NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Norbert Ifeanyi Ekeh, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the identity and any information that would disclose the identity of any patient whose name is disclosed in the Agreed Statement of Facts or patient records filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

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

Indexed as: Ekeh, N.I. (Re)

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

IN THE MATTER OF a Hearing directed
by the Complaints Committee and the Executive Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) or Section 36(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. NORBERT IFEANYI EKEH

PANEL MEMBERS:

DR. M. GABEL (CHAIR)
S. BERI
DR. J. WATTS
DR. B. TAA (PhD)
DR. C. CLAPPERTON

Hearing Date:	**July 11, 2011**
Decision Date:	**July 11, 2011**
Release of Written Reasons:	**August 18, 2011**

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 July 11, 2011. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Norbert Ifeanyi Ekeh 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. Ekeh 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*, ("the Code"), in that his care of patients displayed a lack of knowledge, skill or judgment or disregard for the welfare of his patients of a nature or to an extent that demonstrates that he is unfit to continue to practise or that his practice should be restricted.

RESPONSE TO THE ALLEGATIONS

Dr. Ekeh was not in attendance at the hearing. Through his counsel, Dr. Ekeh admitted the first allegation in the Notice of Hearing that he failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence.

FACTS AND EVIDENCE

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

1. Dr. Norbert Ifeanyi Ekeh ("Dr. Ekeh") is an Obstetrician and Gynaecologist who practises in Toronto, Ontario. At all material times he was a member of the College of Physicians and Surgeons of Ontario (the "College"). Since November 26, 2008, Dr. Ekeh has voluntarily restricted himself from carrying on any surgical, hospital obstetrical, or labour and delivery practice pursuant to an undertaking with the College.

2. On December 2, 2005, the Northumberland Hills Hospital received a concerning report from Dr. X, following an external review of Dr. Ekeh's practice.

3. After interviewing Dr. Ekeh and other hospital staff, reviewing Dr. Ekeh's charts and observing him in surgery, Dr. X prepared a report dated December 2, 2005, setting out the details of his opinion regarding Dr. Ekeh's care and treatment of multiple patients, a copy of which is attached [to the Agreed Statement of Facts and Admission] at Tab 1.

4. Following receipt of Dr. X's report, Northumberland Hills Hospital concluded that it could not further extend or renew Dr. Ekeh's privileges. Dr. Ekeh decided not to reapply. The College of Physicians and Surgeons of Ontario (the "CPSO") was informed in due course and provided with a copy of Dr. X's report. An investigation was commenced pursuant to s.75(a) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991* (the "Registrar's Investigation").

5. In the course of the Registrar's Investigation, the CPSO retained Dr. Z to conduct a review of Dr. Ekeh's practice. Thirty randomly selected charts were reviewed, and interviews were conducted with Dr. Ekeh, as well as the Chief of Anaesthesia and Chief of Staff at Northumberland Hills Hospital.

6. Based on the above-noted review, Dr. Z prepared a report dated October 4, 2007, setting out the details of her opinion regarding Dr. Ekeh's care and treatment of multiple patients, a copy of which is attached [to the Agreed Statement of Facts and Admission] at Tab 2.

7. Dr. Ekeh failed to maintain the standard of practice of the profession in his care and treatment of multiple patients in the following respects:

   a) documentation such as operative notes and discharge summaries was deficient;

   b) needle tips left in patients during surgery in several cases;

   c) improper use of a suction curette resulting in perforation of a patient's bowel;

   d) inadequate use of sutures, and cutting on the wrong side of sutures, displaying a fundamental problem with surgical technique;

   e) failure to recognize that without a proper speculum or additional assistance he would not be able to adequately perform a LEEP biopsy;

   f) failure to recognize obvious vulvar and vaginal cysts in a pre-operative examination, resulting in unnecessary second surgery;

   g) performing an induction of labour without indication;

   h) performing operative deliveries without indication;

   i) performing elective caesarean sections without adequate indication;

   j) failure to administer prophylactic antibiotics for elective repeat caesarean sections;

   k) failure to consider post-surgical prophylactic anticoagulation following caesarean section in the presence of risk factors for a venous thromboembolic event;

   l) failure to transfuse a patient post-caesarean-section until her Hb was 52g/L and she had an altered level of consciousness;

m) transfusion of multiple patients without adequate indication;

n) failure to address significant blood loss by multiple patients during surgery;

o) failure to adequately examine a patient resulting in a failure to detect an inoperable endometrial carcinoma that would have warranted transfer to an oncology unit at a tertiary care centre;

p) failure to offer any non-surgical options such as medical therapy or uterine artery embolization before performing a hysterectomy;

q) failure to offer and adequately discuss the risks and benefits of non-surgical management of perimenopausal symptoms; and

r) performing a laparotomy on a patient before adequately investigating whether it was necessary and considering lower-risk alternatives.

Allegations with respect to Patient A

8. On June 7, 2006, Patient A filed a complaint with the CPSO. In addition to the Registrar's investigation, the College conducted an investigation of Patient A's complaint, in the course of which the College retained Dr. Z to opine on Dr. Ekeh's care and treatment of Patient A.

9. Dr. Ekeh performed an endometrial ablation on Patient A on June 1, 2005. Five days later, Patient A was re-admitted to hospital with severe pain accompanied by an elevated white blood cell count and fever. Ultrasound investigation revealed that the ablation had penetrated Patient A's uterine wall. Patient A remained in hospital until June 10, 2005.

10. On June 20, 2005, Patient A was once again readmitted to hospital in severe pain with an elevated white blood cell count. A CAT scan revealed that the ablation had also penetrated Patient A's ureter. As a result, Patient A was leaking urine into her pelvic cavity.

11. The next day, Patient A was taken by ambulance to a regional health centre. Patient A required a surgically implanted stent in her ureter for several months. This was removed on September 27, 2005.

12. In October of 2005, Patient A continued to experience difficulties. A CT scan revealed that Patient A's right kidney was slightly enlarged and her right ureter was damaged.

13. Thereafter, Patient A continued to experience problems with difficult and painful menstruation.

14. Based on her review of this case, Dr. Z prepared a report dated December 9, 2006, and a supplementary report dated February 5, 2007, setting out the details of her opinion regarding Dr. Ekeh's care and treatment of Patient A, copies of which are attached [to the Agreed Statement of Facts and Admission] at Tabs 3 and 4, respectively. Dr. Ekeh failed to maintain the standard of practice in his care and treatment of Patient A in the following respects:

    a) Dr. Ekeh failed to recognize and appropriately act on evidence of a uterine perforation in Patient A during her surgery; and

    b) Dr. Ekeh failed to recognize and appropriately act on a serious fluid imbalance in Patient A during surgery.

15. Dr. Ekeh admits the facts in paragraphs 1 to 14 above and admits that he failed to maintain the standard of practice of the profession in the practice of obstetrics and gynaecology.

FINDING

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. Ekeh's admission and found that he committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession.

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, which was accepted by the Committee. The terms of that order are set out below and include a reprimand and imposition of terms, conditions and limitations on Dr. Ekeh's certificate of registration. Dr. Ekeh will be required to engage in a remedial program, that is, a residency program or analogous experience, should he wish to return to practice. The Committee understands that considerations such as the length of time he has been absent from practice, along with an assessment of his educational needs, will be factored into the design of any remedial program.

Dr. Ekeh displayed serious deficiencies in his surgical technique and in the care of his surgical patients. His deficits compromised his patients' health and lead to complications that were of concern. Offsetting this aggravating factor, Dr. Ekeh has taken responsibility for his failure to maintain the standard of practice of the profession. As a result, a lengthy, contested hearing is unnecessary. It is also noted that Dr. Ekeh has had no previous disciplinary history with the College.

The Committee had regard to the guiding principles regarding penalty in considering the parties' joint submission. The imposition of terms, conditions and limitations on Dr. Ekeh's practice will protect the public. Furthermore, the remedial program will ensure that Dr. Ekeh will not be able to return to his previous practice until his skills are enhanced. The remedial program will be thorough and carefully crafted, and Dr. Ekeh will not be permitted to practise in a hospital or perform surgery as an obstetrician until he receives approval from the College. He will not be permitted to return to unsupervised surgical practice until he has conformed to a period of supervision following his residency training. Thus, his deficiencies will be addressed. This will assist in preventing future errors in his care, which, in turn, will protect the public. The remedial program will also serve to rehabilitate Dr. Ekeh.

The reprimand will serve to express the profession's abhorrence of Dr. Ekeh's actions and should be a specific deterrent to the doctor. The terms and conditions of the order should also provide general deterrence to the profession. The Committee believes that the

integrity of the profession will be maintained through the reprimand and the imposition of significant terms, conditions and limitations on Dr. Ekeh's practice. It is also appropriate that costs are imposed for a one day hearing.

The Committee is aware that a joint submission on penalty should not be rejected unless it is contrary to the public interest and its acceptance would bring the administration of justice into disrepute. The Committee is satisfied that the penalty jointly proposed by the parties protects the public, maintains the integrity of the profession and provides specific and general deterrence.

ORDER

Therefore, the Committee ordered and directed that:

1. The Registrar impose the following terms, conditions and limitations on Dr. Ekeh's Certificate of Registration:

    a) Dr. Ekeh may practice only in an office setting and shall not engage in surgical practice, any hospital-based obstetrical/gynaecological practice or any labour and delivery practice save for the sole and limited purpose of completing an acceptable remedial program in obstetrics and gynaecology under the guidance and supervision of a preceptor acceptable to the College (the "Remedial Program"). The Remedial Program must be approved in advance by the College and shall consist of any remedial elements the College deems appropriate, including, without limitation, the following elements:

        i) completion of a residency program or analogous experience;
        ii) a period of high supervision during which Dr. Ekeh is restricted from being the Most Responsible Physician;
        iii) direct observation of Dr. Ekeh's patient care; and
        iv) clinical supervision including chart reviews, reports to the College and regular meetings with Dr. Ekeh.

b) The above term, condition and limitation on Dr. Ekeh's certificate of registration shall remain in effect until such time as Dr. Ekeh has completed the Remedial Program and the preceptor has reported to the College that Dr. Ekeh is, in all respects, ready to resume an independent surgical, hospital-based obstetrical/gynaecological and/or labour and delivery practice;

c) One year after completing the Remedial Program and resuming a surgical, hospital-based obstetrical/gynaecological and/or labour and delivery practice, or as soon as practicable thereafter, Dr. Ekeh shall undergo a re-assessment of his practice by an assessor appointed by the College and abide by any recommendations of the assessor;

2. Any costs associated with the Remedial Program, the re-assessment or any other terms of this Order shall be borne by Dr. Ekeh;

3. Dr. Ekeh pay costs to the College in the amount of $3,650.00 within thirty (30) days from the date of this Order;

4. Dr. Ekeh appear before the panel to be reprimanded; and

5. The terms of this Order be recorded on the Register.