

## NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Ejaz Ahmed Ghumman, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names or any information that could disclose the identity of the 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. Ghumman,  
2017 ONCPSD 34**

**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 -**

**EJAZ AHMED GHUMMAN**

**PANEL MEMBERS:**  
**MR. P. GIROUX (Chair)**  
**DR. P. CHART**  
**DR. D. HELLYER**  
**MR. J. LANGS**  
**DR. P. ZITER**

**COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:**

**MS E. WIDNER**

**COUNSEL FOR DR. GHUMMAN:**

**MR. I. MACLEOD**

**INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:**

**MR. R. COSMAN**

**Hearing Date:** July 21, 2017  
**Decision Date:** July 21, 2017  
**Release of Written Reasons:** July 31, 2017

**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 21, 2017. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession, and setting out its penalty and costs order with written reasons to follow.

### **THE ALLEGATIONS**

The Notice of Hearing alleged that Dr. Ejaz Ahmed Ghumman committed an act of professional misconduct:

1. under paragraph 1(1)2 of 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. Ghumman 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. Ghumman entered a plea of no contest to allegation 1, that he has failed to maintain the standard of practice of the profession. Counsel for the College withdrew the allegation of incompetence.

### **THE FACTS**

The following facts were set out in the Statement of Uncontested Facts on Liability, which was filed as an exhibit and presented to the Committee:

## **PART I – FACTS**

### **Background**

1. Dr. Ejaz Ahmed Ghumman (“Dr. Ghumman”) is a 59-year-old general surgeon practising at Erie Shores HealthCare, formerly the Leamington District Memorial Hospital, (“the hospital”).
2. Dr. Ghumman received his medical degree in Pakistan in 1982 and received his specialist qualification in general surgery in Ireland in 1991. Dr. Ghumman obtained a certificate of independent practice in Newfoundland in 1999. He received his specialist qualification in general surgery in Canada in 2004 and his certificate of independent practice in Ontario in 2007.
3. Dr. Ghumman was Chief of Staff at the hospital from 2007. He resigned his position in April 2017, following the referral of this matter to the Discipline Committee of the College.

### **Complaint - Patient X**

4. The College received a letter of complaint from Patient X. The complaint pertained to the care provided by Dr. Ghumman in conducting a laparoscopic cholecystectomy, (a laparoscopic gallbladder removal), and in his post-operative care of the patient following the surgery.
5. Dr. Ghumman initially assessed the patient. At that time, Patient X had symptomatic gall stones. Dr. Ghumman explained treatment options to Patient X and discussed the potential risks and benefits of surgery. Dr. Ghumman obtained Patient X’s informed consent for a laparoscopic cholecystectomy.
6. Patient X attended for a scheduled gallbladder surgery at the hospital. Dr. Ghumman had a pre-surgical discussion with Patient X in the day surgery area, during which they discussed the surgical plan.
7. During surgery, Dr. Ghumman applied a clip on the cystic artery. [The cystic artery provides the main blood supply to the gallbladder.] The clip applier used to place the clip on the cystic artery unexpectedly jammed. The clip applier could not be pulled off as it

might damage an artery. Dr. Ghumman unsuccessfully tried to remove the clip applier with the assistance of nurses who were present in the operating room.

8. Dr. Ghumman considered whether to convert to an open procedure to deal with the jammed clip applier. He decided to continue laparoscopically and to take steps to divide the cystic artery in order to remove the jammed clip applier.
9. The anesthetist suggested using “Filshie clips” as they are applied with a narrower clipper than other clips. Dr. Ghumman proceeded to place a Filshie clip but was concerned that he might have mistakenly placed it on the common bile duct or the right hepatic artery. Dr. Ghumman directed nurses to make several telephone calls but could not find a way to remove the Filshie clip without risking torn vessels or tearing the bile duct. He continued with the procedure and was able to apply another Filshie clip on the cystic artery, which allowed him to divide the cystic artery and remove the jammed clipper. Dr. Ghumman removed the gallbladder, which tore during removal, placed a drain and completed the surgery. In his Operative Report, which is attached at Tab A [to the Statement of Uncontested Facts on Liability], Dr. Ghumman noted that “[i]f it is a clip on the common bile duct, I may have to refer her to a Hepatobiliary Surgeon.”
10. Following the surgery, Dr. Ghumman told the patient that the surgery had gone well, but that a problem occurred near the end of the surgery as he encountered a complication when the clipper jammed. He told Patient X that he was able to remove the jammed clipper, but was concerned that he might have placed a clip on her right hepatic artery or common bile duct.
11. Patient X was discharged home the same day with instructions for monitoring and to return two days later for a follow-up appointment, at which time the drain placed during surgery would be removed and a CT scan performed.
12. Patient X returned two days later for her follow-up appointment and the CT scan. Dr. Ghumman discussed the results of the CT scan with a radiologist at the hospital, who advised Dr. Ghumman that she thought Patient X’s common bile duct looked normal and that she did not visualize a clip on the common bile duct. During Patient X’s visit with Dr. Ghumman that day, she reported feeling unwell, was in pain and that she was having trouble eating.

13. On that day, Dr. Ghumman reported to Patient X's family doctor that he had a small incident during surgery but that he was satisfied, after the CT scan, that the clip was not on the common bile duct. He had been concerned because he had applied the clip "a little bit blind", but now felt the clip was on tissues along the gallbladder, which was not a problem. Dr. Ghumman's note to the family doctor is attached at Tab B [to the Statement of Uncontested Facts on Liability].
14. Dr. Ghumman decided not to remove the drain that day and instructed Patient X to return three days later for removal of the drain and follow up tests.
15. Patient X returned to the hospital to see Dr. Ghumman three days later after attending at a clinic for blood work in the morning. Dr. Ghumman removed the drain. Patient X told Dr. Ghumman that she felt itchy and was unable to eat. By this date, her complexion was jaundiced.
16. The next day, Dr. Ghumman telephoned Patient X and informed her that he had received blood work results and her bilirubin was high. Bilirubin is a substance found in bile. Elevated bilirubin levels may cause jaundice and may indicate problems with the liver or bile duct. It may also account for the type of itching experienced by Patient X. Dr. Ghumman advised Patient X to drink plenty of fluids to stay well hydrated. He advised her to call his office if her condition worsened.
17. The following day, Patient X contacted Dr. Ghumman's office and complained of increased itching. Dr. Ghumman booked an ultrasound appointment and blood work for the next morning.
18. The next day, Patient X returned to the hospital for an ultrasound and blood work. By this time she was extremely itchy and appeared jaundiced. The ultrasound suggested that the common bile duct was obstructed. Blood work indicated that Patient X's bilirubin had increased over the previous three days.
19. Following his review of the test results, Dr. Ghumman advised Patient X that he had bad news; that the clip he was concerned about had actually been placed incorrectly and had likely caused obstruction of the patient's common bile duct. Dr. Ghumman further explained that he had organized her transfer to the London Health Sciences Centre ("London"). Patient X was immediately transported to London for emergency admission and surgery.

20. Surgery took place the following day in London. The hepatobiliary surgeon's operative note on the day of the surgery, attached at Tab C [to the Statement of Uncontested Facts on Liability], states that there was a clip going across Patient X's entire bile duct. The surgery was complicated by intra-operative and post-operative bleeding, which required transfusion of eight units of blood. Patient X remained hospitalized in London for approximately one week after the surgery.

**Failure to Maintain the Standard of Practice with respect to Patient X**

21. The College obtained a report from Dr. Raymond Bruce Gay, a general surgeon practising in Ottawa, Ontario. Dr. Gay has worked as a general surgeon since 1988, including performing cholecystectomies. Dr. Gay's report is attached at Tab D [to the Statement of Uncontested Facts on Liability].
22. In Dr. Gay's opinion, Dr. Ghumman fell below the standard of practice of the profession in his intra-operative and post-operative care of Patient X.
23. Although the technical complication involving the clip applicator during surgery was beyond Dr. Ghumman's control, his actions in response to the problem were below the standard of practice.
24. In coming to his conclusion that Dr. Ghumman failed to maintain the standard of practice in his care of Patient X, Dr. Gay expressed the following specific concerns:
- Dr. Ghumman failed to convert to an open procedure once the clipper became jammed; he should have converted to an open procedure in order to first define the anatomy with careful dissection around the jammed clipper;
  - Despite having a concern that he had injured an important structure, Dr. Ghumman failed to obtain the advice of a hepatobiliary surgeon or another general surgeon, either during or immediately following the surgery. Dr. Ghumman works in a hospital in a small community where there was only one other general surgeon. However, he could have sought assistance through Criticall Ontario, a service that provides urgent and emergent support for hospital-based physicians;
  - Dr. Ghumman's operative note shows that he was aware of the need to obtain the critical view but the Filshie clip applicator was placed in the area of undissected tissue;

- The fact that there was a retained portion of a surgical bag after the surgical procedure demonstrates a lack of care and poor technique.

### **College investigation – s.75(1)(a) of the Code**

25. Subsequently, the College commenced an investigation under s.75 (1)(a) of the *Health Professions Procedural Code* into Dr. Ghumman's surgical practice.
26. In the course of the investigation, the College obtained an additional report from Dr. Gay that included Dr. Gay's review of twenty-five (25) patient charts. The defence obtained responding reports from Dr. Loyd C. Smith, an experienced general surgeon and the Chief of Surgery at North York General Hospital.

### **Failure to maintain the standard of practice – s.75 (1)(a) investigation**

27. Based on the expert opinions contained in the reports described in the preceding paragraph, Dr. Ghumman failed to maintain the standard of practice in the following areas:
  - Overuse of prophylactic antibiotics post-operatively: With respect to some patients, Dr. Ghumman's practice demonstrated prolonged and unnecessary use of prophylactic antibiotics. While there was no evidence of actual harm to a patient, overuse of antibiotics presents a risk of potential harm, particularly in the hospital setting where there is a risk that antibiotic resistance will make treatment of infections more difficult. Both Dr. Gay and Dr. Smith described this as a minor issue;
  - Overuse of surgical drains: With respect to some patients, Dr. Ghumman's practice demonstrated an overuse of surgical drains in the absence of evidence of an abscess requiring drainage or the development of post-operative seromas (collection of clear fluid that may develop post-surgery). There was no evidence of actual harm or potential risk of harm to patients, and both Dr. Gay and Dr. Smith described this as a minor issue;
  - Record-keeping: With respect to one patient, Dr. Ghumman's record-keeping was deficient in that documentation of the patient's consent to a colonoscopy was



incomplete. Both Dr. Gay and Dr. Smith agreed that Dr. Ghumman's documentation needs improvement. There was no evidence of actual harm to any patient.

## **PART II – PLEA OF NO CONTEST**

28. Dr. Ghumman does not contest the facts specified above and he does not contest that, based on these facts, he engaged in professional misconduct, in that:

- (a) He has 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*.

## **THE DISCIPLINE COMMITTEE RULE 3.02**

Rule 3.02 of the Discipline Committee's Rules of Procedure regarding a plea of no contest states as follows:

3.02(1) Where a member enters a plea of no contest to an allegation, the member consents to the following:

- (a) that the Discipline Committee can accept as correct the facts alleged against the member on that allegation for the purposes of College proceedings only;
- (b) that the Discipline Committee can accept that those facts constitute professional misconduct or incompetence or both for the purposes of College proceedings only; and
- (c) that the Discipline Committee can dispose of the issue of what finding ought to be made without hearing evidence.

## **FINDING**

The Committee accepted as correct all of the facts set out in the Statement of Uncontested Facts on Liability. Having regard to these facts, the Committee accepted Dr. Ghumman's plea and

found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession.

## **PENALTY AND REASONS FOR PENALTY**

Counsel for the College and counsel for Dr. Ghumman made a joint submission as to an appropriate penalty and costs order. The proposed order focuses on protection of the public and includes a detailed clinical supervision for twelve months, an individualized education plan, and a practice reassessment. Further, the parties proposed that Dr. Ghumman be reprimanded and pay costs to the College in the amount of \$5,500.00, in addition to the costs of implementing the terms set out in detail in the order.

The Committee understands that where there is a joint submission on penalty, the court has said that the Committee should not depart from the proposed penalty, unless accepting it will bring the administration of justice into disrepute, or is otherwise contrary to the public interest.

The Committee was mindful of the accepted penalty principles in determining the appropriateness of the parties' joint submission on penalty. Protection of the public is the overriding consideration. Specific deterrence of the member, general deterrence of the entire membership, and rehabilitation of the member where possible are particularly relevant to this matter. The penalty order should provide confidence to the public that the College is governing the profession in the public interest. Lastly, the penalty should be proportional to the misconduct.

The Committee considered the nature of the misconduct, mitigating and aggravating factors and the case law submitted by the parties. In addition, the Committee received in evidence and considered a Brief of Letters of Support from professional colleagues and others regarding Dr. Ghumman.

## **Nature of the Misconduct**

Dr. Ghumman is a community surgeon. As such, he plays a critical role in providing surgical care in his community. Patients expect that surgeons will bring their expertise to each and every patient on whom they operate. Patients also trust that their surgeon will maintain the standard of practice of the profession. When that trust is broken, the reputation of the profession suffers and patients are ill-served.

The Committee recognizes that not all surgical procedures are smooth; unexpected complications occur. It is the action taken when untoward events occur that requires the skill of the surgical specialist. Surgery is not merely a technical exercise; the public and the profession reasonably expect that surgeons will be capable of managing appropriately any complications that may arise. As pointed out in the expert report regarding the care of Patient X, Dr. Ghumman's response to the technical complication which occurred did not meet the standard of practice of the profession. Dr. Ghumman had the option of converting to an open procedure and erred in judgment when he did not. He compounded the error when he placed clips in an area he had not adequately visualized.

Dr. Ghumman did not seek advice about the best way to proceed postoperatively. When an obstructive picture developed in the days that followed, the need for referral to a hepatobiliary surgeon became clear. The difficulties encountered by this patient illustrate how important it is to maintain the standard of practice of the profession in community based surgery and to have referral resources accessible and available when required.

In the subsequent investigation of his practice, further minor deficiencies were noted including deficient documentation and overuse of prophylactic antibiotics and surgical drains.

**Mitigating factors**

Dr. Ghumman has demonstrated insight in admitting the allegations and in embracing the re-education and supervision, which is proposed. Dr. Ghumman has resigned from his role as Chief of Staff at the hospital. The College has been saved the time and expense of a contested hearing.

**Letters of Support**

The Committee reviewed the letters of support from surgeons, family doctors, nurses and administrative personnel. These letters portray Dr. Ghumman as a well-respected, conscientious and competent professional. He is described as an effective leader and communicator and an asset to the community. Those who have had personal experience of working with him in the operating room speak positively about his surgical skills and his performance under stress.

**Terms and Purpose of the Order**Reprimand

The reprimand allows the Committee to directly speak to Dr. Ghumman so that he understands the Committee's view of his misconduct. The reprimand also offers the Committee the opportunity to clearly address the expectation of future behavior. Reprimands are viewed as a serious sanction by professionals in general. They serve as a specific and general deterrent.

Chief of Staff Role

The requirement that Dr. Ghumman not re-apply for the Chief of Staff position, until he successfully completes all terms of the Order is appropriate. In the circumstances, it is necessary for Dr. Ghumman to clearly demonstrate that he is maintaining the standard of practice of the profession. Those holding such positions as a Chief of Staff are looked to as models of professional behavior.

### Supervision

Dr. Ghumman will be participating in an intensive graded supervision program over the next twelve months. The terms are detailed in the order. This is structured so as to reassure the public that all reasonable measures are in place and that the standard of practice is maintained. In the initial phase (moderate supervision), in addition to other supervisory terms, all general surgery cases done in the operating room under general anesthetic will be pre-cleared by the supervisor. The supervision will be reduced in a graduated fashion (low-level supervision), depending on the recommendations made by the supervisor regarding Dr. Ghumman's progress.

The period of supervision ordered is intended to address and correct deficiencies and to ensure that the public is safe. Patients having surgery performed by Dr. Ghumman should be reassured that their problems are managed safely and appropriately. The supervision ordered in this matter achieves a rehabilitative function for Dr. Ghumman; it also provides assurance to the public that the College is governing the profession in the public interest.

### Education

An individualized education plan has been developed for Dr. Ghumman addressing specific needs and goals. The clinical supervisor will be facilitating the completion of the plan and reporting progress to the College. The education plan includes clinical supervision, course work, a review of College Policy and other self-study. This program focuses on Dr. Ghumman's needs and addresses his rehabilitation.

### Reassessment

Six months after completion of the period of supervision, a re-assessment of Dr. Ghumman's practice will occur. This will provide additional assurance to the public and to the College that Dr. Ghumman has not only recognized necessary changes, but has implemented them in his practice.

## **Case Law**

Two recent cases (*CPSO v. Pardis* (2017), *CPSO v. Straka* (2016)) were put before the Committee. Both of these cases relate to findings of a failure to maintain the standard of practice of the profession. In both cases the penalty decision is similar to that proposed in the current matter.

## **Conclusion**

The Committee accepts the proposed penalty order as an appropriate sanction and a fair and reasonable disposition in the circumstances of this case.

## **ORDER**

The Committee stated its finding in paragraph 1 of its written order of July 21, 2017, that Dr. Ghumman committed an act of professional misconduct, in that he failed to maintain the standard of practice of the profession.

In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Ghumman appear before the panel to be reprimanded.
3. The Registrar impose the following terms, conditions and limitations on Dr. Ghumman's Certificate of Registration:

### **Chief of Staff Role**

- a) Dr. Ghumman shall not re-apply for the Chief of Staff position at any hospital until successful completion of the re-assessment described in paragraph 11 below.

### **Clinical Supervision**

- a) Dr. Ghumman shall retain a College-approved Clinical Supervisor who will sign an undertaking in the form attached to the Order as Schedule "A";

- b) For a period of twelve (12) months commencing on the date that the Clinical Supervisor is approved by the College, Dr. Ghumman may practise only under the supervision of the Clinical Supervisor;
- c) Clinical Supervision of Dr. Ghumman's practice shall contain the following elements:

### **Moderate-Level Supervision**

- a) For an initial period of approximately four (4) weeks, the Clinical Supervisor will engage in a period of moderate-level supervision, during which time the Clinical Supervisor will at minimum:
  - (i) Review materials provided by the College and have an initial in-person meeting with Dr. Ghumman to discuss practice improvement recommendations;
  - (ii) Thereafter, discuss with Dr. Ghumman once a week by telephone or secure electronic video conference to pre-clear all general surgery cases done in the operating room under a general anaesthetic;
  - (iii) For on-call cases where Dr. Ghumman is not able to speak to his Clinical Supervisor prior to surgery, the Clinical Supervisor will review such cases as soon as possible after the surgery and in any event within approximately 24 hours post-surgery by telephone or secure electronic video conference;
  - (iv) Provide reports to the College once every two (2) weeks, or more frequently if the Clinical supervisor has concerns about Dr. Ghumman's standard of practice or conduct;
  - (v) Discuss with Dr. Ghumman any concerns the Clinical Supervisor may have arising from his meetings with Dr. Ghumman and case reviews;
  - (vi) Make recommendations for practice improvements and ongoing professional development, and inquire into Dr. Ghumman's compliance with any recommendations;
  - (vii) Keep a log of all patient charts reviewed along with patient identifiers.

### **Low-Level Supervision Phase 1**

- a) After the first four (4) weeks of Dr. Ghumman's Moderate-Level Clinical Supervision, upon receipt of a written recommendation from the Clinical Supervisor that Dr. Ghumman

is ready to practise under Low-Level Clinical Supervision, and subject to approval by the College, Clinical Supervision shall continue for a further period of eight (8) weeks during which time the Clinical Supervisor will at minimum:

- (A) Meet with Dr. Ghumman once every two (2) weeks in person to discuss surgical cases and review a minimum of fifteen (15) patient charts, to be selected in the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Ghumman. If the Clinical Supervisor is of the view that fewer than fifteen (15) charts may be reviewed in this period, the Clinical Supervisor shall provide a written recommendation to the College and, subject to approval by the College, may review no fewer than ten (10) patient charts per visit for the remaining portion of this period of clinical supervision;
- (B) Provide reports to the College once per month, or more frequently if the Clinical supervisor has concerns about Dr. Ghumman's standard of practice or conduct;
- (C) Discuss with Dr. Ghumman any concerns the Clinical Supervisor may have arising from his meetings with Dr. Ghumman and chart reviews;
- (D) Make recommendations for practice improvements and ongoing professional development, and inquire into Dr. Ghumman's compliance with any recommendations;
- (E) Keep a log of all patient charts reviewed along with patient identifiers.

### **Low-Level Supervision Phase 2**

- a) After the first eight (8) weeks of Low-Level Clinical Supervision, upon receipt of a written recommendation from the Clinical Supervisor and subject to approval by the College, Clinical Supervision shall continue at Low-Level for the balance of the twelve (12) months of Clinical Supervision, during which time the Clinical Supervisor will at minimum:
  - (i) Meet with Dr. Ghumman once a month in person to discuss surgical cases and review a minimum of ten (10) patient charts, to be selected in the sole discretion of the Clinical Supervisor, and discuss any issues or concerns arising therefrom with Dr. Ghumman;



- (ii) Provide reports to the College once every two months or more frequently if the Clinical supervisor has concerns about Dr. Ghumman's standard of practice or conduct;
- (iii) Discuss with Dr. Ghumman any concerns the Clinical Supervisor may have arising from his meetings with Dr. Ghumman and chart reviews;
- (iv) Make recommendations for practice improvements and ongoing professional development, and inquire into Dr. Ghumman's compliance with any recommendations;
- (v) Keep a log of all patient charts reviewed along with patient identifiers.

### **Individualized Education Plan ("IEP")**

- a) The Clinical Supervisor shall facilitate completion of the education program, set out in an IEP to be provided to the Clinical Supervisor by the College, and shall report to the College in his/her reports as to Dr. Ghumman's progress in completing the IEP.

### **Other Elements of Clinical Supervision**

- a) Throughout the period of Clinical Supervision, Dr. Ghumman shall abide by the recommendations of the Clinical Supervisor and shall complete the IEP in co-operation with the Clinical Supervisor;
- b) If a clinical supervisor who has given an undertaking as set out in Schedule "A" to this Order is unable or unwilling to continue to fulfill its terms, Dr. Ghumman shall, within twenty (20) days of receiving notice of same, obtain an executed undertaking in the same form from a person who is acceptable to the College and ensure that it is delivered to the College within that time;
- c) If Dr. Ghumman is unable to obtain a clinical supervisor in accordance with this Order, he shall cease to practice until such time as he has done so;
- d) Dr. Ghumman shall consent to the disclosure by his Clinical Supervisor to the College, and by the College to his Clinical Supervisor, of all information the Clinical Supervisor or the College deems necessary or desirable in order to fulfill the Clinical Supervisor's undertaking and Dr. Ghumman's compliance with this Order.

### **Re-Assessment**

- a) Approximately six (6) months after the completion of the period of supervision set out above Dr. Ghumman shall undergo a re-assessment of his practice, at his own expense, by a College-appointed assessor (the “Assessor(s)”). The re-assessment shall include the elements outlined in the IEP, to be provided by the College. The Assessor(s) shall report the results of the re-assessment to the College;
- b) Dr. Ghumman shall consent to the disclosure to the Assessor(s) of the reports of the Clinical Supervisor arising from the supervision, and shall consent to the sharing of all information between the Clinical Supervisor, the Assessor(s) and the College, as the College deems necessary or desirable in order to fulfill their respective obligations.

### **Monitoring**

- a) Dr. Ghumman shall inform the College of each and every location where he practices, in any jurisdiction (his “Practice Location(s)”) within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.
  - b) Dr. Ghumman shall cooperate with unannounced inspections of his practice and patient charts by one or more College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
  - c) Dr. Ghuman shall consent to the College’s making appropriate enquiries of the Ontario Health Insurance Plan and/or any person or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.
  - d) Dr. Ghumman shall be responsible for any and all costs associated with implementing the terms of this Order.
4. Dr. Ghumman pay costs to the College for a one day hearing in the amount of \$5,500.00 within 30 days of the date of this Order.

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

**TEXT of PUBLIC REPRIMAND**  
**Delivered July 21, 2017**  
**in the case of the**  
**COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO**  
**and**  
**DR. EJAZ AHMED GHUMMAN**

Dr. Ghumman, it is always difficult to properly deal with medical errors. This can be only too clear to you, given the unfortunate circumstances of the patient we have heard about this morning.

Such errors in judgement are important to address and may have serious consequences.

The Committee is encouraged by your cooperation, agreement to further education and supervision. Your motivation to address deficiencies demonstrates insight and a positive attitude. We acknowledge the letters of colleagues, which portray you as a kind, committed surgeon who is considered an asset to his community.

The Committee, in addition to the terms of your penalty order, expects you to take to heart the recommendations of the reviewers in respect to medical records, antibiotics and the use of drains.

We expect you have learned from this experience and will move forward in providing good medical care to your community.

*This is not an official transcript*