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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. VINEET IQBAL ARORA

PANEL MEMBERS:

MR. J. LANGS
DR. I. ACKERMAN
MS. E.M. MILLS
DR. D. HELLYER
DR. P. GARFINKEL

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MR. K. MAIJALA

COUNSEL FOR DR. ARORA:

MR. M. FLISFEDER
MS. K. GRACE

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R.W. COSMAN

Hearing Date: **January 9, 2019**
Decision Date: **January 9, 2019**
Written Decision Date: **March 5, 2019**

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 January 9, 2019**.** At the conclusion of the hearing, the Committee released a written order stating its finding that Dr. Arora committed an act of professional misconduct and setting out its penalty and costs order with written reasons to follow.

THE ALLEGATION

It was alleged in the Notice of Hearing that Dr. Vineet Iqbal Arora committed an act of professional misconduct:

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

RESPONSE TO THE ALLEGATION

Dr. Arora admitted the allegation of professional misconduct in the Notice of Hearing.

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:

PART I - FACTS

A. DR. VINEET IQBAL ARORA

1. Dr. Arora is a 53-year-old ophthalmologist who received his certificate of registration authorizing independent practice in 1989.

2. Dr. Arora practices in Hamilton, Ontario.

B. BACKGROUND

3. On June 21, 2015, Dr. Arora entered into an Undertaking with the College whereby he agreed to, among other things:

a. restrict his number of daily patient encounters to a maximum of eighty (80) patient encounters per day except on days when he is on-call for the Ophthalmology Service at Hamilton Health Science and St. Joseph's Health Centre; and

b. maintain a call log verifying all patients seen above the ordinary 80 patient maximum.

(the "June 2015 Undertaking"). A copy of the June 2015 Undertaking is attached at Tab 1 to the Agreed Statement of Facts and Admission**.**

C. BREACH OF UNDERTAKING

4. In September 2016, the College received correspondence from the Ministry of Health and Long-Term Care, indicating that on various dates between June 21, 2015 and August 22, 2016, Dr. Arora had claimed for more than 80 fee codes which require a direct encounter with the patient. Dr. Arora was on-call on one of these dates. A copy of the correspondence received from the Ministry of Health and Long-Term Care dated September 2016 is attached at Tab 2 to the Agreed Statement of Facts and Admission.

5. Dr. Arora did not maintain a call log verifying all patients seen above the ordinary 80 patient maximum on the dates when he was on-call.

PART II – ADMISSION

6. Dr. Arora admits the facts at paragraphs 1-5 above, and admits that, based on these facts, he engaged in professional misconduct under paragraph 1(1)33 of O Reg. 856/93, in that he engaged in acts or omissions relevant to the practice of medicine that would be regarded by members as disgraceful, dishonourable or unprofessional by breaching the terms of his June 2015 Undertaking to the College.

FINDING

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

AGREED STATEMENT OF FACTS RELEVANT TO PENALTY

The following additional facts were set out in an Agreed Statement of Facts Relevant to Penalty that was presented to the Committee:

Complaints resolved by the June 2015 Undertaking and a caution-in-person

1. The June 2015 Undertaking was directed by the Inquiries, Complaints and Reports Committee of the College (the "ICRC") in resolution of 2 separate patient complaints. Each of these complaints involved an allegation that Dr. Arora communicated in a rude and unprofessional manner. The ICRC noted that Dr. Arora had a history of complaints regarding communications and expressed its view that Dr. Arora's high-volume, high-stress practice contributed to his communication difficulties. In addition to accepting Dr. Arora's June 2015 Undertaking in resolution of each complaint, the ICRC also directed that Dr. Arora attend at the College to be cautioned in respect to patient communications. Copies of the decisions of the

ICRC, each dated February 13, 2015, are attached at Tabs 1 – 2 to the Agreed Statement of Facts Relevant to Penalty.

Relevant College history

2. Apart from the matter at hand, Dr. Arora has no prior discipline history with the College.

3. Prior to the complaints resolved by the June 2015 Undertaking, Dr. Arora had been the subject of a number of complaints to the College between 1996 and 2011 regarding rude and unprofessional communications with patients.

4. In February 2007, in resolution of several complaints, Dr. Arora entered into an undertaking to complete a course in Medical Record-Keeping for Surgical Specialties and a course in Physician-Patient Communications. The undertaking was fulfilled. The Complaints Committee also directed that Dr. Arora attend at the College to be cautioned in respect to patient communications. Copies of the Complaints Committee's Decisions and Reasons, each dated February 2007, are attached at Tabs 3 – 9 to the Agreed Statement of Facts Relevant to Penalty.

5. On May 14, 2007, the Co-Chair of the Complaints Committee, Dr. Geoff Bond, wrote a warning letter to Dr. Arora. In that letter, he noted Dr. Arora's history of patient complaints regarding communications and conveyed that he expected that the College would not have to deal with matters of a similar nature again. A copy of Dr. Bond's letter of May 14, 2007 is attached at Tab 10 to the Agreed Statement of Facts Relevant to Penalty.

6. In June 2011, in resolution of a patient complaint, the ICRC directed that Dr. Arora attend at the College to be cautioned about maintaining professional communications with patients at all times. A copy of the ICRC's Decisions and Reasons, dated June 15, 2011, is attached at Tab 11 to the Agreed Statement of Facts Relevant to Penalty.

7. On December 5, 2011, the Chair of the ICRC, Dr. Preston Zuliani, wrote a warning letter to Dr. Arora. In that letter, he noted Dr. Arora's caution-in-person regarding unprofessional communications and advised Dr. Arora that the matter of repeated complaints of a similar nature and his failure to respond to the Committee's first warning may be brought to the attention of the

ICRC should such episodes happen again. A copy of Dr. Zuliani's letter of December 5, 2011 is attached at Tab 12 to the Agreed Statement of Facts Relevant to Penalty.

Additional information

7. The June 2015 Undertaking provides that Dr. Arora was to practise under the guidance of a preceptor for a minimum of two (2) years and to see a therapist who is a member of a regulated health profession for a minimum of one (1) year.

8. Dr. Arora continues to meet regularly with his preceptor and see a therapist, although he is no longer required to do so pursuant to the terms of his June 2015 Undertaking. Dr. Arora's therapist, Ms Stephanie Swayne, has continued to provide reports on his progress to the College.

9. In her report to the College dated July 14, 2016, Ms Swayne indicated that by that point she had met with Dr. Arora on 13 occasions since July 2015. Ms Swayne reported:

> Dr. Arora has participated actively in all counselling sessions and consistently demonstrated motivation for self improvement and increased self awareness, and he has been very receptive to my feedback and different perspectives on his history of CPSO complaints. He has worked hard to gain insight into his communication style, the dynamics of his medical practice, and in particular, the power of differential and dynamics in the doctor patient relationship and how this has influenced his past College issues.

A copy of Ms Swayne's report dated July 14, 2016 is attached at Tab 13 to the Agreed Statement of Facts Relevant to Penalty.

10. In a letter dated September 20, 2017, Ms. Swayne wrote:

> Dr. Arora has presented to me as a remarkably open, humble, receptive to feedback, and embracing of my perspective as a non physician who has experience and expertise in interpersonal communication. From the outset of our work together, he has consistently presented as eager to abide by his undertakings and although our focus was not on the

> practical management of his practice, he would show me the measures he had implemented in order to be compliant with the College's expectations and undertaking when I would visit his office.
>
> (...)
>
> Overall, I have been extremely impressed with Dr. Arora's efforts in our sessions and his insight, and his receptiveness to feedback.

A copy of Ms Swayne's letter to the College, dated September 22, 2017 is attached at **Tab 14**. to the Agreed Statement of Facts Relevant to Penalty.

11. Since entering into the June 2015 Undertaking, Dr. Arora has not been the subject of any new patient complaints to the College regarding rude or unprofessional communications.

12. Dr. Arora has advised the College that, since being notified of the College's concerns regarding compliance with the June 2015 Undertaking, he has made a number of changes to his practice, including: implementing a new system to track appointments; instructing his staff to book fewer appointments per day; and making changes to his staff, including hiring new staff.

13. There is no evidence that Dr. Arora has exceeded 80 patient encounters a day since he was informed of the breach of his June 2015 Undertaking by the College, on December 13, 2016.

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 included a suspension and the imposition of a condition on Dr. Arora's certificate of registration that he successfully pass the PROBE Ethics and Boundaries program.

In considering the joint submission on penalty, the Committee was mindful of what is known as the "public interest" test – a test that specifies that a tribunal or court should not depart from a jointly proposed penalty unless the proposed penalty would bring the administration of justice

into disrepute or is otherwise not in the public interest (*R. v. Anthony-Cook*, 2016). This is a high hurdle that has been met in this case.

The Committee considered the filed documents and submissions made by counsel. It also considered the aggravating and mitigating factors that exist in this case, as well as a number of similar cases that were presented to the Committee by counsel.

The Committee took into account the following principles in assessing the proposed penalty. Paramount is the protection of the public. Important also is denunciation of the member's behaviour, and maintenance of public confidence in the profession and the College's ability to regulate the profession in the public interest. Deterrence both of the member and other physicians is also an important principle in determining the penalty. When possible the penalty should provide for rehabilitation of the member. The penalty should as well be proportionate to the misconduct found to have taken place. The weighing of these principles in light of the specific facts and circumstances of the case was undertaken by the Committee in arriving at its decision in accepting the proposed penalty as appropriate and fair.

Aggravating Factors

1. When a physician has signed an undertaking with the College, the College relies on the physician to regard this undertaking with utmost seriousness and to educate himself or herself with respect to its scope, conditions, and limitations. Dr. Arora failed to comply with certain of the terms set out in his undertaking with the College. Failure to comply with an undertaking undermines the public's confidence that the College is capable of regulating the profession in the public interest.

2. Previous significant patient complaints to the Inquiries, Complaints and Reports Committee ("the ICRC") over a prolonged period of years and demonstrated prior concerns with respect to Dr. Arora's unprofessional communications with patients. These resulted in the undertaking of 2015. This history concerned the Committee as Dr. Arora's failure to abide by professional expectations and conditions suggests that Dr. Arora believes that he is outside the purview of the College and potentially not amenable to

remediation. There was a question of subterfuge in his actions in wilfully disregarding the requirements of his undertaking with the College.

Mitigating Factors

1. Dr. Arora has had no history of prior appearance before the Discipline Committee. Assessments and cautions had been directed by the ICRC.

2. Dr. Arora admitted to the finding of professional misconduct and has accepted responsibility for his behaviour.

3. By agreeing to the statement of facts and proposed penalty, Dr. Arora has saved considerable time and cost and the significant emotional burden that would occur for the witnesses in this case if they had been called to testify.

4. Dr. Arora has previously entered into an undertaking with the College and has successfully completed most of its requirements. In addition, the Undertaking of June 2015 provides that Dr. Arora was to practise under the guidance of a preceptor for a minimum of two (2) years and to see a therapist who is a member of a regulated health profession for a minimum of one (1) year. Dr. Arora continues to meet regularly with the preceptor and the therapist, although he is no longer required to do so pursuant to the terms of his June 2015 Undertaking. Dr. Arora's therapist has continued to provide reports on his progress to the College. In a letter dated September 20, 2017, the therapist wrote: "Dr. Arora has presented to me as a remarkably open, humble, receptive to feedback.....he has consistently presented as eager to abide by his Undertakings."

5. Since entering into the June 2015 Undertaking, Dr. Arora has not been the subject of any new patient complaints to the College regarding rude or unprofessional communications.

6. Dr. Arora has advised the College that since being notified of the College's concerns regarding compliance with the June 2015 Undertaking, he has made a number of changes to his practice, including: implementing a new system to track appointments; instructing his staff to book fewer appointments per day; and making changes to his staff, including hiring new staff.

7. There is no evidence that Dr. Arora has exceeded 80 patient encounters a day since he was informed of the breach of his June 2015 Undertaking by the College, on December 13, 2016.

The Committee was informed that due to the limited physician resources supplying the subspecialty work in vitreal retinal surgery in Hamilton, Dr. Arora's medical services were required and any suspension would adversely affect many patients who are very ill. The demand for his services is, nevertheless, not an excuse or justification for professional misconduct, which needs to be addressed by the Committee. The Committee states that its duty is to determine a penalty proportionate to the findings made. To send a message to the profession that the rules governing appropriate conduct are dependent on where a physician practices, or whom he or she treats, would not be in the public interest.

Previous Cases

Although the Committee's decisions are not binding as a precedent, the Committee accepts as a principle of fairness that like cases should be treated alike. As the Divisional Court stated in *Re Stephens and Law Society of Upper Canada*, adopted by the Ontario Court of Appeal in *CPSO v. Peirovy*, 2018, "a conscious comparison should be made between the case under consideration and similar cases wherein sentences were imposed. If the comparison with other cases is not undertaken there may well be such a wide variation in the results so as to constitute not simply unfairness but injustice."

Each case however is unique. There are no previous cases that have come before the College that are identical to the current case. Some have similarities, particularly regarding the breach of an undertaking, which the Committee considered as follows.

Dr. Thomas Mayberry, a family medicine physician, had entered into an Undertaking with the College not to prescribe narcotics, narcotic preparations, controlled drugs or benzodiazepines (*CPSO v. Mayberry*, 2017). The College obtained Narcotics Monitoring System data, which indicated that he had prescribed Alprazolam on two occasions in 2015. The case proceeded on the basis of an agreed statement of facts and Dr. Mayberry admitted the allegations. The Committee accepted a jointly proposed penalty and ordered a two-month suspension of his

certificate of registration, a reprimand, and the payment of hearing costs. The Committee also ordered the imposition of a term, condition and limitation on his certificate of registration requiring that he successfully complete one-on-one instructions in medical ethics.

Dr. Alvin Wah Wing Lau, a family medicine physician, had entered into an Undertaking with the College in 2007 to have a monitor present during his appointments with all patients at his office and walk-in clinic and to ensure that Dr. Lau's chart entries accurately represent the appointment proceedings (*CPSO v. Lau*, 2007). In 2013, there was a second discipline hearing in relation to Dr. Lau's breach of the Undertaking due to a monitor not being present. Dr. Lau had not sought specific advice from the College regarding the best way to deal with situation, where male patients had requested that the nurse monitor be absent. The case proceeded on the basis of an agreed statement of facts and an admission to the misconduct in December 2013. The penalty was contested. The Committee recognized that Dr. Lau's breach of the conditions on his certificate of registration was serious and unprofessional. However, the Committee found that the breach was motivated by his concern for the interests of his patients and not for his own convenience or benefit. The Committee found that Dr. Lau's actions did not incur any risk of harm to his patients. The Discipline Committee ordered a reprimand and the payment of costs.

Dr. David Gary Saul, a general practitioner, had entered into an Undertaking with the College in 2011 that he would no longer provide medical declarations relating to Health Canada medical marijuana authorization and he relinquished his prescribing privileges with respect to Narcotic Drugs, Narcotic Preparations, Controlled Drugs, Benzodiazepines and/or Other Targeted Substances (*CPSO v. Saul*, 2014). Dr. Saul breached the Undertaking by providing forty-three medical declarations relating to Health Canada medical marihuana authorizations for patients, after he agreed to cease this practice. Breaching of the Undertaking in this case was repeated many times and in different ways. The Committee, in its penalty, paid particular attention to the importance of the members of the College complying with orders and undertakings. The Committee ordered a two (2) month suspension of his certificate of registration, imposed terms, conditions and limitations prohibiting Dr. Saul from all practice related to Cannabis, and required him to complete an educational program in ethics satisfactory to the College. In addition he was ordered to pay hearing costs to the College.

Conclusion

Dr. Arora's actions by failing to comply with the terms of his Undertaking represent a clear lack of responsibility on his part. The Committee takes this very seriously. Dr. Arora's professional misconduct in breaching his Undertaking has implications in terms of patient care and professional governance. Both are important. In the Committee's view, any breach of an Undertaking is a serious matter. In this case, the breach of the Undertaking was repeated many times and in different ways. As regulator for the practice of medicine, the College relies on the honesty and integrity of its members. It is the obligation of members to comply with the orders of the College and its committees, and undertakings made by the College. A failure to comply undermines the effective governance of the profession in the public interest.

The Committee took into consideration all of the information above and that Dr. Arora admitted the facts in paragraphs 1-5 of the Agreed Statement of Facts and Admission. The Committee also took into account that the proposed penalty was the subject of a joint submission on penalty. Furthermore, significant improvement had occurred with increased compliance by Dr. Arora with earlier recommendations and the continued fulfillment of others (i.e. meetings with the supervisor and therapist even past the time required). The nature of Dr. Arora's practice and the potential effect on his patients was considered. The proposed commencement date of the suspension was February 25, 2019 at 12:01 a.m., to provide time to ensure that patient care was provided through a colleague. The Committee was informed that the ICRC had agreed to this part of the proposed penalty. The Committee accepted the jointly proposed penalty as appropriate in the circumstances.

ORDER

The Committee stated its finding of professional misconduct in paragraphs 1 of its written order of January 9, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Arora to attend before the panel to be reprimanded.

3. The Registrar to suspend Dr. Arora's certificate of registration for a period of one (1) month, commencing from February 25, 2019 at 12:01 a.m.

4. The Registrar to place the following terms, conditions and limitations on Dr. Arora's certificate of registration:

    a. Dr. Arora will participate in and unconditionally pass the PROBE Ethics & Boundaries program offered by the Centre for Personalized Education for Professionals, with a report or reports to be provided by the provider to the College regarding Dr. Arora's progress and compliance. Dr. Arora will complete this requirement within 6 months, or, if it is not possible to do so within 6 months, at the first available PROBE Ethics and Boundaries program for which Dr. Arora is eligible.

5. Dr. Arora to pay costs to the College in the amount of $6,000.00 within 30 days of the date of the Order.

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