

## ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

**Citation:** *College of Physicians and Surgeons of Ontario v. Maharaj*, 2026 ONPSDT 9

**Date:** March 11, 2026

**Tribunal File No.:** 25-024

### BETWEEN:

College of Physicians and Surgeons of Ontario

**College**

- and -

Ashwin Rajan Maharaj

**Registrant**

### FINDING AND PENALTY REASONS

**Heard:** January 28, 2026

#### **Panel:**

Sophie Martel (panel chair)

Vincent Georgie (public)

Roy Kirkpatrick (physician)

Joanne Nicholson (physician)

Linda Robbins (public)

#### **Appearances:**

Jessica Roher, Robin Goldberg and Elisabeth Widner, for the College

Matthew Sammon, Drew Black and Herschel Chalet, for the registrant

### RESTRICTION ON PUBLICATION

Pursuant to Rule 2.2.2 of the HPDT Rules of Procedure and ss. 45-47 of the Health Professions Procedural Code, no one shall publish or broadcast the names of patients or any information that could identify patients or disclose patients' personal health information or health records referred to at a hearing or in any documents filed with the Tribunal; these restrictions do not apply to the publication or broadcast of the name or of information that could identify Taissa Pavliuc, unless such information could also identify another patient to whom Rule 2.2.2 applies. There may be significant fines for breaching this restriction.

## **Introduction**

[1] Dr. Ashwin Rajan Maharaj practised proctology and gastroenterology at out-of-hospital premises. This referral concerns Dr. Maharaj's treatment of 17 patients. Dr. Maharaj's care of all these patients fell below the standard of practice of the profession and demonstrated deficiencies in knowledge and judgment, exposing patients to a risk of harm. The misconduct and deficiencies were significant. Dr. Maharaj performed examinations that were unnecessary or contraindicated, misdiagnosed patients and performed procedures that were not evidence-based. Dr. Maharaj also failed to obtain informed consent for many of the procedures he performed.

[2] Additionally, Dr. Maharaj failed to properly store sensitive patient health information and shared personal health information without consent. He misrepresented insured services when offering uninsured services as an alternative. He misrepresented his title and qualifications by holding himself out as a surgeon despite not being certified as such. He breached an undertaking given to the College in April 2024 to no longer perform non-evidence-based procedures and procedures that do not align with the standard of practice of the profession.

[3] Relying on an uncontested statement of facts and plea of no contest, we concluded that Dr. Maharaj failed to maintain the standard of practice of the profession, contravened a term, condition or limitation on his certificate of registration, breached a regulation under the *Medicine Act*, 1991, SO 1991, c. 30 by misrepresenting his title and qualifications, and engaged in conduct that is disgraceful, dishonourable or unprofessional. We also concluded that Dr. Maharaj is incompetent.

[4] The parties jointly proposed that we revoke Dr. Maharaj's certificate of registration and order a reprimand. Because the proposed penalty does not bring the professional discipline system into disrepute, we made the requested order at the hearing. Due to the breadth and severity of the misconduct and incompetence, revocation is the only appropriate penalty that adequately protects the public. We also accepted the parties' joint proposal that Dr. Maharaj pay costs of \$6,000.

## **Background**

[5] Dr. Maharaj obtained his certificate of registration in 1993. He practised proctology and gastroenterology at out-of-hospital premises in Toronto and Thornhill.

[6] The College received complaints from seven patients regarding the treatment Dr. Maharaj provided to them between 2019 and 2025. The College retained Dr. Marcus Burnstein, a colorectal surgeon, to provide an opinion about the care Dr. Maharaj provided to these patients. For all seven patients, Dr. Burnstein opined that Dr. Maharaj failed to maintain the standard of practice of the profession and demonstrated a lack of knowledge and judgment, which exposed or was likely to expose patients to harm.

[7] In May 2025, the College Registrar initiated an investigation about Dr. Maharaj's general medicine practice, including his assessment, management and treatment of anorectal conditions. The College retained Dr. Burnstein to review the medical charts of ten additional patients. Dr. Burnstein opined that Dr. Maharaj failed to maintain the standard of practice of the profession for all ten of these patients and that he demonstrated a lack of knowledge and judgment, which exposed or was likely to expose patients to harm.

#### **Failure to maintain the standard of practice, and incompetence**

[8] Dr. Burnstein provided similar opinions in respect of the seven patient complaints and the additional ten patients whose charts he reviewed as part of the Registrar initiated investigation. For all 17 patients, Dr. Burnstein opined that Dr. Maharaj's treatment fell below the standard of practice of the profession and demonstrated a lack of knowledge and judgment, which exposed patients to risk of harm. We outline some of the deficiencies identified by Dr. Burnstein:

- Dr. Maharaj performed flexible sigmoidoscopies under propofol anesthesia in almost every anorectal examination when these were not indicated and at times contraindicated. Dr. Maharaj unnecessarily exposed these patients to the risk of sedation.
- Dr. Maharaj performed anal dilatations on multiple patients, none of which were clinically indicated. Dr. Burnstein explained that anal dilatation is a discredited treatment for all anal pathologies except anal stenosis because dilatation may damage the sphincter muscles and cause incontinence. None of the patients were diagnosed with anal stenosis, and so performing anal dilatation put these patients at risk.

- Dr. Maharaj misdiagnosed multiple patients and then performed surgery that was not clinically indicated. For example, he diagnosed patients with hemorrhoidal disease when their complaints and symptoms did not support this diagnosis.
- Dr. Maharaj performed multiple procedures that are not recognized, accepted or evidence-based, including excising skin tags and hemorrhoids using a hot snare, treating skin tags/external hemorrhoids with laser hemorrhoidoplasty (LHP) and, treating a fissure by closing it with a suture. In one case, Dr. Maharaj conducted a repeat LHP on a patient and excised two hemorrhoids three months after conducting an ineffective LHP on this patient. Dr. Burnstein opined that proceeding with more anal surgery only three months after ineffective anal surgery showed extremely poor judgment. Dr. Maharaj should instead have revisited his diagnosis and pursued non-surgical treatment options.

[9] Dr. Maharaj's treatment of patients not only fell below the standard of practice but also injured them. For example, Dr. Maharaj misdiagnosed Patient C with advanced hemorrhoidal disease when she had no symptoms of such. He then performed surgery on several internal and external hemorrhoids that was not clinically indicated during which the patient's external skin split. The patient's chief complaint was *pruritus ani* or anal itch, which, according to Dr. Burnstein, virtually never responds to operative management. Furthermore, she was recovering from an anal operation that had been performed five weeks earlier. Dr. Burnstein opined that performing the operation was a gross error in judgment and injured Patient C.

[10] Dr. Maharaj also demonstrated a lack of knowledge in his statements about anatomy and treatment options with patients, such as misrepresenting rubber band ligation (RBL) and hemorrhoidectomy during his discussions with some patients.

[11] Dr. Maharaj failed to obtain informed consent from his patients. In some cases, he obtained a blanket consent before examination and diagnosis, then determined and performed procedures while patients were sedated, without obtaining consent for the specific treatment delivered. A blanket consent to treat whatever he found on examination

by whatever technique he chose does not meet the standard of practice for obtaining informed consent.

[12] Finally, according to Dr. Burnstein, Dr. Maharaj's documentation was not accurate, complete or comprehensive and fell below the standard of practice.

[13] Relying on Dr. Burnstein's opinion, as found in the statement of uncontested facts and plea of no contest, we conclude that Dr. Maharaj failed to meet the standard of practice of the profession. Dr. Burnstein's opinion also supports our finding of incompetence.

[14] To make a finding of incompetence under s. 52(1) of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c. 18, a panel must be satisfied that the registrant's professional care of a patient displayed a lack of knowledge, skill, or judgment of a nature or to an extent that demonstrates that the registrant is unfit to practise or that the registrant's practice should be restricted.

[15] Dr. Maharaj displayed a lack of knowledge and judgment in his treatment of 17 patients, as noted above. He performed examinations that were unnecessary and/or contraindicated, including examinations under sedation without proper justification. He misdiagnosed patients and carried out unwarranted procedures including treatments that are neither recognized, accepted or evidence-based. He demonstrated a lack of knowledge in his statements about anatomy and treatment options and failed to obtain informed consent.

[16] Dr. Maharaj's lack of knowledge and judgment is of such an extent that at the very least his practice should be restricted, especially considering the substantial deficits outlined by Dr. Burnstein.

### **Disgraceful, dishonourable or unprofessional conduct**

[17] Dr. Maharaj failed to properly store and dispose of photographs that two patients sent him of their anuses via text message by retaining these photographs on his personal cell phone and failing to save them in the patients' medical charts. He also stored photos of two patients' faces on his personal cell phone. He sent sensitive

personal health information of other patients without their consent to Patient D. This included a video of one patient being treated by Dr. Maharaj.

[18] Dr. Maharaj engaged in disgraceful, dishonourable or unprofessional conduct by failing to properly store and destroy patient photographs and by sharing sensitive personal health information without consent. In doing so, he demonstrated a profound disregard for patients' highly sensitive personal health information, and breached the College's policies on Medical Records Documentation, Protecting Personal Health Information and Professional Behaviour.

[19] Dr. Maharaj further engaged in disgraceful, dishonourable or unprofessional conduct by misrepresenting insured services (RBL and hemorrhoidectomy) when offering an uninsured service (LHP) as an alternative, contrary to the College's policy on Uninsured Services.

#### **Breach of a term, condition or limitation on his certificate of registration**

[20] On April 23, 2024, Dr. Maharaj signed an undertaking with the College in which he undertook, among other things, to no longer perform endoscopic hemorrhoidectomies or any other procedure or treatment that is not evidence-based, or which does not align with the standard of practice of the profession. Dr. Maharaj contravened this term, condition or limitation on his certificate of registration by performing at least eight procedures on eight different dates between August 2024 and March 2025 that were not evidence-based and that do not align with the standard of practice of the profession. These included excising skin tags and hemorrhoids using a hot snare, treating a fissure by closing it with a suture, and performing LHP to treat a patient's skin tag/external hemorrhoid.

#### **Contravening a regulation under the *Medicine Act***

[21] Dr. Maharaj represented his title and qualifications on various websites as "Surgeon," "General Surgeon," "Staff General Surgeon," and/or "General Surgery." Dr. Maharaj is not certified by the Royal College of Physicians and Surgeons of Canada in a surgical specialty or subspecialty and he is not formally recognized in writing by the College as a surgical specialist or subspecialist. In misrepresenting his title and qualifications, he contravened s. 9 of Ontario Regulation 114/94 made under the

*Medicine Act*, 1991. Under para. 27 of s. 1 of Ontario Regulation 856/93 under the *Medicine Act*, it is professional misconduct to contravene a regulation under that *Act*.

### **Penalty and costs**

[22] The parties jointly proposed a reprimand, revocation of Dr. Maharaj's certificate of registration and costs of \$6,000.

[23] Our role is limited when the parties agree on penalty. We should only depart from a joint submission if the proposed penalty would bring the administration of justice into disrepute or is otherwise not in the public interest: *R. v. Anthony Cook*, 2016 SCC 43. This is a high threshold. A disciplinary body that rejects a joint submission on penalty must show why the proposed penalty is so unhinged from the circumstances of the case that it must be rejected: *Bradley v. Ontario College of Teachers*, 2021 ONSC 2303.

[24] We are satisfied that the proposed penalty would not bring the administration of physician regulation into disrepute. We are also satisfied that the proposed penalty appropriately balances the penalty goals: the protection of the public, general and specific deterrence, rehabilitation and expressing the Tribunal and the profession's disapproval of the misconduct. As detailed below, Dr. Maharaj's prior involvement with the College's Inquiries Complaints and Report Committee (ICRC) had already made clear the concerns about multiple aspects of his practice and the need to undergo instruction and to address these concerns. Despite these measures, problems persisted such that we give little weight to the goal of rehabilitation in this case.

### ICRC history

[25] Between 2003 and 2024, the ICRC and its predecessor, the Complaints Committee, dealt with multiple complaints about Dr. Maharaj's documentation deficiencies, informed consent, communication and adherence to standards of practice:

- In July 2003, the Complaints Committee cautioned Dr. Maharaj in person about what is required to obtain and document informed consent.
- In June 2004, the Complaints Committee cautioned Dr. Maharaj in writing, again about the importance of obtaining and documenting informed consent for procedures he performs.

- In November 2010, the ICRC directed that an undertaking be negotiated with Dr. Maharaj about concerns with his general practice, including infection control procedures and routinely performing unindicated procedures. Dr. Maharaj signed an undertaking in December 2010 in which he agreed to employ certain procedures only when indicated rather than as a matter of routine and only when specific consent was obtained. He also undertook to submit to an assessment of his practice and to abide by the recommendations of the assessor.
- In July 2013, following a patient complaint about his unprofessional behaviour and communications, the ICRC required Dr. Maharaj to complete a Specified Continuing Education or Remediation Program (SCERP) in communication skills.
- On December 14, 2016, following concerns about Dr. Maharaj's conduct during an independent medical examination, the ICRC required that he complete a SCERP that included one-on-one instruction in communications, as well as self-directed learning on the College's Practice Guide and its policy on Consent to Treatment.
- On March 22, 2024, the ICRC disposed of four patient complaints by cautioning Dr. Maharaj about performing experimental non-evidence-based treatment, failing to obtain informed consent, failing to take an adequate history and to fully examine a patient, and needing to reflect on his ethical obligations as a physician. Dr. Maharaj also signed an undertaking on April 23, 2024, in accordance with the ICRC's direction and concerns.

[26] The above ICRC dispositions do not constitute a prior discipline history. They nevertheless demonstrate that Dr. Maharaj has previously been cautioned about the importance of obtaining and documenting informed consent, as well as not performing procedures that are not indicated and that are not evidence-based. It is concerning that despite these cautions, Dr. Maharaj continued to not obtain informed consent and to perform non-indicated and non-evidence-based procedures. Additionally, we note that Dr. Maharaj was directed and undertook to engage in education and instruction regarding his professional obligations, which do not appear to have resulted in any

significant change to his practice. There is no evidence that rehabilitation would be effective at this point.

#### Severity of the misconduct and incompetence findings

[27] The misconduct and incompetence findings in this case were extremely serious, took place over multiple years, and were multi-faceted. The findings cover every aspect of Dr. Maharaj's practice: misrepresenting his title and qualifications, failing to obtain informed consent, incomplete documentation, inadequate and/or inappropriate examinations, misdiagnosing, performing procedures that were not indicated and/or contraindicated, breaching patient confidentiality, misrepresenting insured versus uninsured services, and not adhering to an undertaking with the College. There were deficiencies in Dr. Maharaj's treatment of all 17 patients reviewed by Dr. Burnstein. Patients are entitled to safe, evidence-based care grounded in sound clinical judgment, informed consent, accurate documentation and respect for privacy. Dr. Maharaj's disregard of all these important elements requires that we revoke his certificate. As such, the jointly submitted penalty of revocation does not bring the administration of physician regulation into disrepute. On the contrary, due to the breadth and severity of the misconduct and incompetence, revocation is the only penalty that is appropriate to protect the public and maintain its confidence in the self-regulation of the profession.

[28] We also accept the parties' joint proposal that a reprimand be delivered. The reprimand provides an opportunity to publicly denounce the misconduct and to maintain public confidence in the medical profession and its ability to self-regulate.

#### Costs

[29] We accept the parties' agreement to costs of \$6,000, which reflects the tariff rate in the Rules of Procedure.

#### **Order**

[30] For the above reasons, our order provides:

1. The Tribunal requires the registrant to appear before the panel to be reprimanded.
2. The Tribunal directs the Registrar to revoke the registrant's certificate of registration effective immediately.

3. The Tribunal requires the registrant to pay the College costs in the amount of \$6,000.00 by February 27, 2026.

**ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL**

**Tribunal File No.: 25-024**

**BETWEEN:**

College of Physicians and Surgeons of Ontario

**College**

- and -

Ashwin Rajan Maharaj

**Registrant**

**The Tribunal delivered the following Reprimand  
by videoconference on Wednesday, January 28, 2026**

**\*\*\*NOT AN OFFICIAL TRANSCRIPT\*\*\***

Dr. Maharaj,

Our findings reveal a pattern of serious and wide-ranging misconduct that exposed patients to risk of harm. We have found, and you do not contest, that in your proctology and gastroenterology practice:

- you failed to maintain the standard of practice of the profession;
- your conduct constituted disgraceful, dishonourable or unprofessional conduct;
- you contravened a term, condition or limitation on your certificate of registration;
- and
- you breached a regulation under the *Medicine Act* by misrepresenting your title and qualifications.

We have also found that you are incompetent.

Seven patients complained to the College about your assessment and treatment of a range of medical issues between 2019 and 2025. The College's independent expert, a colorectal surgeon, concluded that, in each case, your care fell below the standard of practice and demonstrated deficiencies in knowledge, skill and judgment, and exposed or was likely to expose patients to harm.

You performed anorectal examinations that were unnecessary or contraindicated, including examinations under propofol anesthesia without proper justification. You misdiagnosed patients and proceeded to carry out unwarranted procedures, including

treatments that are neither recognized, accepted nor evidence based. You demonstrated a lack of knowledge in your statements about anatomy and treatment options. Further, you failed to obtain informed consent. In some cases, you obtained blanket consent before examination and diagnosis, then determined and performed procedures while patients were sedated, without obtaining consent for the specific treatment delivered. This approach fell alarmingly short of the standard of practice and compromised your patients' ability to make informed decisions about their healthcare. Your documentation was not accurate, complete or comprehensive and fell below the standard of practice.

The College's subsequent Registrar's investigation, including a further review of ten patient charts, revealed similar deficiencies, including misdiagnoses, unindicated and non-evidence-based procedures, and procedures performed under anesthesia without appropriate justification. This placed patients at an unacceptable risk of harm. We also found that you engaged in disgraceful, dishonourable or unprofessional conduct by failing to properly store and destroy patient photographs, including sensitive and graphic images, and by sharing sensitive personal health information, including treatment videos, with another patient without patient consent. In doing so, you demonstrated a profound disregard for patients' highly sensitive personal health information and breached the College's policies on medical records, privacy and professional conduct. You further engaged in disgraceful, dishonourable or unprofessional conduct by misrepresenting insured services when offering uninsured services as an alternative, contrary to college policy.

In April 2024, you undertook to cease performing procedures that were not evidence-based or consistent with the standard of practice. You later breached that undertaking by continuing to perform non-compliant procedures, thereby contravening a term, condition or limitation on your certificate of registration. You also contravened a regulation under the *Medicine Act* by misrepresenting your title and/or qualifications by holding yourself out as a surgeon, despite not being certified by the Royal College of Physicians and Surgeons of Canada in a surgical specialty or subspecialty.

Between 2003 and 2024, the College's Inquiries Complaints and Reports Committee dealt with deficiencies in your documentation, informed consent, communication and adherence to standards of practice. You were cautioned and counselled on multiple occasions and, in 2013 and 2016, were required to complete Specified Continuing Education or Remediation Programs addressing consent and communication. In 2024, four public complaints led to further cautions concerning non-evidence-based treatments, failures to obtain informed consent, inadequate history-taking and examination, and ethical concerns, culminating in your April 2024 undertaking. Even though the ICRC emphasized the nature and importance of your professional obligations multiple times, you failed to ensure that you complied with them.

The scope and seriousness of your misconduct is profound. Patients are entitled to safe, evidence-based care grounded in sound clinical judgment, informed consent, accurate documentation and respect for privacy. The breadth and severity of your misconduct has resulted in the revocation of your certificate of registration. We are confident that this most severe sanction is necessary to protect the public.