NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Mohamed Abdel Hadi Elmorsi Ismail, this is notice that the Discipline Committee ordered that there be a ban on publication of the names of any patients or any information that would identify 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..… 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: Ontario (College of Physicians and Surgeons of Ontario) v. Ismail, 2020 ONCPSD 45

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. MOHAMED ABDEL HADI ELMORSI ISMAIL

PANEL MEMBERS:

DR. ERIC STANTON (CHAIR)
MR. JOSE CORDEIRO
DR. PAUL HENDRY
MS LINDA ROBBINS
DR. IDA ACKERMAN

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS SIMMY DHAMRAIT-SOHI

COUNSEL FOR DR. ISMAIL:

MS SARAH MARTENS

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. JESSE HARPER

Hearing Date: September 15, 2020
Decision Date: December 15, 2020
Release of Reasons Date: December 15, 2020

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario ("the College") heard this matter via videoconference on September 15, 2020. During the hearing, the Committee stated its finding that the member committed an act of professional misconduct. The Committee reserved its decision on penalty.

THE ALLEGATION

The Notice of Hearing alleged that Dr. Mohamed Abdel Hadi Elmorsi Ismail committed an act of professional misconduct:

1. 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 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.

RESPONSE TO THE ALLEGATION

Dr. Ismail admitted the allegation in the Notice of Hearing, that he engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

AGREED STATEMENT OF FACTS AND ADMISSION

THE FACTS

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

Background

1. Dr. Mohamed Abdel Hadi Elmorsi Ismail ("Dr. Ismail") is a forty-seven (47) year old anaesthesiologist. He received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College") on June 30, 2017.

2. Dr. Ismail currently holds privileges and practices at the St. Thomas Elgin General Hospital ("STEGH") in St. Thomas. Since approximately November 2018, Dr. Ismail holds affiliations with various Out of Hospital Premises in Mississauga, Ancaster, St. Catharines, Burlington, Oakville and Toronto.

3. Between 2017 and 2019, Dr. Ismail held privileges at the Windsor Regional Hospital (the "WRH") in Windsor, Ontario. Dr. Ismail was appointed to the WRH's Professional Staff on October 5, 2017. He resigned his privileges at WRH effective July 1, 2019.

Dr. Ismail's Agreement with the Windsor Regional Hospital

4. On October 30, 2018, Dr. Ismail was working a shift at the WRH. While working with Dr. Ismail, operating room nursing staff reported having witnessed Dr. Ismail coming out of the washroom and walking with an unsteady gait, looking pale and slurring his speech, and repeatedly asking the same questions. The nursing staff reported these concerns to WRH.

5. On November 2, 2018, while Dr. Ismail was working a shift at WRH, operating room nursing staff again reported having observed Dr. Ismail coming out of washroom

walking with an unsteady gait and slurring in his speech. The nursing staff reported these concerns to WRH.

6. On November 2, 2018, as a result of the concerns raised regarding Dr. Ismail's conduct and capacity, Dr. X, the Chief of Staff at WRH, met with Dr. Ismail. Dr. Ismail voluntarily agreed to cease exercising his privileges at WRH until reassurance was provided to WRH regarding Dr. Ismail's ability to safely provide anaesthesia services.

7. On November 8, 2018, Dr. Ismail provided WRH a letter from his family physician which stated that he was medically fit to return to work. WRH determined that this letter was insufficient to reassure WRH that Dr. Ismail was in fact fit to return to work.

8. On November 12, 2018, Dr. X sent a letter to Dr. Ismail advising of the next steps WRH proposed in order to provide Dr. Ismail with an opportunity to address the concerns raised regarding his conduct and capacity on October 30 and November 2, 2018. In the letter, WRH advised that it would not initiate Immediate Mid-Term Action in accordance with the hospital's By-Law or recommend restrictions or conditions to Dr. Ismail's privileges at WRH, if Dr. Ismail agreed to comply with the terms specified by WRH.

9. Among the various terms, WRH requested that: (1) Dr. Ismail take a leave of absence from WRH and during the leave of absence, voluntarily agree not to exercise his privileges at WRH and undertake not to provide anaesthesia services at any other hospital or facility; (2) Dr. Ismail engage with the Physician Health Program ("PHP") of the Ontario Medical Association on specified terms, including to undergo a comprehensive assessment through the PHP Assessment Service or an alternative third party assessment acceptable to WRH.

10. In the days following receipt of Dr. X's letter, Dr. Ismail sent, what he acknowledged during the College investigation were, inappropriate and unprofessional text messages to Dr. X and inappropriate and unprofessional emails to WRH in which he expressed frustrations with the PHP process, and the way the hospital was handling the matter.

11. On November 22, 2018, Dr. Ismail entered into an agreement with WRH, which included the following terms:

- He agreed not to exercise his privileges at WRH until such time that the hospital received information satisfactory to it that Dr. Ismail may safely return to practice, and hospital approved the return;
- He undertook to notify WRH if he intended to provide services at any other hospital or facility in Ontario and to provide fifteen (15) days written notice prior to the commencement of any such practice; and
- He also confirmed that he had contacted PHP as requested by WRH but was pursuing the possibility of an alternative third-party assessment, details of which would be provided to the hospital for review and approval.

12. On November 22, 2018, Dr. Ismail confirmed to WRH that he was currently not providing anaesthesia services at any other hospital or facility.

Dr. Ismail Provided Anaesthesia Services at a Hospital Or Facility Without Notice to WRH Contrary To His Agreement

The Report to the College

13. On March 8, 2019, WRH notified the College that it had received information on March 5, 2019, that Dr. Ismail may have been providing anaesthesia services at a facility in Ontario. Contrary to his agreement with WRH, Dr. Ismail did not notify WRH of his

intention to provide anaesthesia services at a hospital or facility. WRH had received no written notice from Dr. Ismail.

14. On March 6, 2019, on inquiry by WRH, Dr. Ismail confirmed that he had been providing anaesthesia services without notice to WRH. Dr. Ismail stated that since November 22, 2018, "he has only assisted with sedation in relation to endoscopy procedures on a few occasions in Toronto and area between the end of January and February 1."

The College Investigation

15. During the investigation, the College obtained data from Ontario Health Insurance Plan ("OHIP") for claims submitted by Dr. Ismail for services rendered to all patients between the time period of October 1, 2018 and June 11, 2019. A copy of Dr. Ismail's relevant OHIP claims, between time period November 2, 2018 to February 1, 2019, is at Tab A to the Agreed Statement of Facts and Admission.

16. The OHIP data shows that between November 22, 2018, and February 1, 2019, Dr. Ismail repeatedly submitted claims for anaesthesia services rendered to patients at hospitals and facilities in Ontario. He did not provide notice to WRH of his intention to provide these services, contrary to his agreement.

17. The OHIP data confirms that Dr. Ismail provided misleading information to WRH on November 22, 2018 (referred to above in paragraph 12), when he stated that he was currently not providing anaesthesia services at any other hospital or facility in Ontario. The OHIP data shows that on the same date, Dr. Ismail submitted twenty-seven (27) claims to OHIP for anaesthesia services provided to fifteen (15) different patients.

18. The OHIP data also shows that between December 3, 2018, and December 8, 2018, Dr. Ismail submitted claims for anaesthesia services provided to over thirty-five (35) patients at STEGH.

19. Following his leave of absence from the WRH, in November 2018, Dr. Ismail applied for Term privileges in the Department of Anaesthesia at STEGH. His application for Term privileges received temporary approval from STEGH on December 3, 2018. Contrary to his agreement with WRH, Dr. Ismail did not provide WRH notice of his intention to provide anaesthesia services at STEGH.

20. During the College investigation, the College also learned that Dr. Ismail was practising at the Castlemore Endoscopy and Digestive Disease Clinic in Brampton. The College received records from the Castlemore Endoscopy and Digestive Disease Clinic of all the patients Dr. Ismail provided anaesthesia services to at the clinic between the dates of November 21, 2018 and February 1, 2019. A copy of the records received from the Castlemore Endoscopy and Digestive Disease Clinic are at Tab B to the Agreed Statement of Facts and Admission.

21. Between November 21, 2018 and February 1, 2019, Dr. Ismail provided anaesthesia services to fifty-two (52) patients at the Castlemore Endoscopy and Digestive Disease Clinic as follows:

- On November 21, 2018, Dr. Ismail provided anaesthesia services to eleven (11) patients;
- On November 27, 2018, Dr. Ismail provided anaesthesia services to twenty-six (26) patients;
- On January 23, 2019, Dr. Ismail provided anaesthesia services to seven (7) patients; and
- On February 1, 2019, Dr. Ismail provided anaesthesia services to eight (8) patients.

22. On March 6, 2019, in response to WRH's inquiry seeking confirmation that Dr. Ismail was abiding by the terms of his agreement WRH, Dr. Ismail provided misleading and inaccurate information, when he stated that since November 22, 2018, "he has only assisted in sedation in relation to endoscopy procedures on a few occasions in Toronto and area between the end of January and February 1." In fact, the OHIP data [at Tab A to the Agreed Statement of Facts and Admission] and records [at Tab B to the Agreed Statement of Facts and Admission] show that Dr. Ismail was repeatedly providing anaesthesia services at hospital and facilities since November 2018, including at STEGH, Cornwall Community Hospital and the Castlemore Endoscopy and Digestive Disease Clinic.

23. Dr. Ismail engaged in disgraceful, dishonourable or unprofessional conduct by repeatedly providing anaesthesia services at a hospital or facility in Ontario without notice to WRH contrary to his agreement with WRH.

Dr. Ismail Created and Submitted Fraudulent Letters of Employment

The Report to the College

24. On March 21, 2019, WRH notified the College that it had received further concerning information in respect to Dr. Ismail.

25. The College was advised that on March 18, 2019, WRH's Director of Medical Affairs, Ms. Y, was contacted by Ms. X, a representative from Helen Ziegler & Associates, Inc, a recruitment agency.

26. Ms. X had contacted Ms. Y to confirm the accuracy of an employment letter she had received directly from Dr. Ismail, which was purportedly written and signed by Ms. Y.

27. Ms. Y confirmed that she did not write the employment letter on behalf of Dr. Ismail and the signature on the letter was not hers.

The College Investigation

28. During the investigation, the College received further information from Ms. X of Helen Ziegler & Associates, Inc.

29. Ms. X advised that Helen Ziegler & Associates, Inc. is a recruitment agency that recruits healthcare professionals for hospitals in the Middle East. Dr. Ismail was offered a locum position at one of Helen Ziegler & Associates, Inc. client hospitals. Ms. X was responsible for collecting documents from Dr. Ismail in preparation for credentialing at a hospital in the Middle East.

30. On March 14, 2019, Ms. X emailed Dr. Ismail a list of necessary documents needed as part of his credentialing application. Among various documents, Ms. X required Dr. Ismail to submit an employment letter or employment certificate from WRH, as this hospital was listed as Dr. Ismail's current employer in his curriculum vitae.

31. On March 18, 2019, Dr. Ismail sent Ms. X a fraudulent employment letter, dated January 29, 2019, (the "January Employment Letter"), purportedly written and signed by Ms. Y, Director of Medical Affairs at WRH. A copy of this January Employment Letter is attached at Tab C to the Agreed Statement of Facts and Admission.

32. The January Employment Letter did not contain information about Dr. Ismail's dates of service at WRH. Ms. X required this additional information and requested Dr. Ismail to provide an employment letter which included dates of service.

33. Later the same day on March 18, 2019, Dr. Ismail sent Ms. X another fraudulent letter of employment dated March 11, 2019 (the "March Employment Letter"), which

now contained dates of service at WRH. This letter was again purportedly written and signed by Ms. Y, Director of Medical Affairs at WRH. A copy of the March Employment Letter is attached at Tab D to the Agreed Statement of Facts and Admission.

34. Ms. Y did not write the January Employment Letter or the March Employment Letter. Both of these employment letters were fraudulently created by Dr. Ismail.

35. In his response to the College investigation, Dr. Ismail provided the College with an unaltered original employment letter that he had received from WRH (the "Original Employment Letter") in the past for the purposes of a mortgage application. A copy of this employment letter dated December 7, 2017 is attached at Tab E to the Agreed Statement of Facts and Admission.

36. During the investigation, Dr. Ismail initially provided misleading information to the College that he had only "revised the dates" and "did not alter the content" of the Original Employment Letter. In fact, the January Employment Letter and March Employment Letter show that Dr. Ismail had not only revised the date of the Original Employment Letter but also altered the contents. Dr. Ismail subsequently, in a further response to the College investigation, corrected the misleading information he had provided to the College after locating the Original Employment Letter and comparing it to his fraudulent letters.

37. In addition to submitting the fraudulent employment letters to Helen Ziegler & Associates, Dr. Ismail also submitted the fraudulent January Employment Letter and the fraudulent March Employment Letter to a second agency, DataFlow Group, for the purpose of obtaining employment overseas.

38. Dr. Ismail engaged in disgraceful, dishonourable or unprofessional conduct by creating and submitting fraudulent letters of employment.

ADMISSION

39. Dr. Ismail admits the facts specified above, in paragraphs 1 to 38, and admits that, based on these facts, he engaged in professional misconduct, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, under paragraph 1(1)33 of Ontario Regulation 856/93, made under the *Medicine Act, 1991*.

FINDING

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

PENALTY AND REASONS FOR PENALTY

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

BACKGROUND

1. Dr. Mohamed Abdel Hadi Elmorsi Ismail ("Dr. Ismail") is a forty-seven (47) year old anaesthesiologist. He received his certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario (the "College") on June 30, 2017.

2. Dr. Ismail was born in Egypt. He is married and has three (3) children.

DR. ISMAIL'S INTERACTIONS WITH THE PHYSICIAN HEALTH PROGRAM

3. In late November 2018, the Windsor Regional Hospital ("WRH") referred Dr. Ismail to the Ontario Medical Association's Physician Health Program ("PHP") for an assessment as a result of concerns raised regarding Dr. Ismail's conduct and capacity at the WRH on October 30, 2018 and November 2, 2018.

4. On January 23, 2019, Dr. Ismail underwent an independent clinical evaluation, specifically regarding potential substance use disorders. The evaluation was conducted for PHP by the Work, Stress and Health Program at the Centre for Addiction and Mental Health ("CAMH"). In the CAMH report dated March 7, 2019, the evaluation found that Dr. Ismail did not have a substance use disorder. Despite this, the report noted a discrepancy between Dr. Ismail's self-reported medication history and oxazepam, identified in his urine toxicology test (done on January 25, 2019) during the evaluation. Therefore, the report recommended "substance use (no diagnosis) monitoring" for a period of one year, including a workplace monitor for that period of time.

5. Following Dr. Ismail's evaluation with CAMH, and while Dr. Ismail's PHP assessment was in process, the PHP received additional information from WRH about other issues (which are the subject of these proceedings) regarding Dr. Ismail. In addition, on March 25, 2019, Dr. Ismail reported to the PHP that on February 1, 2019, while on shift, his workplace was concerned about his health and he was sent to the emergency room by ambulance. He added that he did not remain in the emergency department for the evaluation. In light of this new information, the PHP recommended that Dr. Ismail undergo a second independent clinical evaluation.

6. Between April 29 and May 2, 2019, Dr. Ismail underwent a second clinical evaluation at Acumen Assessments in Lawrence, Kansas. In a report dated June 5, 2019, among

other things, the evaluation found that Dr. Ismail was fit to practice medicine with mental skill. During the evaluation, Dr. Ismail underwent urine testing (on April 29, 2019) and fingernail testing (on May 2, 2019). The report states that: "[t]he results of the urine and finger nail testing done in the evaluation were negative for medications and drugs of abuse (other than the prescribed Tramadol) and for metabolites of Propofol." The report also states that "the results of the nail tests are reported to cover a period of six months, taking the window of detection back to late October/Early November 2018." However, the report concluded that "the ruling out of a medication misuse/addiction problem can only happen with a period of monitoring." The report recommended that "in order to ensure that Dr. Ismail can remain fit to practice with safety, it will be important for him to undergo a period of diagnostic monitoring."

7. Effective July 18, 2019, Dr. Ismail entered into a one (1) year Concurrent Behavioural Substance Use (No Diagnosis) Monitoring Contract with PHP (the "PHP Contract"). A copy of the PHP Contract is at Tab A to the Agreed Statement of Facts on Penalty.

8. The final report of the PHP, dated August 10, 2020, confirms that Dr. Ismail has successfully completed the terms of the PHP Contract and no further monitoring has been requested by PHP, and states that "Dr. Ismail has been fully compliant with all aspects of the PHP monitoring program."

PRIOR HISTORY WITH THE COLLEGE

Incapacity Investigation

9. In February 2019, the College received information from Dr. S, the Medical Director of Castlemore Endoscopy and Digestive Disease Clinic in Brampton (the "Castlemore Clinic") concerning Dr. Ismail. Dr. S reported that on February 1, 2019, Dr. Ismail, who was about to provide anaesthesia services to a patient at the Castlemore Clinic, appeared disoriented and confused. Another physician working at the Castlemore Clinic stopped Dr. Ismail from providing the anaesthesia services to the patient. The

Castlemore Clinic called emergency services and Dr. Ismail was taken to hospital. Dr. S reported that upon discussion with other staff, he learned that Dr. Ismail had looked disoriented prior to the procedure and was spending long periods of time in the washroom. Dr. Ismail appeared to have blood stains on his clothing, bruising above his left eye, and discolouration and bruising of his left decubital fossa.

10. On March 8 and March 20, 2019, the College received further information (which is the subject of these proceedings) from the WRH concerning Dr. Ismail's conduct and capacity. In WRH's report to the College on March 8, 2019, it stated that prior to October 30, 2018, no formal concerns had been raised about Dr. Ismail's conduct or capacity at the hospital.

11. Based on the information from Castlemore Clinic and the WRH, on April 16, 2019, the Inquiries, Complaints and Reports Committee proceeded with a capacity inquiry, pursuant to section 58 of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991,* S.O. 1991, c. 18, to inquire whether Dr. Ismail was incapacitated.

12. As stated in paragraph 7 above, effective July 18, 2019, Dr. Ismail entered into the PHP Contract.

13. As a resolution to the College's incapacity investigation, Dr. Ismail entered into an Undertaking to the College whereby he acknowledged he had entered into the PHP Contract. Among other things, Dr. Ismail undertook to remain a participant in the PHP, and to fully comply with the requirements of the PHP Contract. A copy of Dr. Ismail's Undertaking to the College, dated October 2, 2019, is attached at Tab B to the Agreed Statement of Facts on Penalty.

14. Dr. Ismail has successfully completed the terms of the PHP Contract and he has met all the terms of the Undertaking to the College, dated October 2, 2019. Therefore Dr. Ismail is no longer subject to the College Undertaking.

Other History

15. Dr. Ismail has no prior history with the Discipline Committee.

16. Dr. Ismail has not been the subject of any prior complaints to the College.

SUBMISSIONS ON PENALTY

A number of matters regarding penalty were agreed by the parties. Both parties agree that Dr. Ismail should be required to appear before the panel to be reprimanded, be subject to a suspension of some duration, complete instruction in ethics, and pay costs to the College. The parties disagree, however, as to the length of an appropriate suspension, and depending on the length of the suspension, may disagree as to the appropriate quantum of costs.

Regarding the length of the suspension, the College is of the view that a six-month suspension is appropriate. Counsel for Dr. Ismail submits that a one-month suspension is appropriate.

PENALTY AND REASONS FOR PENALTY

In consideration of the appropriate penalty, the Committee was guided by the well-recognized penalty principles. First and foremost, the penalty must provide public protection. Further, it must convey the Committee's disapproval and denunciation of the misconduct and be proportional to the Committee's misconduct finding. The penalty must maintain the integrity of the profession and public confidence in the College's

ability to regulate the profession in the public interest. The penalty should serve as a specific deterrent to the member and general deterrent to the entire profession. Further, where appropriate, the penalty should promote the member's rehabilitation.

In coming to its penalty Order, the Committee considered the nature of the misconduct set out in the Agreed Statement of Facts and Admission, Agreed Statement of Facts on Penalty, as well as the other documents submitted by the parties. The Committee also considered aggravating and mitigating factors on penalty and reviewed prior cases of this Committee.

Aggravating Factors

The Committee considered the following aggravating factors:

1. Dr. Ismail's misconduct was multifactorial in that he: breached his agreement with the WRH by providing anaesthesia services to patients without notifying the hospital; sent inappropriate and unprofessional communications to the WRH; created and submitted fraudulent letters of employment to two employment agencies and also misrepresented these letters to the College.

2. Dr. Ismail entered into the agreement with the WRH on November 22, 2018 and was in breach of the agreement immediately. Illustrative of this are OHIP records indicating that on November 22, 2018, Dr. Ismail submitted twenty-seven (27) claims to OHIP for anaesthesia services provided to fifteen (15) different patients.

3. Dr. Ismail's conduct was dishonest, deceitful and lacking in professional integrity;

4. There was potential for patient harm since Dr. Ismail's capacity to provide safe anaesthesia services to patients remained under assessment at the time of the breaches.

Mitigating Factors

The Committee considered the following mitigating factors:

1. Dr. Ismail admitted to his misconduct, which saved witnesses from testifying, and the College the time and expense of a contested hearing.

2. Dr. Ismail has no history with the College or the Discipline Committee.

Counsel for Dr. Ismail submitted that there were other potential mitigating factors that the Committee should consider.

Firstly, Counsel for Dr. Ismail submitted that Dr. Ismail breached an agreement with the WRH, and not a College undertaking or a restriction on his certificate of registration. The Committee does not find that to be a mitigating factor. While more serious breaches may result in a different penalty finding, the Committee is considering the penalty that is appropriate for the misconduct of Dr. Ismail. It is not a mitigating factor to say that his misconduct could have been worse.

Counsel for Dr. Ismail also submitted that the breach of the agreement was not specifically related to the provision of patient care and there is no evidence that any harm resulted to patients from his misconduct. Further, it was submitted that there was no risk of harm to patients as Dr. Ismail knew he did not have a substance use disorder. The Committee also does not accept this as a mitigating factor. Dr. Ismail's agreement with the WRH arose out of concerns regarding his capacity to safely provide anaesthesia services. By that agreement, Dr. Ismail agreed to undergo a comprehensive assessment through the Physician Health Program (or an alternative third party assessment) to provide reassurance to the WRH of his ability to safely return to practice. In the Committee's view, where patient safety may be at risk, as it was here, it

is not an answer for Dr. Ismail to claim that his breach of the agreement with the WRH should be mitigating because he knew he did not have a substance use disorder.

Counsel for Dr. Ismail also submitted that his cooperation with the College should also be a mitigating factor. The Committee once again disagrees. Dr. Ismail initially provided misleading information to the College concerning his falsification of employment letters. While he later cooperated with the College in narrowing the issues and filing agreed statements at the hearing, when viewed in light of the prior dishonesty in the College investigation, at best it is a neutral factor.

Counsel further submitted that the Committee should consider that Dr. Ismail has already suffered irreparable harm to his reputation and career as a result of his actions. There was no evidence submitted to the Committee in this regard. In any event, even if there were evidence, Dr. Ismail's harm to his reputation is a result of his misconduct, and does not affect the need for the Committee to determine a penalty that is in line with the aforementioned penalty principles.

Finally, Counsel submitted that Dr. Ismail's compliance with the PHP and agreement to complete instruction in ethics should be considered mitigating factors. However, the Committee only gives this minimal weight. Certainly, Dr. Ismail's admission to the misconduct at issue, resulting in the agreement to complete instruction in ethics, is a mitigating factor. However, physicians are expected to comply with agreements with hospitals where they work, and while Dr. Ismail complied with certain terms of the agreement with the WRH, he clearly breached other terms.

Prior Cases

Although prior cases of this Committee are not binding as precedent, the Committee has accepted as a principle of fairness that generally, like cases should be treated alike. Counsel for the College and Counsel for Dr. Ismail referred to a number of cases and

submitted books of authorities in support of their penalty positions. A selection of these cases is summarized below.

Select Cases Submitted by College

1. In *Ontario (College of Physicians and Surgeons of Ontario) v. Abdurahman*, 2018 ONCPSD 42, Dr. Abdurahman, a general surgeon, provided services to an Ontario hospital under an Alternate Payment Plan (APP). He left the region to do locums despite the APP's prohibition of this practice. Dr. Abdurahman provided many of these prohibited services at some distance away from the hospital while he was supposed to be on-call in the APP hospital's region, putting patients in that region at risk. Dr. Abdurahman sought to retroactively falsify on-call schedules to reflect that he was not on-call while away performing locums elsewhere. Dr. Abdurahman admitted the allegation of disgraceful, dishonourable or unprofessional conduct, which the Committee characterized as an "ethical failure". His penalty included a nine-month suspension, a reprimand, training in ethics, five years of clinical supervision, and a fine to the Minister of Finance. He was also ordered to pay costs to the College.

   This case is similar to the matter at hand in that a hospital agreement was breached and Dr. Abdurahman attempted to falsify documents. Dr. Abdurahman's misconduct resulted in a significant suspension.

2. In *Ontario (College of Physicians and Surgeons of Ontario v. Attuah, K.,* 2013 ONCPSD 30, Dr. Attuah, an obstetrician/gynecologist, was found to have engaged in disgraceful, dishonourable or unprofessional conduct by repeatedly breaching an undertaking and orders that limited the number of patients he could see per week, restricted his practice to his own specialty, and required that he practice under the supervision of a monitor. The matter proceeded by way of an Agreed Statement of Facts, however, the penalty was contested. The penalty

included a three-month suspension and a reprimand. Dr. Attuah was also ordered to pay costs to the College.

Dr. Attuah's misconduct involved the breach of an agreement, a College undertaking, but in contrast to the matter at hand, did not also include the falsification of records.

3. In *Ontario (College of Physicians and Surgeons of Ontario) v. Deluco*, 2005 ONCPSD 8, the physician was found to have engaged in disgraceful, dishonourable or unprofessional conduct by examining two female patients in breach of an order prohibiting the examination of female patients without the presence of a third party who was acceptable to the college. The penalty included a six-month suspension. Dr. Deluco was also ordered to pay costs to the College.

4. *In Ontario (College of Physicians and Surgeons of Ontario) v. Garry,* (Decisions and Reasons for Decision dated April 5, 2000)*,* Dr. Garry, a general practitioner who held staff privileges at an Ontario hospital, was found to have committed professional misconduct by signing false or misleading documents. The hearing proceeded by an Agreed Statement of Facts and Penalty. The Committee found that Dr. Garry misrepresented to his hospital that he maintained professional liability coverage over a period of nine years when he did not. The Committee ordered a two-month suspension in addition to a reprimand and costs. The Decision provides the following:

> The Committee found Dr. Garry's action in this matter is very serious, dishonest in his initial actions, and in its repetitions thereafter. Hospitals and patients have a right to rely on the integrity of information on insurance coverage supplied by physicians. Dr. Garry obtained the benefit of hospital privileges without bearing one of its burdens. Members of the public are entitled to assume that their physician has professional liability insurance coverage.

This case and the resultant penalty highlights the seriousness ascribed to a breach of hospital bylaw, in this case Dr. Garry's misrepresentation to the hospital that he had liability insurance when he in fact did not as required.

5. In *Ontario (College of Physicians and Surgeons of Ontario) v. Gutman, 2017 ONCPSD 47,* affirmed 2018 ONSC 6936 (Div Ct), Dr. Gutman, a family physician, was found to have engaged in disgraceful, dishonourable or unprofessional conduct by breaching prescribing restrictions and a prohibition on engaging in professional encounters with female patients. The hearing proceeded by way of an Agreed Statement of Facts and Admission. There was disagreement as to the length of the penalty. The College sought a suspension of nine months and Counsel for Dr Gutman sought a suspension of four months. The Committee ordered a seven-month suspension, a reprimand, as well as training in ethics and maintaining appropriate boundaries. Dr. Gutman was also ordered to pay costs to the College. Dr. Gutman appealed and the decision was upheld by the Divisional Court.

6. In *Ontario (College of Physicians and Surgeons of Ontario) v. Newell, 2012 ONCPSD 32,* Dr. Newell, a psychiatrist, was found to have engaged in disgraceful, dishonourable or unprofessional conduct by representing herself as a Fellow of the Royal College after her fellowship was removed and breaching an Order of the Discipline Committee which placed terms, conditions and limitations on her certificate of registration. The Committee found that there was no evidence that Dr. Newell's actions were willful or fraudulent, but stemmed from "sloppy paperwork and insufficient attention to correspondence". In accordance with a joint submission on penalty, the Committee's order included a three-month suspension, a reprimand and the continuance of the terms, limitations and conditions on her practice. Dr. Newell was also ordered to pay costs to the College.

The Committee concluded that there was no evidence that Dr. Newell's actions were either willful or fraudulent. Despite this, as illustrated by the penalty imposed, the Committee was of the view that Dr. Newell's conduct constituted a significant breach requiring a significant penalty.

7. In *Ontario (College of Physicians and Surgeons of Ontario) v. Noriega, E.H.*, 2013 ONCPSD 26, Dr. Noriega was found to have engaged in disgraceful, dishonourable or unprofessional conduct by breaching an undertaking flowing from a 2009 referral to the Discipline Committee for allegations of sexual abuse and sexual impropriety. The breach involved failing to ensure a sign was posted in his waiting room and examination room; and failing to ensure a chaperone was present during the entirety of his female patient encounters. The Committee also found that Dr. Noriega misled the College investigator by indicating that he did not see female patients in the consultation room. The College proposed a nine-month suspension, while counsel for Dr. Noriega suggested a two to three-month suspension. The Committee found that the findings were "serious as they go to the heart of the governance of the profession". The Committee viewed this breach as a "serious act of professional misconduct which calls for a significant penalty" and ordered a six-month suspension and reprimand.

8. In *Ontario (College of Physicians and Surgeons of Ontario) v. Varenbut*, 2015 ONCPSD 40, Dr. Varenbut, a family physician who held appointments at several hospitals, was found to have engaged in disgraceful, dishonourable or unprofessional conduct. Dr. Varenbut contravened hospital policy by failing to disclose that he had been the subject of a College investigation or that restrictions had been imposed on his certificate of registration. This failure to report occurred between 2005 and 2013. Further, Dr. Varenbut failed to disclose to his Department Chair that he was the subject of a Discipline Committee finding, as required by University policy The Committee accepted the parties' joint submission on penalty and ordered a three-month suspension, a public

reprimand, and costs to the College. The Committee offered the following reasoning:

> Physicians seeking hospital or university appointments, or renewal of their privileges, are required to report fully and accurately complaints, investigations, findings, restrictions and legal actions against them in the preceding year. Different institutions may have slightly different reporting obligations in the information they require. Dr. Varenbut failed in meeting this reporting requirement not once, but multiple times over several years, with multiple hospitals and the university where he taught. This failure is intolerable, even if inadvertent as submitted by his counsel. To disregard one's professional obligations through a lack of diligence and to mislead public institutions are serious matters.

Again, this case highlights the importance of complying with hospital reporting obligations, and the Committee's issuance of significant penalties where these obligations are not adhered to.

Select Cases Submitted by Dr. Ismail

1. *In Ontario (College of Physicians and Surgeons of Ontario) v. Lau, A.W. W.*, 2014 ONCPSD 5, Dr. Lau was found to have engaged in disgraceful, dishonourable or unprofessional conduct by breaching a 2007 undertaking that required him to have a monitor present during appointments with all patients. The case proceeded by way of an Agreed Statement of Facts and Admission and the penalty was contested. The Committee found that the breach was motivated by Dr. Lau's concern for the interests of his patients and "not for his own convenience or benefit". Further, the Committee found that Dr. Lau's actions did not incur any risk of harm to his patients and that in the over five years that the conditions had been in force there had been no negative reports from those

authorized to monitor the various components of the conditions. The Discipline Committee's Order, which was in accordance with the penalty proposed by Dr. Lau's Counsel, included a reprimand and the payment of costs.

2. In *Ontario (College of Physicians and Surgeons of Ontario) v. Yu*, 2017 ONCPSD 54, Dr. Yu, a family physician, was found to have engaged in disgraceful, dishonourable or unprofessional conduct by breaching a 2016 undertaking that prohibited him from prescribing controlled substances. Dr. Yu prescribed controlled substances to three patients on three occasions in late 2016. Dr. Yu's position was that this breach was unintentional and inadvertent. The prescriptions were renewals and he did not give sufficient due diligence to the medications listed, which included prescriptions for controlled substances. The Committee found that although the breach may have been unintentional, it did not negate the seriousness of breaching an undertaking with the College. The Committee accepted the parties' joint submission on penalty and ordered a three-month suspension and a reprimand. Dr. Yu was also ordered to pay costs to the College.

3. In *Ontario (College of Physicians and Surgeons of Ontario) v. Roy*, 2018 ONCPSD 66, Dr. Roy, a general practitioner practising in Toronto, was found to have engaged in disgraceful, dishonourable or unprofessional conduct by breaching an undertaking with the College requiring him to, among other things, practice under the guidance of a supervisor. Dr. Roy's supervisor was no longer able to fulfil his role due to a conflict of interest. In accordance with the undertaking, Dr. Roy was required to cease prescribing controlled substances until he obtained another clinical supervisor acceptable to the College. Dr. Roy was found to have intentionally breached his undertaking by continuing to prescribe controlled substances during the approximately three-week period he did not have a supervisor. The parties disagreed on the appropriate length of suspension (but otherwise agreed on penalty). The Committee rejected Dr. Roy's penalty proposal of a one-month suspension stating that it:

> [……] did not reflect the seriousness of the misconduct, not only because there was a breach of the Undertaking, but also because of the serious concerns about risk to his patients and the general public which underly the need for the undertaking, as well as his opioid prescribing in the brief time of his breach.

Ultimately, the Committee ordered a three-month suspension, a reprimand and instruction in ethics. Dr. Roy was also ordered to pay costs to the College.

The cases submitted on Dr. Ismail's behalf generally feature physicians who breached undertakings with the College or orders of the Discipline Committee, but were subject to suspensions of lesser duration ranging from zero to three months. In the Committee's view, these cases do not reflect the breadth of the misconduct in this matter.

Dr. Ismail breached his agreement with the WRH by providing anaesthesia services at another facility; he potentially put patients at risk by providing these services while capacity issues remained in question; he sent inappropriate and unprofessional communications to the WRH; and he submitted fraudulent documents to two employment agencies and misrepresented these letters to the College. Given the nature, breadth and seriousness of Dr. Ismail's misconduct, the Committee is of the view that the matter at hand is clearly distinguishable from the cases provided, and a lengthier penalty is warranted.

Letters of Support

Counsel for Dr. Ismail submitted letters of support from colleagues and the Chief of Anaesthesia at Dr. Ismail's current institution, St. Thomas Elgin General Hospital (STEGH). The letters from colleagues predate the hearing and do not account for Dr. Ismail's misconduct. The Chief's letter acknowledges he was aware of Dr. Ismail's

misconduct but wrote that a lengthy suspension would have a negative impact on the department which was under stress due to the COVID pandemic.

In assessing this resource concern, the Committee considered the case of *Ontario (College of Physicians and Surgeons of Ontario) v. Deluco*, 2005 ONCPSD 8 which states:

> While physician shortage is an unfortunate state and serious problem in many parts of Ontario, it cannot be a mitigating factor in this case. Physicians in under serviced areas must be held to the same standard as all physicians in the province. Most importantly, the patients in such areas cannot be subjected to lesser standards of physician conduct.

Similarly, in *Ontario (College of Physicians and Surgeons of Ontario) v. Taylor,* 2017 ONCPSD 17, the Committee had this to say with respect to resource concerns:

> The Committee was sensitive to the concerns expressed by patients that Dr. Taylor's penalty might deprive the community of a valued practitioner. A shortage of resources, however, cannot be used to justify a lowering of professional standards.

For these reasons, the Committee placed little weight on the Letters of Support received on Dr. Ismail's behalf in determining an appropriate penalty. Regarding the letter from the Chief of Anaesthesia at STEGH, in the Committee's view, resource concerns should not impact the Committee's penalty Order, particularly the duration of the suspension.

ANALYSIS

The Committee agrees with the elements of the proposed penalty that were agreed upon by the College and the member. Specifically, that Dr. Ismail must appear before the panel to be reprimanded, complete instruction in ethics, and pay costs to the

College. Having applied the penalty principles in light of the unique facts and circumstances of the case, the Committee is of the view that these agreed-upon elements are fair, just and appropriate. The Committee's analysis with respect to the disputed suspension period follows.

Duration of Suspension

There were several issues that the Committee considered in determining the suspension period to be imposed. On this issue, Counsel for Dr. Ismail submitted that a breach of an agreement with a hospital is not as significant as a breach of an Order of the Discipline Committee or an Undertaking with the College. The Committee disagrees with this view.

As with the College, Ontario hospitals, as public institutions, are accountable to the public. Hospitals operate in accordance with bylaws, policies and procedures that physicians are expected to follow. The public expects that health care professionals providing care to patients at hospitals abide by the rules to which they are subject. As such, any agreements a physician enters into with a hospital should be adhered to with the same honesty and transparency as would be expected in respect of an agreement with the College in its regulatory capacity.

Dr. Ismail's agreement with the WRH allowed him to maintain his privileges at the hospital provided he abide by its terms. In breaching this agreement, there was the potential for patient harm, as at the time there were unresolved concerns about his capacity to perform anaesthesia services.

Counsel for Dr. Ismail submitted that while "Dr. Ismail's conduct was serious...it simply does not rise to the level of threatening the foundation of professional regulation". The Committee again disagrees. Physicians who do not act in compliance with hospital obligations threaten the foundation of institutional professional oversight and impugn

the regulation of the profession more broadly. The case law considered by the Committee illustrates that breaches of hospital rules are considered serious matters warranting a serious penalty. The Committee agrees.

The Committee was disappointed that Dr. Ismail committed this misconduct so early in his career having obtained his independent license only three years prior. Dr. Ismail should have known that such misconduct was unacceptable and a strong deterrent against future misconduct is necessary. Considering the reasons outlined above, the Committee is of the view that a six-month suspension is warranted.

In the draft order submitted by the parties at the hearing, the contemplated start date for any suspension was November 1, 2020, presumably to provide Dr. Ismail with time to arrange his affairs and permit STEGH to address any staffing issues. While that date has since passed, the Committee agrees that such a period of time is appropriate. Accordingly, the Committee finds that the suspension shall begin at 12:01 a.m. on January 1, 2021.

Costs

Counsel for Dr. Ismail indicated that she intended to make further submissions on costs if the Committee should find that a suspension of less than six months is warranted. Those submissions would relate to negotiations with the College leading up to the hearing that she felt it was not appropriate to disclose until the Committee had made a finding on penalty. However, counsel for Dr. Ismail acknowledged that if the Committee imposed a penalty of six months, costs at the tariff rate were appropriate. Accordingly, no further submissions are required given the Committee's finding regarding the length of suspension.

CONCLUSION

An agreement with a hospital is an important undertaking and the College must be able to trust that a member will regard it with the utmost seriousness and abide by it. Repeatedly breaching a hospital agreement reflects a blatant disregard for a physician's responsibility to comply with hospital agreements, policies and procedures. In addition, falsifying documents and misrepresenting them to a College investigator are serious transgressions warranting a significant penalty.

The six-month suspension and public reprimand will serve as a clear and necessary denunciation of the misconduct and help maintain the public's confidence in the integrity of the profession. Further, they will serve as a specific deterrent to Dr. Ismail, who is so early in his career, and a general deterrent to the profession. The penalty signals that respect must be accorded to hospitals and the rules set by these public institutions. Doing so is essential in maintaining public trust in hospitals, in the physicians who provide care there, and in the profession more broadly.

ORDER

THEREFORE, THE DISCIPLINE COMMITTEE ORDERS AND DIRECTS:

1. Dr. Ismail attend before the panel to be reprimanded.
2. The Registrar suspend Dr. Ismail's certificate of registration for a period of 6 months, commencing from January 1, 2021 at 12:01 a.m.
3. The Registrar to place the following terms, conditions and limitations on Dr. Ismail's certificate of registration effective immediately:
    a. Dr. Ismail will participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Ismail will complete the PROBE program within six (6)

months of the date of this Order, and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.

4. Dr. Ismail to pay costs to the College in the amount of $10,370 within thirty (30) days of the date of this Order.

TEXT of PUBLIC REPRIMAND
Delivered March 26, 2021
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. MOHAMED ABDEL HADI ELMORSI ISMAIL

This is not an official transcript

Dr. Ismail:

It is of great concern to this Committee that you committed multiple acts of professional misconduct which occurred within two years of receiving your certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario.

The practice of medicine is a privilege.

Professionalism is the translation of the values of the medical profession into action.

It is what is expected of every member.

It encompasses every aspect of a member's practice, including the member's interactions with patients, colleagues, staff, health care institutions and the member's governing body.

Integrity, honesty, respect and behaving appropriately are essential elements of professionalism.

Your misconduct demonstrated a blatant disregard for each of these elements.

Your deceit was evident when you provided misleading and inaccurate information to your governing body during the course of the investigation.

In addition, you demonstrated not only poor judgement but also dishonesty when you provided, on more than one occasion fraudulent letters to a recruitment organization .

This misconduct cannot and, indeed, will not be tolerated by the public or the profession.

Appropriate and respectful communications with one's colleagues or hospital staff is also an expectation of the profession.

You demonstrated a lack of respect with your inappropriate and unprofessional text messages to a colleague as well as inappropriate and unprofessional emails to the Windsor Regional Hospital.

Furthermore, as a physician, you are required to abide by any conditions and comply with any terms of an agreement you have, not only with your governing body, but also with any health care institution you are affiliated with.

You failed to do so when you failed to comply with the terms of an agreement with the Windsor General Hospital which was put in place with a goal to protect the public interest.

Actions such as yours not only demonstrate a lack of professional integrity but also have the potential to undermine public trust in the profession.

In addition, your misconduct has not only brought dishonour to yourself but also the profession as a whole. Again, this will not be tolerated by the public or the profession.

Dr. Ismail, as this reprimand draws to a close, it is our expectation, in moving forward, that you will have learned from this experience and that you will not appear before a Disciplinary panel again.