Indexed as: Hamdy, Hazem Ali (Re)

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

IN THE MATTER OF a Hearing directed
by the Complaints Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(2) 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. HAZEM ALI HAMDY

PANEL MEMBERS:

DR. P. CHART
G. DEVLIN
DR. J. WATTS
E. ATTIA (PhD)
DR. M. DAVIE

Hearing Date:	**October 13, 2010**
Decision Release Date:	**October 13, 2010**
Release of Written Reasons:	**November 9, 2010**

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons of Ontario (the "Committee") heard this matter at Toronto on October 13, 2010. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Hamdy 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. Hamdy 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. Hamdy admitted the first allegation in the Notice of Hearing, that he has 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 was filed as an exhibit at the hearing and presented to the Committee:

FACTS

Background

1. Dr. Hazem Ali Hamdy is a member of the College of Physicians and Surgeons of Ontario (the College) who was issued a certificate of registration authorizing independent practice on September 19, 1980.

2. Dr. Hamdy obtained his medical degree in 1968. He holds a specialty certification in Family Medicine and is a general practitioner in Ottawa. Prior to being referred to the College's Discipline Committee, Dr. Hamdy performed elective cosmetic circumcisions in his clinic, Ottawa Men's Clinic.

Patient A

3. On January 30, 2008 Patient A, an 18-year-old male, presented to Dr. Hamdy's office with a complaint of penile pain during erection. After performing a physical examination on Patient A, Dr. Hamdy advised Patient A of the nature and cost of an elective circumcision procedure.

4. Patient A elected to have the procedure, which took place in Dr. Hamdy's office on February 4, 2008. Patient A returned to Dr. Hamdy's office on February 4th, 5th and 6th with complaints of bleeding, swelling and pain, and was treated by Dr. Hamdy on those days. On February 6, Dr. Hamdy referred Patient A to the hospital, where he underwent a further surgical procedure.

College's Medical Inspector

5. Dr. James W. L. Wilson (Dr. Wilson) provided an opinion to the College regarding Dr. Hamdy's care and treatment of Patient A. Dr. Wilson reviewed various materials provided by the College and concluded that the setting in which the procedure was carried out (Dr. Hamdy's clinic office) did not meet the standard for an operating

environment at an Independent Health Facility.

6. Dr. Wilson opined that:

> …circumcision is an operative procedure which needs to be conducted in an appropriate environment… [and he would] not regard as being acceptable that surgical procedures were being carried out in a non-sterile environment. Cross patient contamination must be regarded as being a significant risk in this situation. Autoclaves (flash sterilization) are no longer regarded as providing acceptable sterilization for surgical instruments in hospital settings and ambulatory clinics would need to meet the same standards.

7. At page 4 of his report, Dr. Wilson stated that Dr. Hamdy appears not to understand the modern standards for assurance of sterility for invasive procedures. A copy of Dr. Wilson's report, dated October 28, 2008 is attached as Appendix "A" [to the Agreed Statement of Facts].

8. On November 11, 2008 Dr. Wilson provided an addendum to his report. In this report he restated that:

> …the knowledge and judgment Dr. Hamdy exercises is inadequate for the conduct of surgical procedures in an environment that does not meet the standards of care.

A copy of this addendum report is attached as Appendix "B" [to the Agreed Statement of Facts].

9. As of May 1, 2009 Dr. Hamdy has been prohibited from performing adult circumcisions in his office practice, pursuant to an Interim Order of the College's Executive Committee. The Interim Order has also prohibited Dr. Hamdy from performing intra-articular injections and office surgical procedures that cause a break in the skin unless there is a Registered Nurse or Registered Practical Nurse present.

ADMISSION

10. Dr. Hamdy admits the facts set out above and admits that he failed to maintain the standard of practice of the profession in respect of his sterilization techniques and sterilization of his operating environment.

11. Dr. Hamdy admits that this constitutes professional misconduct under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991*.

FINDINGS

The Committee noted that, in the letters from the independent expert who had assessed the medical practice of Dr. Hamdy (Appendices A and B), the expert comments that the circumcision referred to in the summary of the Agreed Statement of Facts was carried out using an acceptable technique. Moreover, he commented that Dr. Hamdy was attentive post-procedure and responded appropriately to the patient's concerns. Dr. Hamdy's clinical judgment appeared to have been satisfactory regarding management of the post-operative protocol complications.

On the other hand, the expert stated "I am concerned about Dr. Hamdy's clinical practice of providing surgical procedures in an ambulatory setting which does not meet modern standards for sterility." He went on to state that the use of standard auto-claves is no longer acceptable as a means of controlling cross-contamination, and the actual room, equipped with the living plants and carpets, did not meet environmental standards of care for invasive surgical procedures.

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts. Having regard to these facts, the Committee accepted Dr. Hamdy'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 in respect of his sterilization techniques and sterilization of his operating environment.

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

Discipline Committee Proceeding

1. On October 13, 2010, before the Discipline Committee of the College, Dr. Hamdy pleaded guilty and was found guilty of professional misconduct for failing to maintain the standard of practice of the profession in respect of his sterilization techniques and sterilization of his operating environment in February 2008 when he performed a circumcision on Patient A.

Chronology of College Activities

2. On September 3, 2008 the College received a complaint from a patient who had undergone a circumcision by Dr. Hamdy in February 2008 (Patient A).

3. On October 7, 2008, the Executive Committee of the College approved an appointment of investigators under section 75(1)(a) of the Health Professions Procedural Code after it considered information from the Complaints Committee regarding the care and treatment provided by Dr. Hamdy to Patient A.

4. On March 4, 2009 the Complaints Committee referred allegations of professional misconduct to the Discipline Committee of the College related to the complaint of Patient A.

5. On July 10, 2009 the College received correspondence from Dr. Hamdy indicating his intention to co-operate with the College with regard to section 75(1)(a) investigation. Therefore, rather than referring further the allegations to the Discipline Committee the parties agreed that the substance of the investigation would be taken into account at the penalty stage of the hearing with respect to the public complaint.

6. On December 2, 2009 the results of the section 75(1)(a) investigation were

returned to the Inquiries, Complaints and Reports Committee.

Section 75(1)(a) Investigation

7. The College retained the services of a urologist, Dr. James. W. L. Wilson (Dr. Wilson), to review, among other materials, 25 patient charts from Dr. Hamdy's office practice.

8. Dr. Wilson's review focused on Dr. Hamdy's care and management of patients presenting for circumcision and for patients having problems with male sexual dysfunction, including androgen deficiency syndromes. As requested by the College, Dr. Wilson submitted a preliminary report based on his initial review since he believed that Dr. Hamdy's practice was likely to expose his patients to harm. A copy of this report is attached as Appendix "A" [to the Agreed Statement of Facts on Penalty].

9. Dr. Wilson opined that the procedure room used by Dr. Hamdy would appear not to meet the standard for an ambulatory surgical procedure suite:

> …The oxygen tank is reported to have expired 2 years prior to the date of [College] inspection. The oxygen mask is reported as being visibly dirty… No other resuscitation medications were listed as being available. Patients undergoing procedures under local anesthetic occasionally have vaso-vagal reactions and the availability of atropine to counteract this reaction would be strongly advised.

10. Dr. Wilson further found that Dr. Hamdy's handling of surgical instruments and cleaning materials was of major concern:

> The instruments are manually cleaned, then placed in an autoclave. There is no assurance that the autoclave is functioning properly, as there is no test done to ensure the proper temperatures and steam pressures are reached. Biological markers which provide assurance of sterility are not used and there is no documentation of equipment

> servicing. The surgical instruments appear to be stored in non-sterile plastic containers… For more invasive procedures where instruments are being re-used, maintenance of standards for sterilization are critical to prevent transmission of infectious agents and blood borne pathogens between patients.
>
> A sharps container was not available in the Procedure Room but was in the adjacent room. This is inadequate. Dr. Hamdy reports using Kleenex for control of surgical bleeding which is substandard. Kleenex is a non-woven cellulose fiber and tends to disintegrate when wet leaving the risk of fibers becoming lodged in the wound. Standard surgical sponges should be used.
>
> Dr. Hamdy reports cleaning the examining – procedure table with water and occasionally with Windex. This latter agent is not a standard anti-microbial cleanser. The risk of cross contamination between patients would be high.

11. Moreover, Dr. Wilson stated that the emergency response measures at Dr. Hamdy's office do not meet the standard for an ambulatory surgical facility:

> Dr. Hamdy does not report that he is qualified in Advanced Cardiac Life Support training and indicated his response in case of an emergency would be to call 911. This is unacceptable in modern medical practice… Immediate institution of cardio-pulmonary resuscitation must be done in the case of a cardiac arrest.

12. The College retained Dr. John E Mahoney (Dr. Mahoney), a urologist, to provide an opinion on Dr. Hamdy's treatment and care of patients in the areas of circumcision and sexual dysfunction. Dr. Mahoney reviewed, among other things, 21 patient charts from Dr. Hamdy's office and concluded that with respect to treatment of sexual dysfunction, Dr. Hamdy meets the standard of practice, however with respect to the procedure of

circumcision Dr. Hamdy does not meet the standard of practice. A copy of this report is attached as Appendix "B" [to the Agreed Statement of Facts on Penalty].

13. Dr. Mahoney opined that:

> Dr. Hamdy displays both a lack of skill in the sense that so many of his skin sutures fell out. I also believe he demonstrates a lack of judgement when he deliberately does not cleanse a wound or uses sterile technique when performing a penile procedure. One usually gets away with excellent penile skin healing due [to] above average blood supply to the penile skin. … Dr Hamdy exploits this factor and has fairly good results, however when a large hematoma forms or drains, or there is a wound infection, the penile skin does not heal through. …Dr. Hamdy's main problem is essentially not being able to look after his complications and it is in this area where he especially falls below the standard of care.
>
> …Dr. Hamdy poses a risk of harm to patients when performing circumcisions, or any procedure whereby sterile technique is not observed. …there is evidence that his ability to suture may be impaired, and his infection rate is higher than he stated in a personal publication.

14. The College also retained Dr. Michael Anthony John (Dr. John), a medical microbiologist. Dr. John provided an opinion on the standard of care provided by Dr. Hamdy in relation to the infection control aspects of his practice generally and, specifically, Dr. Hamdy's practice of not disinfecting skin prior to administering injections, taking blood and performing minor surgical procedures. A copy this report is attached as Appendix "C" [to the Agreed Statement of Facts on Penalty].

15. Dr. John opined that Dr. Hamdy's practice of performing minor surgical procedures without prior skin disinfection and his practice of performing intra-articular

injections or aspirations without prior skin disinfection do not meet the standard of practice.

16. Dr. John stated in his report that Dr. Hamdy failed to prove that his non-sterile technique is safe. He further found that his failure to perform skin disinfection prior to arthrocentisis and intra-articular injections and his failure to perform preoperative skin antisepsis are likely to expose his patients to harm.

Interim Order

17. On April 28, 2009, the Executive Committee imposed terms, conditions and limitations on Dr. Hamdy's Certificate of Registration pending a hearing before a panel of the Discipline Committee. The interim suspension remains in effect to date and a copy of the Interim Order is attached as Appendix "D" [to the Agreed Statement of Facts on Penalty].

On July 10, 2009 Dr. Hamdy self-reported a breach of this Interim Order, which involved giving an intra-articular injection without a registered nurse or registered practical nurse being present. A copy of this correspondence is attached hereto Appendix "E" [to the Agreed Statement of Facts on Penalty].

PENALTY DECISION AND REASONS FOR DECISION

The College and counsel for the Dr. Hamdy agreed to a complex series of penalties which included a period of suspension, a restriction in specific practices, supervision of practice and facilities, the participation in a series of educational requirements, a practice assessment done after one year, unannounced inspections and a reprimand. They also jointly proposed a repayment of costs.

The Committee was mindful of the fact that, when a joint submission is made by the parties, the penalty should be accepted unless doing so would be contrary to the public interest and would bring the administration of justice into disrepute. The Committee took into consideration the fact that the neglect of environmental and equipment safety concerns was an offence that exposed patients to potential danger and could reasonably

be characterized as serious. It also took into account the fact that Dr. Hamdy had already breached on one occasion an interim order of the Executive Committee of the College, an event which he self-reported to his counsel and to the College and which he had explained had been done on compassionate grounds. The Committee also took under consideration mitigating factors, including Dr. Hamdy's willingness to cooperate with the College's investigation and his acceptance of the expert's opinion and of penalty, with consequent limitation of the expense of a prolonged hearing.

The Committee felt that the components of the penalty were sufficient to maintain public confidence in the profession as well as providing protection for the public. The penalty provided general and specific deterrents as well as the opportunity for rehabilitation.

Counsel for the College presented a series of similar decisions by the College and the Committee was persuaded that the severity of the penalties was consistent with penalties imposed in recent years for somewhat similar findings (CPSO and Dr. Daniel Charles Sweet 2004, CPSO and Dr. Daniel Charles Sweet 2008, CPSO and Dr. Howard Wu 2009).

The Committee was particularly concerned about the issues of cleanliness and infection control that were generated in the reports of both experts and made a recommendation that Dr. Hamdy undergo an educational program in infection control as a priority. This recommendation was accepted by all parties.

ORDER

Therefore, the Committee ordered and directed that:

1. Dr. Hamdy appear before the panel to be reprimanded.

2. The Registrar suspend Dr. Hamdy's certificate of registration for a period of three (3) months commencing from the date of this Order.

3. The Registrar impose the following specified terms, conditions and limitations on Dr. Hamdy's certificate of registration for an indefinite period or for the specified period of times set out herein:

   (a) Dr. Hamdy shall not perform circumcisions and shall post a sign, in the form attached as Appendix "A", in a prominent place in the waiting room and in the examination/procedure rooms in his office.

   (b) Dr. Hamdy shall use sterile procedures at all times in his office.

   (c) At his own expense, Dr. Hamdy shall engage in monthly supervision of infection control practices and procedures by a supervisor who has been approved by the College and who has executed an undertaking in the form attached as Appendix "B", for a period of two (2) years from the date of this Order.

   (d) At his own expense, Dr Hamdy shall ensure that a member of a regulated health profession, who has been approved by the College and who has executed an undertaking in the form attached as Appendix "C", be present for all intra-articular injections and office surgical procedures that cause a break in the skin for a period of one (1) year from the date of this Order.

   (e) At his own expense, Dr. Hamdy shall successfully complete, within approximately 18 months, education programs acceptable to the College in:

      (i) Record-Keeping;
      (ii) Ethics; and
      (iii) Communications and Informed Consent;

      and shall provide proof to the College of his successful completion of the College approved education programs as set out above in paragraphs 3(e)(i)-(iii).

(f) At his own expense, Dr. Hamdy shall successfully complete, within approximately 6 months, an education program acceptable to the College in:
(i) Infection Control
and shall provide proof to the College of his successful completion of the College approved education program.

(g) At his own expense, Dr. Hamdy shall undergo a reassessment of his practice in approximately one (1) year from date of the Order.

(h) Dr. Hamdy shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

4. Dr. Hamdy pay to the College costs in the amount of $3650 within 30 days of the date of this Order.

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