## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Vipul Kumar Bhupal, 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 the patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

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

**Indexed as: Bhupal, V. K. (Re)**

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

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

**B E T W E E N:**

**THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO**

**- and -**

**DR. VIPUL KUMAR BHUPAL**

**PANEL MEMBERS:**

**DR. W. KING (CHAIR)**
**D. DOHERTY**
**DR. P. POLDRE**
**S. BERI**
**DR. F. SLIWIN**

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| **Hearing Date:** | June 6, 2014 |
| **Decision Date:** | June 6, 2014 |
| **Release of Written Reasons:** | July 8, 2014 |

# PUBLICATION BAN

## DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 6, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

## THE ALLEGATIONS

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

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

2. under paragraph 1(1)33 of 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; and

3. under paragraph 1(1)5 of O.Reg 856/93, in that he had a conflict of interest.

It is also alleged that Dr. Bhupal is incompetent as defined by subsection 52(1) of the Code.

## RESPONSE TO THE ALLEGATIONS

Dr. Bhupal admitted the first allegation in the Notice of Hearing that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the remaining allegations.

## FACTS AND EVIDENCE

The following Agreed Statement of Facts was filed as an exhibit and presented to the Committee:

## FACTS

### *Background*

1. Dr. Vipul Kumar Bhupal ("Dr. Bhupal") is a general practitioner who, at all material times, practiced in Toronto, Ontario. He graduated from medical school at the University of Toronto and has been practicing in Ontario since 1989.

2. At all material times, Dr. Bhupal's office was located in Toronto, Ontario. As set out in further detail below, Dr. Bhupal admits that he failed to maintain the standard of practice of the profession in his care and treatment of five patients.

### *Investigation under s. 75(1)(a) of the Health Professions Procedural Code*

3. Dr. Bhupal referred patients for echocardiograms and stress echocardiograms at Company 1, a company which rented part of Dr. Bhupal's office space from him. A s. 75(1) (a) investigation was commenced in April, 2011 to inquire into, among other things, the appropriateness of Dr. Bhupal's referrals of patients to Company 1 for cardiac testing.

### *Expert Opinions*

4 In the course of s.75(1)(a) investigation into Dr. Bhupal's practice, the College appointed Dr. X as a medical inspector to provide an opinion regarding Dr. Bhupal's care and treatment of patients.

5. Drs. Y and Z were retained by Dr. Bhupal to respond to the expert opinion of Dr. X.

**ADMISSION**

6. Dr. Bhupal admits that he failed to maintain the standard of practice of the profession in his referral of patients to Company 1 for echocardiography and stress echocardiography in the following respects:

- Patient A: Dr. Bhupal ordered echocardiograms without appropriate indications, and failed to order a lipid profile to fully assess the patient's cardiovascular risk, even though the patient had a history of high LDL and had been prescribed Lipitor in the past. Dr. Bhupal further failed to refer the patient to a cardiologist for a nuclear stress test following her echocardiograms and stress echocardiograms, and failed to maintain the standard of practice with respect to record keeping in that his chart lacked adequate means of tracking test results.

- Patient B: Dr. Bhupal ordered multiple echocardiograms and stress echocardiograms without sufficient indication for this patient, even after a cardiologist indicated they were unnecessary. A first echocardiogram was ordered and justified in August 2006 for this 36 year old male who was suffering from general fatigue, and a follow-up on this first echocardiogram was appropriately done one month later. Several repeat echocardiograms were done until in July, 2007, the patient was referred to a cardiologist. In October 2007, the patient was assessed by the cardiologist, whose assessment, provided to Dr. Bhupal, states: "*I reassured him that I do not think anything serious is going on. I will arrange for a stress test and an echo so I can review it personally with regards to the minimal pericardial fluid. I have not changed any medications for now. The beta-blocker may be useful in terms of treating both the blood pressure and the PVCs.*" The stress tests were performed by the cardiologist in October, 2007 and the reports were provided to Dr. Bhupal. The cardiologist indicated "*I reassured him about the stress test. It looks good.*" The cardiologist also mentioned that a 2D echocardiogram was done and essentially was entirely normal other than a very small

pericardial effusion. The patient had agreed to see him in six months, at which point the cardiologist would do one more echo and if it was stable, there would be no more echocardiograms. The patient was seen again by the cardiologist in October, 2008, and the cardiologist indicated he was not concerned. Six days later, the patient was seen by Dr. Bhupal for a physical, and Dr. Bhupal ordered an echocardiogram and stress echocardiogram, as well as a Holter and abdominal ultrasound. An echocardiogram was repeated in October, 2009 and a stress echocardiogram further that month, then repeated in August, 2010, and March 2011. That is, the patient underwent twelve echocardiograms over a period of five years. Even after the cardiologist suggested that the echocardiogram report was clinically insignificant, Dr. Bhupal continued to order echocardiograms and stress echocardiograms on this patient.

- Patient C: Dr. Bhupal failed to order appropriate laboratory tests and ordered stress echocardiography without indication before conducting an appropriate history and physical exam for this 33 year old patient who presented with palpitations. That is, Dr. Bhupal did not order basic laboratory tests such as a complete blood count, TSH, sugar, electrolytes and lipids. A stress echocardiogram should not be a first line test in this case, and Dr. Bhupal did not complete other tests to properly assess the likelihood of coronary artery disease.

- Patient D: Dr. Bhupal ordered unnecessary repeat echocardiography for this patient, even after consultation with a cardiologist who indicated the following: the cardiologist would be doing repeat tests; he does not believe the pain to be cardiac; and his impression is that there is nothing serious going on. After several negative stress echocardiograms and without clear-cut symptoms or risk factors suggestive of coronary artery disease, Dr. Bhupal failed to maintain the standard by ordering further repeated echocardiograms and stress echocardiograms. Further, Dr. Bhupal failed to maintain the standard of practice with regard to his record keeping in that his chart contains no details

of physical findings or history pertaining to his ordering of echocardiography and stress echocardiography for this patient.

- Patient E: Dr. Bhupal ordered stress echocardiography without appropriate indications in a 27 year old patient with a two week history of dizziness with exertion, no chest pain or shortness of breath. The patient had had a normal echocardiogram eight months previously. There was no blood work, EKG or Holter, which should have been the first steps taken by Dr. Bhupal.

7. Dr. Bhupal admits the facts specified in paragraphs 1 through 5 above and admits that, based on these facts, he has failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act*, 1991.

**FINDINGS**

Counsel for the College clarified in her submissions, and counsel for Dr. Bhupal acknowledged, that the conclusions regarding the manner in which Dr. Bhupal failed to maintain the standard of practice in his care of these five patients, as expressed in paragraph 6 of the Agreed Statement of Facts, derived from the opinions of the expert retained by the College and the two experts retained by Dr. Bhupal, referred to in paragraphs 4 and 5.

The Committee accepted as true all of the facts and opinions set out in the Agreed Statement of Facts. Having regard to these facts and opinions, the Committee accepted Dr. Bhupal's admission and found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession.

**PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for Dr. Bhupal made a joint submission as to the appropriate penalty and costs. The Committee is aware that a joint submission should be accepted by the panel unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute. In considering the proposal, the

Committee reviewed the Agreed Statement of Facts and the Joint Book of Authorities and considered the submissions of the parties.

The Committee considered the aggravating factors in this case. Dr. Bhupal ordered significant, unwarranted and expensive cardiac investigations at a premature stage of patient contact and sent patients for these investigations to a testing facility owned by his tenant. The nature of the tests ordered is such that it could be unnecessarily concerning, intrusive and inconvenient for patients. It is also expensive for the health care system. On the other hand, Dr. Bhupal failed to order basic laboratory tests, and failed to refer to, or abide by, a specialist, when indicated. In addition, he failed to adequately chart indications for testing and test results. It is a critical for patient care that the correct tests are ordered at the right time and that a physician acts in the best interests of their patients.

The Committee considered the mitigating factors in this case. Dr. Bhupal has no previous discipline history. He admitted and took responsibility for his actions, thus saving the College the costs of a fully contested hearing. Dr. Bhupal no longer rents space to Company 1 or refers patients there. He completed a course in medical record keeping prior to the hearing and has made changes to his clinical practice, including his record keeping practices.

Although the Committee is not bound by prior decisions of the Discipline Committee, it is desirable that similar cases be treated in a like manner. The Committee is of the view that the proposed penalty laid out in the Joint Submission is consistent with the penalties ordered in prior, similar cases of the Discipline Committee.

Finally, the Committee agreed with the submission of the parties that the proposed penalty would uphold the relevant penalty principles of public protection, specific and general deterrence, rehabilitation of the member and maintain public confidence in self-regulation. The public reprimand will serve as specific and general deterrence. Dr. Bhupal’s practice will be reassessed in six months by an independent assessor and Dr.

Bhupal must abide by the assessor's recommendations. This will serve the principle of rehabilitation of the member, as well as providing public protection.

The Committee determined that this was an appropriate case to order costs at the tariff rate of $4,460.00 for a one-day hearing.

**ORDER**

Therefore, having stated the findings in paragraph 1 of its written order of June 6, 2014, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Bhupal appear before the panel to be reprimanded.
3. the Registrar to impose the following terms, conditions and limitations on Dr. Bhupal's Certificate of Registration:

    (i) Within 6 months of the date of this Order, Dr. Bhupal shall undergo a Comprehensive Practice Assessment by an assessor or assessors appointed by the College (the "Assessor(s)").

    (ii) Dr. Bhupal shall abide by any and all recommendations of the Assessor(s), including with respect to any practice improvements and/or ongoing professional development and/or education.

    (iii) Dr. Bhupal shall be solely responsible for all fees, costs and expenses associated with his compliance with the terms of this Order.

4. Dr. Bhupal pay costs to the College in the amount of $4,460.00, within thirty (30) days of the date of this Order.

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