

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Magdy Messiha Hanna, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity and any information that would disclose the identity of the patients whose names are disclosed 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: Hanna, M. M. (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. MAGDY MESSIHA HANNA

PANEL MEMBERS:

**DR. C. CLAPPERTON
D. DOHERTY
DR. J. KIRSH
S. BERI
DR. B. LENT**

Hearing Date:	June 25, 2012
Decision Date:	June 25, 2012
Release of Written Reasons:	July 25, 2012

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 25, 2012. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and that the member is incompetent and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Magdy Messiha Hanna 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.

The Notice of Hearing also alleged that Dr. Hanna is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code which is schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (the “Code”).

RESPONSE TO THE ALLEGATIONS

Dr. Hanna admitted all allegations in the Notice of Hearing.

FACTS AND EVIDENCE

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

Facts

Background

1. Dr. Magdy Messiha Hanna (“Dr. Hanna”) is a member of the College of Physicians and Surgeons of Ontario (the “College”) who was issued a certificate of registration authorizing independent practice in 1996.
2. He practices family medicine in Scarborough, Ontario.
3. On or about August 31, 2009, the College received information from Toronto Police Service, which reported an incident whereby a pharmacist contacted the police with concerns related to a man who presented with four (4) different patient prescriptions for Talwin issued by Dr. Hanna. The patron advised the pharmacist that the pills were for the people named on the prescriptions, who all live in [Europe]. The police contacted Dr. Hanna who confirmed that he wrote the prescriptions for these patients individually because each had an empty pill bottle for the same prescription but he had not examined them or recorded the physician whose name was on the empty pill bottle.
4. No criminal charges were laid as a result of the Toronto Police Services investigation.
5. As a result of this information received from Toronto Police Service, the College’s Inquiries, Complaints and Reports Committee commenced an investigation into Dr. Hanna’s practice pursuant to section 75(1)(a) of the Health Professions Procedural Code, which is schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 (the “Code”), on or about October 13, 2009.

College’s Medical Inspector

6. As part of the College’s investigation, Dr. X was appointed as a Medical Inspector to provide an opinion regarding Dr. Hanna’s medical practice.
7. As part of his investigation, Dr. X reviewed 15 medical records, as well as pharmaceutical printouts pertaining to 25 patients for whom Dr. Hanna was unable to provide any medical records. Dr. X also conducted an interview with Dr. Hanna.

8. Dr. X provided an opinion on this matter in a report dated November 14, 2010. This report is attached at Appendix A [to the Agreed Statement of Facts and Admission] and forms part of this Agreed Statement of Facts and Admission.

9. On or about May 2, 2011, Dr. X provided an addendum to his original report. The May 2, 2011, addendum is attached at Appendix B [to the Agreed Statement of Facts and Admission] and forms part of this Agreed Statement of Facts and Admission.

Admission

10. Dr. Hanna admits the facts set out above and admits that he:

(a) failed to maintain the standard of practice of the profession and is incompetent as defined in subsection 52(1) of the Code in his prescribing to 25 individuals without conducting an assessment, physical, or maintaining a chart; and

(b) failed to maintain the standard of practice of the profession in his care, treatment and/or medical record keeping in relation to the patients referenced in Dr. X's reports.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Hanna's admission and found that:

(1) he committed an act of professional misconduct, in that he 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*; and

(2) he is incompetent as defined by subsection 52(1) of the Code, in that his care of patients displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order. The proposed penalty called for the imposition of terms, conditions and limitations on Dr. Hanna's certificate of registration, a reprimand, and the requirement that Dr. Hanna pay costs to the College.

The Committee heard submissions from College Counsel regarding the principles to be considered when deciding on penalty. The Committee has discretion to accept or reject a joint submission, but is aware that the law provides that it should accept the joint submission unless to do so would be contrary to the public interest and bring the administration of justice into disrepute.

College Counsel asked the Committee to consider various mitigating factors in its deliberations. Dr. Hanna's admission of his inappropriate prescribing obviated the need for a lengthy and costly hearing. The Committee also noted that Dr. Hanna had completed both the College's Medical Record-Keeping course and the Prescribing course since the events giving rise to these findings.

In considering the proposed penalty, the Committee was concerned that Dr. Hanna's inappropriate prescribing could have put patients at risk, and wanted to be certain that the penalty would not permit this inappropriate behaviour to continue. The assessor also noted inconsistencies in the information provided by Dr. Hanna. The assessor reviewed prescriptions written by Dr. Hanna and filled at pharmacies in 2009. The pharmacies provided a list of the medications written by Dr. Hanna (Talwin, Endocet or Ritalin). Dr. Hanna informed the assessor that he kept no record with respect to these patients because these patients presented to him only once. The assessor noted that this is inconsistent with the pharmacy records which documented that many had been provided with multiple prescriptions over time. The assessor also noted that Dr. Hanna had previously stated that he always prescribed patient medication for one month periods, but for all of these patients prescriptions were for 240 tablets, enough for two months. The assessor also questioned why multiple family members living at the same address were provided with

the same prescriptions and why all of these prescriptions were for the same amount, specifically 240 tablets.

The assessor made the following comments among his conclusions:

“Of greatest concern was the result of the reviews of pharmacy narcotic/controlled drugs for 2009 for patients for whom there were no medical records, yet many prescriptions. These are detailed in the body of my report and appendix 3. Dr. Hanna's answers to my enquiries about these prescriptions did not provide any explanation and frankly were not believable. I have continuing concerns that we do not have the full story about these prescriptions.”

These observations by the assessor raised serious concerns among Committee members about Dr. Hanna's integrity and honesty.

After careful consideration of the proposed penalty, however, the Committee concluded that the imposition of the terms, conditions and limitations on Dr. Hanna's certificate of registration, specifically the prohibition on prescribing narcotics and other controlled drugs, will protect the public from the potential risks of inappropriate prescribing. Furthermore, the regular monitoring of Dr. Hanna's clinical care, particularly the adequacy of his medical records will also protect the public and should serve as a specific deterrent to Dr. Hanna. The posting of the sign informing patients and those accompanying them about the prohibitions on Dr. Hanna's prescribing of narcotics and other controlled drugs should also serve to inform and protect the public.

The Committee trusts that successful completion of the educational program on Medical Ethics will further reinforce for Dr. Hanna the need to follow widely-accepted clinical principles in all encounters with patients, whether the patient is well known to the physician or being seen on only one occasion. The Committee expects that the penalty order will serve to enhance public confidence and trust in the profession and its ability to self-regulate. The reprimand should not be taken lightly. It is a denunciation of the behaviour in question and it is expected that the reprimand will serve as a specific deterrent to Dr. Hanna and as a general deterrent to the rest of the profession.

College Counsel provided the Committee with two previous decisions that involved inappropriate prescribing (*Martin* and *Sheffield*). The Committee reviewed these

decisions and agreed that the proposed penalty was proportionate and consistent with the circumstances and penalties in those cases.

The Committee was satisfied that the key penalty principles were addressed, and that the proposed penalty was fair, just and commensurate with the factual circumstances of this case.

ORDER

Therefore, the Committee ordered and directed that:

1. the Registrar place the following terms, conditions and limitations on Dr. Hanna's Certificate of Registration:

- (a) Dr. Hanna is prohibited from prescribing:
 - (i) Narcotic Drugs (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
 - (ii) Narcotic Preparations (from the Narcotic Control Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19);
 - (iii) Controlled Drugs (from Schedule G of the Regulations under the *Food and Drugs Act*, S.C., 1985, c. F-27); or
 - (iv) Benzodiazepines/Other Targeted Substances (from the Benzodiazepines and Other Targeted Substances Regulations made under the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19)

(A summary of the above-named drugs [from Appendix I to the Compendium of Pharmaceuticals and Specialties] is attached [to the Order] as Schedule "A"; and the current regulatory lists are attached [to the Order] as Schedule "B").

- (v) Monitored Drugs (as noted in Schedule "C" [to the Order])

- (b) Dr. Hanna shall post a clearly visible sign in his waiting room in the form set out at Schedule “D” [to the Order]. For further clarity, this sign shall state as follows: “Dr. Hanna has relinquished his prescribing privileges with respect to Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and/or Other Targeted Substances and Monitored Drugs.”
 - (c) Dr. Hanna will undertake to practise under the guidance of a clinical supervisor, for six (6) months, who is acceptable to the College (“Clinical Supervisor”) and who shall meet with him on a monthly basis and review 10 charts per month. Attached [to the Order] as Schedule “E” is a copy of the Clinical Supervisor’s undertaking.
 - (d) Within approximately one (1) year, Dr. Hanna shall undergo a re-assessment of his clinical practice by a College-appointed assessor (“Assessor”). The Assessor shall report the results of this assessment to the College and Dr. Hanna shall abide by all recommendations made by the Assessor and the College.
 - (e) Dr. Hanna must successfully complete, at his own expense, College-facilitated instruction in Medical Ethics.
 - (f) Dr. Hanna shall cooperate with unannounced inspections of his practice and such other steps as the College may take for the purpose of monitoring and enforcing his compliance with the terms of the Order, such as giving consent to the College to make appropriate enquiries of OHIP and/or any person or institution who may have relevant information in order for the College to monitor Dr. Hanna’s compliance with this Order.
2. Dr. Hanna appear before it to be reprimanded, with the fact of the reprimand recorded on the register.
 3. Dr. Hanna pay costs to the College in the amount of \$3,650.00 within thirty (30) days from the date of this Order.

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