsel for the defence argued that incompetence can be dealt with by restrictions (section 50(1) of the Code) and that professional misconduct could similarly be dealt with by conditions and restrictions.

Counsel for defence stated that the opportunity to assist in surgery had been offered to Dr. Jain and since surgical assistants are in short supply, Dr. Jain would be fulfilling a public need. The proposal by defence counsel requested a limited right to order pre and post-operative narcotics. It was also stated that Dr. Jain was prepared to take all courses recommended, arrange for reports to be sent on a six-monthly basis and that he wished to be able to request variation to this restriction after two years.

PENALTY DECISION

The Discipline Committee orders that Dr. Jain s certificate of registration be revoked and further, that he receive a recorded reprimand.

REASONS FOR PENALTY

The members of the Discipline Committee considered the evidence before them and were in complete agreement that they could not accept the described circumstances of Dr. Jain s life as justification for his lack of consideration for the welfare of not one but many patients. Although there was evidence offered in his defence regarding his wish to relieve pain and distress, particularly in Dr. N. s assessment, this was not evident in Dr. Jain s treatment of his patients.

There is good evidence that Dr. Jain is not a naive doctor, that he received good training and must have known what he was doing. His treatment and management of many patients demonstrated a serious lack of judgement with great risk to those patients.

The Committee noted that voluntarily gave up his privilege to prescribe narcotics only to start prescribing them again. He breached his undertaking to the College. He has made only minor efforts to maintain his skills and has not followed advice with regard to psychotherapy.

The Committee is of the opinion that Dr. Jain s flagrant failure to maintain the standard of practice of the profession and his disgraceful, dishonourable and unprofessional behaviour, together with contravention of the federal law, require the imposition of the most severe penalty, that is revocation. The Committee is not persuaded that the proposed restricted certificate of registration would serve as a deterrent either to Dr. Jain in future or to members of the College, nor would it offer any protection to the public which is the responsibility of this College.

The Committee is also of the view that the finding of incompetence warrants revocation of Dr. Jain s certificate of registration to practice medicine.