

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Dolly Teresa Nahri, this is notice that the Discipline Committee ordered that no person shall publish or broadcast any information that could identify a patient under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

Every person who contravenes an order made under ... section 45 or 47... is guilty of an offence and on conviction is liable,

(a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or

(b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v.
Nahri, 2015 ONCPSD 9**

**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. DOLLY TERESA NAHRI

PANEL MEMBERS:

**DR. E. STANTON (CHAIR)
D. GIAMPIETRI
DR. D. KRAFTCHECK
S. BERI
DR. S. BODLEY**

Hearing Date: November 25, 2014
Decision Date: November 25, 2014
Release of Written Reasons: March 2, 2015

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 November 25, 2014. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Nahri 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 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 conduct or 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.

RESPONSE TO THE ALLEGATIONS

Dr. Nahri admitted the allegations in the Notice of Hearing, that she has failed to maintain the standard of practice of the profession, and that she has engaged in conduct or 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.

FACTS AND EVIDENCE

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

Background and Overview

1. Dr. Dolly Teresa Nahri (“Dr. Nahri”) is a family physician who received her certificate of registration authorizing independent practice in 1993. She practised in London, Ontario until 2004, when she moved to Ottawa. In March 2007, Dr. Nahri acquired her own clinic, the Access Medical Centre in Ottawa, where during the material time she provided family physician services, including walk-in services.
2. Dr. Nahri’s staff at the Access Medical Centre included international medical graduates who were not Ontario licensed physicians, who were directly involved in patient care. Dr. Nahri inadequately supervised these individuals and did not delegate care to them appropriately.
3. Before opening her own clinic, Dr. Nahri had some exposure to delegation of care to unlicensed individuals at another clinic. Delegation is indeed permissible under College policy, if certain criteria are met and procedures followed. Dr. Nahri has stated that she believed that hiring unlicensed individuals would enable her to provide care to a greater number of patients, including during a time period when she would otherwise have had to reduce her practice for health reasons. However, she failed to familiarize herself with her professional obligations in regard to delegation and supervision of patient care and other issues arising from her employment of these individuals. These obligations included those set out in the College’s Delegation of Controlled Acts policy, attached as Schedule 1 (to the Agreed Statement of Facts). The College’s policy acknowledges that delegation “in appropriate circumstances can result in more timely delivery of health care, and can promote optimal use of health-care resources and personnel.” However, it requires a number of safeguards, including the establishment of a physician-

patient relationship, the existence of a medical directive or direct order, appropriate evaluation of the delegate, informed patient consent, and quality assurance steps including appropriate supervision and documentation.

Patient A

4. In October 2010, the College received a complaint from Patient A. Patient A was a patient in Dr. Nahri's family practice. When Patient A became pregnant, she saw Dr. Nahri once regarding her pregnancy. Dr. Nahri's office staff then directed Patient A to receive follow-up care from Malalai Hamidi. Office staff explained to Patient A that Ms. Hamidi was practising as a general practitioner in Canada until her certification as an "obgyn" was recognized in Canada, but that she was trained as an "obgyn" in her home country. Ms. Hamidi was referred to as "Dr. Hamidi" by Dr. Nahri's office staff, and Patient A believed that she was a registered physician.
5. Patient A had seen Ms. Hamidi for care on one occasion in March 2009 when she had attended at the Access Medical Centre to see Dr. Nahri but was able to see Ms. Hamidi faster. Patient A then saw Ms. Hamidi for pregnancy-related care on three occasions in September and October 2010.
6. Dr. Nahri was not present in the office for any of the appointments between Ms. Hamidi and Patient A.
7. In providing pregnancy-related care to Patient A, Ms. Hamidi carried out physical examinations and assessments of Patient A, made diagnoses, and provided medical advice. Ms. Hamidi provided requisitions for ultrasounds and bloodwork, and a medical certificate excusing Patient A from some activities due to her pregnancy. Dr. Nahri reviewed Patient A's chart and discussed Patient A's care with Ms. Hamidi during this time period, but this was not documented.
8. Ms. Hamidi has never been registered to practise medicine in Ontario. She advises she has medical training in Afghanistan. She has worked as a licensed optician in Ontario. She was hired by Dr. Nahri in 2007, at which time she

received an orientation to the clinic. Initially Dr. Nahri accompanied her into the examination room to see patients, but over time Ms. Hamidi came to receive minimal direct supervision, including while performing controlled acts. Dr. Nahri did not provide medical directives, but did review Ms. Hamidi's care and orally approve or correct it.

9. Ms. Hamidi identified herself to patients as "Dr. Hamidi," as did Dr. Nahri's staff. Services performed by Ms. Hamidi were billed to the Ontario Health Insurance Plan under Dr. Nahri's billing number. The fees received were shared between Dr. Nahri and Ms. Hamidi, who received a 35% share.
10. The College obtained an independent opinion from Dr. X, which is attached at Schedule 2 (to the Agreed Statement of Facts) and forms part of this Agreed Statement of Facts and Admission. As opined by Dr. X, the clinical outcome experienced by Patient A was not adversely affected by the care provided by Ms. Hamidi. However, Dr. Nahri demonstrated lack of knowledge regarding appropriate delegation, lack of skill in appropriately obtaining patient consent and providing appropriate supervision, and lack of judgment with respect to the use of stamped prescription pads. Harm or injury might occur in light of the degree to which Dr. Nahri was delegating roles and responsibilities in a clinical setting without appropriate supervision.
11. Dr. Nahri cooperated with the College during its investigation and, in her response to the College investigation, described herself as having been "naïve and ill informed" about the role that international medical graduates could play in her practice. She stated that it had not been her intention to represent Ms. Hamidi as a licensed physician, but that she could understand patients' confusion in view of information provided by her staff. Dr. Nahri agreed that her attempts at efficiencies were inappropriate. Dr. Nahri explained that when she was not in the office, she was available by telephone and reviewed patients with Ms. Hamidi.

Broad Investigation into Dr. Nahri's Practice

12. In September 2010 as a result of information received from a member of the public, a broad investigation into Dr. Nahri's practice was initiated.
13. The College retained private investigators who attended at the Access Medical Centre on November 8, 9, and 11, 2010. The clinic was open for walk-in care, but staff advised that Dr. Nahri saw patients by appointment only. Three private investigators posed as patients seeking care. Each was seen by one of two individuals, neither of whom was Dr. Nahri. One introduced herself as "Doctor Odette" and one introduced herself as "Doctor Dina." They took note of the private investigators' described symptoms and carried out investigations and/or examinations, in two cases writing prescriptions and in one case providing a requisition for diagnostic imaging.
14. None of the individuals who provided care to the private investigators at Dr. Nahri's clinic was a registered physician entitled to practice medicine in Ontario.
15. On November 11, 2010, College investigators attended at the Access Medical Centre and interviewed unregulated workers Ms. Hamidi, Nermine Youssef, Dina Al Asadi, and Odette Yassa, learning that:
 - Dr. Nahri had left pre-signed prescription pads, requisition pads and consultation requests for use by staff members providing patient care.
 - Office staff billed the Ontario Health Insurance Plan using Dr. Nahri's billing number for services provided by staff members.
 - Ms. Al Asadi advised that she trained in medicine in Iraq. She had been working at the Access Medical Centre since April 2009. Ms. Al Asadi advised that she worked under Dr. Nahri's supervision providing patient care, but that the supervision was sometimes provided by telephone.
 - Ms. Yassa advised that she was a certified obstetrician gynecologist in Egypt. She had been working at the Access Medical Centre since May

2010, providing patient care. For the first two months of her employment, Dr. Nahri was in the room with Ms. Yassa during examinations, but supervision had decreased over time such that Ms. Yassa was in the room alone when examining patients. Dr. Nahri reviewed the charts of patients seen by Ms. Yassa, and Ms. Yassa consulted with her by telephone, though not with respect to every diagnosis or treatment plan. Ms. Yassa identified herself to patients as “Dr. Odette.”

- Ms. Youssef advised that she was a general practitioner and anatomist in Egypt. She had been working at the Access Medical Centre for approximately six weeks. Ms. Youssef advised that she triaged patients and prepared the information for Dr. Nahri’s review, but did not independently write prescriptions or interpret laboratory reports. Ms. Youssef was volunteering in Dr. Nahri’s office as an educational experience due to her interest in gaining Ontario licensure.

16. Dr. Nahri employed another individual, Nabil Kebbe, from approximately September 2008 to September 2009. Mr. Kebbe advised that he has a medical degree from Romania and practised in Lebanon as a general practitioner. He is not licensed as a physician in Ontario. Mr. Kebbe provided care to walk-in patients during his time at the Access Medical Centre, and was sometimes referred to as a “doctor” to patients.
17. The College retained Dr. X as a Medical Inspector to evaluate the care provided by Dr. Nahri, including with respect to her supervision of and delegation to staff. Dr. X’s reports, dated March 20, 2013, and April 22, 2013, are attached at Schedule 3 (to the Agreed Statement of Facts) and form part of this Agreed Statement of Facts and Admission. Dr. X reviewed information obtained during the investigation, as well as the charts of 28 patients (including those of the private investigators retained by the College who attended at Dr. Nahri’s clinic). As found by Dr. X, among other things:

- Supervision of staff and delegation of controlled acts fell below the expectations and the standards of the profession. Dr. Nahri's clinical practice, behaviour and conduct in this regard exposed her patients to potential harm or injury.
 - It was difficult to determine from the charts who was providing the care, as notations were not signed. Charting was below the standard of practice of the profession. Dr. Nahri failed to document patient consent to be examined and treated by a staff member. In many cases management of continuity of care was below the standard of practice.
18. Dr. Nahri cooperated throughout the College investigation. In her response to Dr. X's report, Dr. Nahri acknowledged that she had not provided adequate supervision and delegation to the individuals working in her clinic during the period in question. She stated that as a result of the College investigation she had "made many positive changes in her practice," including reducing the size of her practice and ceasing to provide walk-in care. In addition, she described improvements made to her record-keeping, including with regard to completion of cumulative patient profiles, diabetic flow sheets, well baby growth charts, and immunization records.

Breach of Interim Undertaking

19. After investigators attended at the Access Medical Centre in November 2010, Dr. Nahri agreed to enter into an interim undertaking with the College to protect patients while the College investigation was ongoing, or until any allegations against her were finally determined by the Discipline Committee. As a result, Dr. Nahri ceased to employ international medical graduates or other unregulated workers to provide patient care.
20. The interim undertaking also obliged her to review the records of all patients who had received patient care directly from staff members, and to document having done so. Dr. Nahri did undertake such a review as required. However, initially

she failed to adequately document her review, in breach of her undertaking. After being alerted to the problem by the College in 2011, Dr. Nahri took steps to document her review.

21. Since entering into her interim undertaking with the College, Dr. Nahri has reduced the size of her practice and has become a sole practitioner.
22. Dr. Nahri has never before been the subject of discipline proceedings. Prior to the investigations underlying this matter, Dr. Nahri had been the subject of one public complaint since receiving her certificate of independent practice in 1993, in an unrelated matter with respect to which no action was ultimately taken.

ADMISSION

23. Dr. Nahri admits the facts set out above at paragraphs 1-22, and admits that they show that she failed to maintain the standard of practice of the profession in her care of patients, and that she has engaged in conduct or an act or omission that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

FINDINGS

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. Nahri's admission and found that she committed an act of professional misconduct in that she has failed to maintain the standard of practice of the profession, and that she has engaged in conduct or 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.

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 Committee was mindful of the law that a joint submission should be accepted unless to do so would be contrary to the public interest and bring the administration of justice into disrepute.

The relevant penalty principles considered by the Committee were specific and general deterrence, protection of the public, rehabilitation of the member, maintaining the integrity of the profession, and public confidence in self-regulation.

After careful consideration, the Committee accepted the jointly proposed penalty as being both in the public interest and just.

Public trust is a fundamental principle of the profession of medicine. This trust must be earned on a daily basis and should never be taken for granted. Dr. Nahri allowed the employees of her clinic to represent themselves as physicians and treat members of the public. This is a serious breach of public trust. In addition, our remuneration system for services is based on the honour system. Allowing billing under her OHIP number for services provided by these unlicensed physicians is unacceptable and cannot be tolerated by the College.

The Committee considered aggravating and mitigating factors. Aggravating factors included the fact that the inappropriate delegation of medical acts was not an isolated event but was a pattern of Dr. Nahri's practice which exposed patients to potential harm. Dr. Nahri demonstrated a particular lack of judgment in allowing the use of pre-signed prescription pads. Perhaps most egregiously, Dr. Nahri breached her undertaking when she failed to document her review of the charts of all patients treated by the international medical graduates (IMGs) adequately.

There were mitigating factors that the Committee considered. Dr. Nahri had no previous discipline findings. She admitted the allegations, and took full responsibility for her actions. This acknowledgement of her shortcomings was not a last minute admission of misconduct but showed that she had insight into her problematic judgment and behaviour early in the investigative process. She co-operated with the College's investigation and discipline process and entered into an undertaking early during the investigation. Dr. Nahri has already implemented a number of changes to her practice, which include reducing the size of her practice and no longer delegating medical acts to IMGs.

The penalty order imposed addresses the penalty principles listed above. A suspension will act as a specific and general deterrent. The practice supervision and provisions for reassessment are in place to protect the public. The requirement for ethics instruction is rehabilitative, and the reprimand is intended to denounce the conduct and provide specific deterrence to Dr. Nahri and general deterrence to the profession. The awarding of costs of \$4,460.00 to the College is, in the opinion of the Committee, appropriate and the amount represents a portion of the true costs of conducting an investigation and holding a hearing.

ORDER

Therefore, having stated the findings in paragraph 1 of its written order of November 25, 2014, on the matter of penalty and costs, the Committee ordered and directed that:

2. Dr. Nahri to attend before the panel to be reprimanded.
3. the Registrar suspend Dr. Nahri's certificate of registration for a period of six (6) months, commencing from January 1, 2015 at 12:01 a.m.
4. the Registrar to impose the following terms, conditions and limitations on Dr. Nahri's certificate of registration:

- (a) Dr. Nahri shall successfully complete by June 2015 a one-on-one educational program in ethics acceptable to the College, in accordance with the portion of the Individualized Education Program attached hereto at Schedule “B” that relates to Dr. Nahri’s educational needs related to her role as Professional.

- (b) Dr. Nahri shall, before June 1, 2015, retain a College-approved clinical supervisor, who will sign an undertaking in the form attached hereto as Schedule “A,” and whose role shall be guided by the Individualized Education Program attached hereto at Schedule “B.” Commencing on the day that Dr. Nahri resumes practice following her suspension, Dr. Nahri may practice only under the supervision of the Clinical Supervisor and will abide by all recommendations of her Clinical Supervisor with respect to her practice, including but not limited to her recordkeeping, practice improvements, practice management, and continuing education. Dr. Nahri shall no longer be subject to this term, condition and limitation after a period of at least twelve (12) months, and shall be released therefrom only upon receipt of satisfactory report(s) from her Clinical Supervisor and approval, in its sole discretion, by the College.

- (c) If Dr. Nahri fails to retain a Clinical Supervisor as required above or if, prior to the completion of the required period of supervision above, Dr. Nahri’s Clinical Supervisor is unable or unwilling to continue in that role, Dr. Nahri shall retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached hereto as Schedule “A” within twenty (20) days, failing which she shall cease to practice until such time as she has retained a College-approved Clinical Supervisor.

- (d) Approximately twelve (12) months following the completion of the required period of supervision, Dr. Nahri shall undergo a reassessment of her practice by a College-appointed Assessor. The assessment shall include a review of Dr. Nahri’s patient charts, direct observations, and interviews with staff and/or patients. Dr. Nahri shall abide by all recommendations made by the

Assessor, and the Assessor shall report the results of the assessment to the College.

- (e) Dr. Nahri shall consent to sharing of information among the Assessor, the Clinical Supervisor, the College and the provider of the educational program in ethics as any of them deem necessary or desirable in order to fulfill their respective obligations.
 - (f) Dr. Nahri shall inform the College of each and every location where she practices, in any jurisdiction (her “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, until the report of the assessment of her practice have been reported to the College.
 - (g) Dr. Nahri shall cooperate with unannounced inspections of her practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing her compliance with the terms of this Order.
 - (h) Dr. Nahri shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor her compliance with this Order.
 - (i) Dr. Nahri shall be responsible for any and all costs associated with implementing the terms of this Order.
5. Dr. Nahri pay to the College costs in the amount of \$4,460.00, within thirty (30) days of the date of this Order.

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

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v.
Nahri, 2015 ONCPSD 9**

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B E T W E E N:

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- and -

DR. DOLLY TERESA NAHRI

PANEL MEMBERS:

**DR. E. STANTON (CHAIR)
D. GIAMPIETRI
DR. D. KRAFTCHECK
S. BERI
DR. S. BODLEY**

Hearing Date: November 25, 2014
Decision Date: November 25, 2014
Reprimand Date: November 25, 2014
Release of Written Reasons: March 2, 2015

PUBLICATION BAN

TEXT of PUBLIC REPRIMAND
Delivered November 25, 2014
in the case of the
COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO
and
DR. DOLLY TERESA NAHRI

Dr. Nahri, it is always unfortunate when a member of our profession appears before this Committee. Your disgraceful, dishonourable and unprofessional conduct has breached the faith and trust of the profession, and it has brought dishonour not only to yourself, but also to the profession as a whole.

However, the Committee recognizes that you have accepted responsibility for your behaviour, and as a result of the College investigation have made many positive changes in your practice. While the Committee recognizes that you took steps early on to correct the breach in your undertaking, nevertheless, a breach of an undertaking is a serious matter, and to do so is to undermine our privilege of self-regulation and to discredit our solemn duty to protect the public which we serve.

The inappropriate delegation of Controlled Acts is also a serious matter. While this was described as to being a result of being naïve and ill-informed, nevertheless, it had potential for causing harm to your patients. As a self-governing profession we, through this College, make policy to govern the profession. As a member of this self-governing profession, it is your obligation to know and follow these policies.

The Committee was also concerned to hear that members of your staff were being introduced as doctor, thereby misleading the public to believe they were being seen, examined and treated by a qualified physician who holds a licence to practise in Ontario. This has the effect of eroding the public trust in our profession.

We have trust that you have taken heart to the seriousness of your inappropriate behaviour and after your rehabilitation program will strive in the future to act honourably and professionally so as to bring credit not only to yourself but also to the profession.

You may be seated.