NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Baldeep Takhar, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the names of patients and any information that could disclose the identity of patients referred to orally or in the exhibits 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… 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: Ontario (College of Physicians and Surgeons of Ontario) v. Takhar, 2019 ONCPSD 30

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. BALDEEP TAKHAR

PANEL MEMBERS:

MR. PIERRE GIROUX
DR. CAROLE CLAPPERTON
DR. DEBORAH HELLYER
MR. MEHDI KANJI
DR. MELINDA DAVIE

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. MORGANA KELLYTHORNE

COUNSEL FOR DR. TAKHAR:

MR. MATTHEW LERNER
MR. SEAN LEWIS

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. G. FORREST

PUBLICATION BAN

Hearing Date:	**May 24, 2019**
Decision Date on Finding:	**May 24, 2019**
Decision Date on Penalty:	**May 27, 2019**
Written Decision Date:	**July 16, 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 May 24, 2019**.** At the conclusion of the hearing, the Committee stated its finding that Dr. Baldeep Takhar committed an act of professional misconduct and reserved its decision on penalty. On May 27, 2019, the Committee released its order on penalty, with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Baldeep Takhar 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. 856/83), in that she has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1)33 of O. Reg. 856/93, in that she has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional;

It was also alleged that that Dr. Takhar is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Takhar admitted the first allegation in the Notice of Hearing, that she failed to maintain the standard of practice of the profession. Counsel for the College withdrew the second allegation and the allegation of incompetence 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:

BACKGROUND

1. Dr. Baldeep Takhar ("Dr. Takhar") is a 52 year-old family physician who received her certificate of registration authorizing independent practice from the College of Physicians and Surgeons of Ontario ("the College") in November 2004.

2. At the relevant time, Dr. Takhar practised family medicine in Cambridge and Kitchener, Ontario. Dr. Takhar also maintained a cosmetic medicine practice which is not the subject of this matter.

FACTS

3. In November 2013, Dr. Takhar, along with three other doctors, created the Franklin Family Health Organization ("FHO"). Dr. Takhar assumed the role of "Lead FHO Physician." Dr. Takhar had previously been a signatory member at another FHO, the Canamera FHO, since 2011.

4. Between December 2013 and December 2015, the practices of Dr. Takhar and the Associate Lead Physician, Dr. Jodie Wang, grew quickly. The Franklin FHO's total patient enrolment count grew from 8,774 to 18,123 patients. Patients were rostered under approximately seven member physicians, but some member physicians left the FHO and most patients came to be rostered under Dr. Takhar or Dr. Wang. During this time period, Dr. Takhar's individual patient enrolment count increased from 4,453 patients to 7,282 patients.

5. Dr. Takhar practised at two locations of the Franklin FHO in Kitchener, and at one location in Cambridge. A further location opened in Guelph in 2014, which was run by two other member physicians.

6. The FHO was staffed by both signatory physicians (who were members of the FHO) and locum physicians who were paid by the hour, as well as other staff such as physician assistants, nurse practitioners, registered practical nurses, and office staff.

7. Patients enrolled with the Franklin FHO were rostered to an individual physician. However, the Franklin FHO used a "shared care model", in which each patient could book an appointment to see any of the physicians on staff or walk in on the weekend to do so. The rapid growth of the Franklin FHO and the problems that arose in implementing the "shared care model" contributed to Dr. Takhar's failure to maintain the standard of practice of the profession, as outlined below.

8. After receiving information of concern regarding Dr. Takhar's clinical and administrative practices, the College commenced an investigation into her family practice in September 2014. An expert was retained who reviewed twenty-two family practice charts and related records, and interviewed Dr. Takhar. The College expert opined in reports in March and October 2016 that Dr. Takhar had failed to maintain the standard of practice of the profession with respect to record keeping, practice management, and clinical management of patients.

9. In the period reviewed by Dr. Cohen (i.e. 2005 through January 2015), Dr. Takhar failed to maintain the standard of practice of the profession as set out below.

10. In terms of clinic management, Dr. Takhar rostered too many patients at the Franklin FHO and personally to herself, without ensuring that continuity of care could be provided to rostered patients.

11. The Franklin FHO used an electronic medical records system ("EMR"). However, the system in place for physicians to be alerted as to test results or possible charting errors did not reliably reflect whether a result entered into the system had been reviewed by a physician, whether a patient had taken a test that had been ordered, or whether a test result was lost. There was no clear policy or procedure administratively on who should receive this information or

follow up in this regard. It was also difficult to determine who was the "most responsible physician" for the patient. This resulted in inconsistent follow-up, and in necessary follow-up sometimes being missed.

12. In terms of medical record keeping, issues were identified with Dr. Takhar's charting practices in a number of the charts reviewed:

a. Information was missing in the comprehensive patient profiles of patients rostered to her, including regarding social history, past medical history, preventive health history, and immunizations;
b. Progress notes were frequently incomplete or vague as to history, physical examination, diagnosis, plan, and follow-up;
c. Patient charts lacked appropriate diabetes care documentation regarding a diabetic patient and a potentially diabetic patient whose care was reviewed; and
d. The patient charts did not document the clinical indication for tests Dr. Takhar ordered or medications she prescribed.

13. In terms of clinical care, following review of the patient charts from this same period, the College's expert opined that Dr. Takhar's clinical care of patients did not meet the standard of practice of the profession in the following ways:

a. Letters referring patients to specialists for consultation did not set out all the necessary clinical details;
b. Follow-up on test results for rostered patients and patients for whom she had ordered tests was inconsistent, and necessary follow-up was sometimes delayed or missed;
c. Follow-up for her patients regarding recommended preventive healthcare was inconsistent, including for Pap smears, mammograms, faecal occult blood tests, and immunizations;
d. Vitamin B12 injections were given without documented clinical indication, and the chart did not indicate why oral B12 had not been given instead;

e. Testing was ordered that appeared to be excessive and lacking documented clinical indication in some cases, including bloodwork and ECHO cardiograms;
f. Necessary physical examinations were not always documented;
g. Follow-up for patients with hypertension was sometimes not carried out;
h. Antibiotics were prescribed to some patients without noting clinical indication in the chart, and in one instance there was no indication why primary care guidelines were not followed regarding otitis media (ear infection) in children; and
i. Medications were prescribed to some patients without noting a clear clinical indication in the chart.

ADMISSION

14. Dr. Takhar admits the facts specified above, and admits that, based on these facts, she engaged in professional misconduct, in that she 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*.

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

AGREED STATEMENT OF FACTS REGARDING PENALTY

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

Clinical Supervision and Cooperation with the College

1. Dr. Takhar cooperated with the College's investigation into her practice, attending for interviews with Dr. Irene Cohen, the expert retained to review her practice, on January 11 and

February 8, 2016, providing responses throughout the investigation, and acknowledging that there were issues in her practice during the time period under investigation.

2. Pending the discipline hearing, Dr. Takhar agreed to abide by an interim undertaking to the College requiring, among other things, that her practice be under clinical supervision.

3. Dr. Takhar has been supervised by Dr. John Crosby and, in his absence, by Dr. Michael Tenki, who have made regular reports to the College. Their supervision reports are at Tab 1 to the Agreed Statement of Facts Regarding Penalty.

4. Dr. Takhar's clinical supervisors' reports have been positive, indicating improvement during the supervising period and no ongoing issues or concerns by the date of the hearing. For example, on April 19, 2018, Dr. Crosby stated in his report:

> Dr. BT is doing perfectly. 84 chart reviews are included.
>
> She is adding the age of death for family history and the occupation of each patient. She realizes this is important…
>
> She is charting extremely well with a very detailed Cumulative Patient Profile, history and physical exam.
>
> She is adding a well thought out differential diagnosis and her plans follow all the latest expert guidelines as appropriate…
>
> Her patients are all on target with lab. Opioid and antibiotic prescribing is perfect and she uses opioid contracts for all patients on them.
>
> She is doing an extremely good job and I can find no mistakes.
>
> She just has to maintain this.

5. During Dr. Tenki's supervision of Dr. Takhar's practice in March 2018, he also reported positively about her practice. He noted in his report dated April 2, 2018:

> At our first meeting, I identified a couple of minor issues, including the need for a little

> more historical detail and the need to ensure that patients' cumulative patient profiles were continuously updated after each visit. I made recommendations at that meeting and found Dr. DT to be cooperative. She was receptive to my input and adopted my recommendations for more detail as was evident at subsequent sessions.
>
> Dr. DT demonstrated appropriate skill and knowledge. Her assessment, investigations, diagnoses and treatments were sound. And she demonstrated good insight regarding when to refer. I witnessed nothing that was inappropriate.
>
> …
>
> In summary, I would consider Dr. DT's medical record-keeping and practice habits to be slightly above average. I found her to be cooperative and receptive to my constructive criticism. She made progress while under my supervision.

6. The College requested Dr. Crosby to put particular focus on the concerns identified by Dr. Cohen's review of Dr .Takhar's practice. Dr. Crosby has stated that he does not see these concerns continuing to be present in Dr. Takhar's practice at the present time. For example, on December 12, 2018, Dr. Crosby noted:

> The clinical assessment is now completely documented making it clear as to what was actually done in the visit.
>
> 1. Every single adult patient is having BP measurement documented as well as weight and pulse.
> 2. Knowledge of common guidelines: Clinical guidelines are being followed for otitis media, vitamin B supplementation, pap smears and osteoporosis.
> 3. Preventative Health: Dr. Takhar is now documenting all advice given re pap tests, mammograms and FOBT kits.
> 4. Immunizations: All childhood vaccines are given. All adult patients are asked about their tetanus status and offered vaccine as needed. Pneumovax and flu vaccines are offered as appropriate. Every patient is

given vaccine advice and guideline sheet upon their attendance at the clinic and advised to schedule appointments.

5. Diagnostic Testing: Bloodwork is ordered as appropriate. Very few echo cardiograms or loop monitors are ordered and if ordered, their use is appropriate.
6. Prescribing: All narcotic prescriptions are done in moderation and according to strict Canadian pain and opioid guidelines. All patients have urine testing and controlled substance contracts. Antibiotic use is limited to only bacterial infections and good advice is given to patients to avoid antibiotic use. Other medications are used appropriately.
7. Follow up with patients is offered and is timely. All blood results and other testing results are followed up promptly. INR patients are followed up closely.
8. No unnecessary B12 shots have been given in the year I have been monitoring Dr Takhar. I have seen no inappropriate treatments of hypothyroidism.
9. Complete neurological examinations and psychiatry examinations have been documented. Previously I understand there was no documentation of complete physical examinations but by slowing down this is now all documented. She uses the Hamilton depression score.
10. Every visit follow-up is done on previous tests and this is documented in each case. Note is made of decisions made and future plans.
11. Complete musculoskeletal exams are documented and both normal and abnormal findings documented.
12. All referrals that I have seen are complete and sufficient information has been provided and they are appropriate.

Dr. Takhar's Practice during the Relevant Time Period

7. During the relevant time period, Cambridge was an underserviced area, with a shortage of physicians. Dr. Takhar has stated that the intention in adopting a "shared care model" for the Franklin FHO was to facilitate the recruitment of doctors and reduce the doctor shortage in the area. However, Dr. Takhar's practice and the FHO grew quickly during a time when Dr. Takhar was balancing multiple personal and professional responsibilities.

Dr. Takhar Advises She Has Made Practice Changes

8. Dr. Takhar has advised that she has made a variety of practice changes since the time period during which her practice was investigated, including:

(a) Dr. Takhar has reduced her practice to a single site, rather than the five different practice locations that she managed at the time. The Franklin FHO now has fewer sites and other physicians manage some of them;

(b) the Franklin FHO now ensures that each patient has a "most responsible physician," and that patients are advised who this is, although they may continue to see other physicians at the FHO as needed;

(c) Dr. Takhar has completed a course on medical record-keeping at the University of Toronto, the certificate of completion being attached at Tab 2 to the Agreed Statement of Facts Regarding Penalty;

(d) Dr. Takhar has added a dictation system to her computers and is taking steps to improve her typing;

(e) Dr. Takhar has the Franklin FHO use technology to ask patients to update relevant details in the waiting room;

(f) Dr. Takhar ensures that administrative guidance to doctors and nurse practitioners at the Franklin FHO regarding record keeping expectations is consistent;

(g) test results at the Franklin FHO are sent to both the ordering physician and the patient's most responsible physician;

(h) the Franklin FHO uses technology to facilitate preventive care and access to updated clinical guidelines and medical information; and

(i) the Franklin FHO has hired extra front desk staff and phone staff.

History with the College

9. Decisions of the Inquiries, Complaints and Reports Committee ("ICR Committee") and Complaints Committee in which action was taken in respect of Dr. Takhar's practice are at Tab 3 to the Agreed Statement of Facts Regarding Penalty.

10. Dr. Takhar was the subject of two decisions by the ICR Committee in July 2010. In a Registrar's decision, the ICR Committee cautioned Dr. Takhar regarding appropriate screening and prevention, relying on other physicians to provide care to her patients, and adequate documentation. The panel also required Dr. Takhar to undergo a specified continuing education or remediation program by successfully completing a program of education in record keeping for family physicians. In its decision regarding a complaint, the ICR Committee cautioned Dr. Takhar regarding appropriate screening, periodic reviews of current medications, and adequate records.

11. In December 2007, the College's Complaints Committee cautioned Dr. Takhar regarding her prescribing to a patient with acne.

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 Order consisted of a reprimand, costs payable to the College in the amount of $6000.00, and the imposition of terms conditions and limitations on Dr. Takhar's certificate of registration requiring attendance at a family medicine program/conference, successful completion of educational training in "Effective Team

Interactions" and ethics and boundaries, and an assessment of Dr. Takhar's practice within one year of the Order date.

In considering the jointly proposed penalty, the Committee took into account the Supreme Court decision of *R. v. Anthony-Cook,* 2016 SCC 43. In this criminal law case, the Court stated the following at para. 25:

> *It is an acceptable and highly desirable practice for Crown and defence counsel to agree to a joint submission on sentence in exchange for a plea of guilty. These agreements are common-place and vitally important to the criminal justice system, as well as our justice system at large.*

The case of *R. v. Anthony-Cook,* (2006) establishes the public interest test, which is widely applied outside of the criminal law context, including by this Committee. Specifically, the public interest test provides that a joint submission on penalty must be accepted, unless doing so would bring the administration of justice into disrepute, or is otherwise contrary to the public interest.

In assessing the appropriateness of the jointly proposed penalty, the Committee was cognizant of the basic principles underlying penalty orders. First and foremost the penalty must provide for public protection, which reflects the College's mandate to protect the public. It should serve as a specific deterrent to the member and general deterrent to the profession, signalling that this type of misconduct will not be tolerated. The penalty should uphold the integrity of the profession and public confidence in the College's ability to regulate the profession in the public interest. Also, to the extent possible, the penalty should serve to rehabilitate the member.

Submissions Considered by the Committee

The Committee considered the jointly submitted Agreed Statement of Facts, the Agreement Statement of Facts Regarding Penalty, the joint submission on penalty, and prior similar cases of this Committee. Further, a compilation of decisions of the ICR Committee and Complaints Committee in which action was taken in respect of Dr. Takhar's practice were entered into the record as an exhibit and considered by the Committee.

The Committee had concerns about aspects of Dr. Takhar's prior history that may suggest a propensity for non-compliance with requirements when unmonitored. For this reason, the Committee considered not accepting the joint submission on penalty, and asked the parties for additional submissions on whether the Committee should accept the joint submission. After hearing additional submissions, the Committee reserved to deliberate on the issue. Ultimately the Committee accepted the joint submission on penalty. The Committee's rationale for accepting the joint submission on penalty is outlined below.

Aggravating Factors

The Nature of the Misconduct

Dr. Takhar had too many patients rostered to her practice. The "shared care" model, where a patient may see different physicians and/or care providers at each appointment, was poorly managed. At times, the "most responsible physician" for a given patient could not be identified. This led to clinical care deficiencies, including insufficient test result follow-up and inadequate medical record keeping. The Committee notes that there are generally economic incentives for a physician to take on a large roster of patients, but a physician must always maintain the standard of practice of the profession. In this case, Dr. Takhar did not maintain the standard of practice of the profession in several areas that are foundational to good patient care.

It is quite easy to imagine how these deficiencies - encompassing practice management, clinical care, medical record keeping and test result follow-up - would potentially lead to serious errors and put patients at risk. Comprehensive medical records are a core tool in facilitating continuity of care, and are especially vital where a shared care model is employed. Dr. Takhar's practice deficiencies compromised patient care, and in the Committee's view are very serious.

Prior History with the College

While the Agreed Statement of Facts Regarding Penalty did not specifically refer to all of Dr. Takhar's prior history with the College, the Committee was provided with Dr. Takhar's complete past history with the College as an attachment to the Agreed Statement of Facts Regarding Penalty. That record disclosed that there were eight matters considered by the ICR Committee between 2007 and 2017. The Committee noted that Dr. Takhar's past history of complaints with

the College includes matters with respect to Dr. Takhar's clinical care, advertising practices and medical-record keeping.

In 2007, Dr. Thakar was cautioned by the ICR Committee with respect to deficiencies in her assessment and treatment of acne for the complainant's 15 year old daughter.

In 2008, Dr. Takhar was issued a written caution with respect to prescribing narcotics to her former husband during the course of their relationship, contrary to the College's *Treatment of Self and Family Members* policy. (The Committee placed no weight on other issues raised in this complaint.)

In 2010, Dr. Takhar was cautioned by the ICR Committee regarding appropriate screening, periodic reviews of current medications, and adequate record keeping, in the care of the complainant's husband, a patient with Parkinson's disease, hypertension and hyperlipidemia.

Also in 2010, Dr. Takhar was cautioned by the ICR Committee regarding appropriate screening and prevention, relying on other physicians to care for her patients, and with respect to adequate documentation. Dr. Takhar was required to successfully complete a program of education in recordkeeping for family physicians.

Between 2013 and 2014, the ICR Committee considered three separate matters pertaining to Dr. Takhar's advertising practices, particularly her breach of the advertising provisions of Ontario Regulation 114/94 made under the *Medicine Act, 1991*. In these matters, the ICR Committee determined that Dr. Takhar engaged in improper advertising through the use of patient testimonials, "before and after" photographs, and misleading advertising of cosmetic treatments. These three matters resulted in the issuance of one written caution and two cautions in person.

In 2017, in response to a complaint received pertaining to Dr. Takhar's professionalism and administrative conduct, Dr. Takhar was provided advice by the ICR Committee regarding her medical record keeping. Specifically, Dr. Takhar was advised that addendums to the medical record must be done in a timely manner to ensure the accuracy of the information contained in the record.

In analyzing Dr. Takhar's past history in the context of the current case, the Committee paid particular attention to those that related to Dr. Takhar's practice deficiencies, which are relevant to the matters at hand. The Committee was struck by the fact that record keeping remains an issue despite a previous record keeping course and cautions by the ICR Committee regarding record keeping in 2010. The period reviewed by the College expert, Dr. Cohen, during which Dr. Takhar failed to maintain the standard of practice of the profession, was from 2005 through to January 2015. Thus, clearly some of the issues which are the subject of the present proceeding pre-date 2010 and extend well past 2010, indicating that problems remained despite the cautions received and the courses taken.

Mitigating Factors

The Committee considered the following as mitigating factors:

- This was Dr. Takhar's first appearance before Discipline Committee.

- Dr. Takhar admitted to the misconduct, which saved the College the time and expense of a contested hearing.

- Dr. Takhar has made a variety of practice changes since the time period during which her practice was investigated. Dr. Takhar's clinical supervisor's reports have been excellent, signaling significant improvement during the supervisory period.

Prior Cases

The Committee accepts as a principle of fairness that like cases should be treated alike. The Committee was provided with a Joint Book of Authorities with three cases that were previously before the Discipline Committee: *CPSO v. Huebel*, 2015 ONCPSD 7, *CPSO v. Lo, H.*, 2014 ONCPSD 4; and *CPSO v. Haines, A.M.*, 2014 ONCPSD 24. While the Committee is aware that prior decisions may be of some assistance in its determination of an appropriate penalty, the Committee understands that it is not bound by its previous decisions, and each case must be considered on its specific facts.

In *CPSO v. Huebel (2015)*, Dr. Huebel admitted to failing to maintain the standard of practice of the profession with respect to his emergency department care of two patients. The Committee imposed terms, conditions, and limitations on Dr. Huebel's certificate of registration and ordered a reprimand and the payment of costs.

Similar to Dr. Takhar, Dr. Huebel had a history of related complaints with the College, including another investigation into his emergency medicine practice. Flowing from that investigation, Dr. Huebel undertook remedial and educational efforts to expand his knowledge base and improve his practice. Prior to the hearing, Dr. Huebel entered into an undertaking with the College requiring a period of clinical supervision. The supervisor expressed no concerns about Dr. Huebel's care or treatment of patients.

In *CPSO v. Lo (2013)*, Dr. Lo's record keeping had been found to be deficient due to its illegibility, scant content, lack of detailed history, diagnoses and treatment plans, and the frequent use of abbreviations. Deficiencies were also identified in Dr. Lo's patient care and treatment. In considering the evidence and submissions on penalty and costs, the Committee took into account that Dr. Lo had completed two previous record keeping courses. Further, intensive long term practice monitoring led to improvements in areas of concern prior to the penalty hearing. It was notable that there was an absence of previous discipline findings. There was no joint submission in that case, however, neither party recommended a suspension. Dr. Lo's penalty included terms, conditions and limitations on his certificate of registration, a reprimand, and costs in accordance with the tariff rate.

In *CPSO v. Haines (2014*), Dr. Haines failed to maintain the standard of practice of the profession in his prescribing of opioids and benzodiazepines. The case proceeded on the basis of an Agreed Statement of Facts and Admission and a joint proposal on penalty. The Committee noted that upon hearing of the College's investigations, Dr. Haines updated his medical knowledge and prescribing practice. Dr. Haines also signed an undertaking to practice under the guidance of a supervisor suitable to the College. The Committee ordered the imposition of terms, conditions and limitations on his certificate of registration, including ongoing assessment of his practice, as well as a reprimand and hearing costs payable to the College.

The Committee noted that in each of the above three cases, a suspension of the physician's certificate of registration was not ordered. Similar to Dr. Takhar, each physician made efforts to improve their practice deficiencies, and showed significant improvements which were acknowledged by the Committee.

Conclusion

As noted above, the Committee expressed concerns with respect to the proposed joint submission. While Dr. Takhar's current excellent supervision reports suggest that she has now remediated her practice, the Committee was particularly concerned about the fact that Dr. Takhar continued to have problems with practice management and record keeping after having been cautioned by the ICR Committee in 2010. However, the Committee concluded in light of the test in *R v. Anthony Cook* that the proposed penalty was not outside of the range of appropriate penalties in the circumstances of this case as to bring the administration of justice into disrepute, or otherwise be contrary to the public interest.

In particular, the Committee notes that Dr. Takhar will be required to take several educational courses that will further facilitate her rehabilitation. The requirement that she submit to an assessment of her family medicine practice by an assessor or assessors selected by the College will address the consistency and sustainability of Dr. Takhar's efforts to address practice deficiencies in the long-term. The public reprimand acts as a specific deterrent to Dr. Takhar and general deterrent to the profession that this type of misconduct will not be tolerated. Further, it signals the importance of rigorous medical record keeping and clinical care.

ORDER

The Committee stated its finding in paragraph 1 of its written order of May 27th, 2019. In that order, the Committee ordered and directed on the matter of penalty and costs that:

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

3. The Registrar place the following terms, conditions and limitations on Dr. Takhar's certificate of registration:

(i) Dr. Takhar shall attend the entirety of Pri-Med Canada, or the College of Family Physicians of Canada's Family Medicine Forum, or another similar family medicine program or conference acceptable to the College. Dr. Takhar shall complete this requirement within seven (7) months of the date of this Order or, if no such program or conference is available within that time, as soon thereafter as one is available. Dr. Takhar shall provide proof of her attendance to the College within one (1) month of completion, including the number of credits received;

(ii) Dr. Takhar shall attend and successfully complete the course, "Effective Team Interactions," offered by SAEGIS. Dr. Takhar shall complete this requirement within six (6) months of the date of this Order and shall provide her certificate of attendance to the College within one (1) month of completion, including the number of credits received. If the program is unavailable within that time, Dr. Takhar may fulfill this requirement by completing another program related to this topic acceptable to the College within the same time period and forthwith providing proof of completion to the College;

(iii) Dr. Takhar shall 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. Takhar's progress and compliance. Dr. Takhar shall complete this requirement within six (6) months of the date of this Order;

(iv) Within approximately twelve (12) months of the date of this Order, Dr. Takhar shall submit to an assessment of her family medicine practice by an assessor or assessors selected by the College (the "Assessment"). The Assessment may include chart reviews, direct observation of Dr. Takhar's care, interviews with colleagues and co-workers, feedback from patients and any other tools deemed necessary by the Assessor. The results of the Assessment will be reported to the College and may form the basis of further action by the College; and

(v) Dr. Takhar shall be responsible for any and all costs associated with implementing the terms of this Order.

4. Dr. Takhar pay costs to the College in the amount of $6,000.00 within thirty (30) days of the date of this Order.