ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Kadri,* 2023 ONPSDT 10
Date: April 6, 2023
Tribunal File No.: 21-010

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Albert Kadri

FINDING REASONS

Heard: November 7-11, 14-18, 28-30, 2022, December 1-2, 5-7, 2022, January 31, 2023 and February 2-3, 14, 2023, by videoconference

Panel:

Ms. Sophie Martel (chair)
Dr. Stephen Hucker
Mr. Shahab Khan
Dr. Roy Kirkpatrick
Ms. Linda Robbins

Appearances:

Ms. Pinta Maguire, Ms. Anna S.P. Wong, Ms. Jessica Amey and Ms. Joie Chow, for the College
Dr. Albert Kadri, self-represented

RESTRICTION ON PUBLICATION

The Tribunal ordered, under ss. 45-47 of the Health Professions Procedural Code, that no one may publish or broadcast the names or any information that would identify patients referred to during the Tribunal hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this order.

INTRODUCTION

[1] The College of Physicians and Surgeons of Ontario alleges that Dr. Kadri committed professional misconduct and that he was incompetent.

[2] More specifically, the College alleges that Dr. Kadri engaged in disgraceful, dishonourable or unprofessional conduct in his disruptive conduct with the Windsor Regional Hospital (WRH) staff and administrators, in inappropriately communicating and advocating with patients, in inappropriately billing the chronic dialysis team fee (CDTF) under the Ontario Health Insurance Plan (OHIP), and in his inappropriate recruitment of a junior physician.

[3] The College also alleges that Dr. Kadri failed to maintain the standard of practice of the profession by refusing to work within the parameters of the restructured model of care for the renal program at the WRH, by sending orders to a hospital where he no longer held privileges, and by not referring patients to team-based care and hospital-based nephrologists. Additionally, the College alleges that Dr. Kadri is incompetent.

[4] The College further alleges that Dr. Kadri contravened the terms of the interim and amended orders of the Inquiries, Complaints and Reports Committee (ICRC) by failing to provide a signed OHIP consent form in a timely manner, by failing to provide a patient log as prescribed, and by failing to properly transfer patients to the WRH within the prescribed timelines.

[5] While he does not admit the allegations against him, Dr. Kadri did not significantly dispute some of the facts in respect of the allegations. He believes that the WRH restructured model of care is not safe. As a result, he submits that his conduct in objecting to the WRH model of care was justified.

[6] We conclude that the College has proven the allegations against Dr. Kadri and find that he engaged in disgraceful, dishonourable or unprofessional conduct, that he failed to maintain the standard of practice of the profession, that he is incompetent, and that he contravened the terms of the ICRC orders. These are our reasons.

STRUCTURE OF THE DECISION

[7] There are many allegations and findings. We have structured our decision in the following order:

- Introduction
- Structure of the decision
- Comments about the hearing
- Background information
- The evidence and analysis in respect of our conclusions regarding:
    - The disgraceful, dishonourable or unprofessional conduct. This section is subdivided into four parts:
        - The disruptive conduct with the WRH staff and administrators (which encapsulates several aspects)
        - The communications and advocacy with patients
        - The billing of the CDTF
        - The recruitment of a junior physician and directions given to that physician
- The failure to meet the standard of practice of the profession and incompetence. We address the expert evidence under this heading.
- The contravention of the ICRC orders
- A summary of our conclusions

THE HEARING

[8] The College called nine witnesses: Jonathan Foster (a WRH vice president and former director of the WRH renal program), Dr. Amit Bagga and Dr. Amit Patel (nephrologists with privileges at the WRH), Dr. Syed Amin (a physician Dr. Kadri recruited), Dr. Jude Coutinho (a medical advisor at OHIP's provider services

branch), Ms. Z and Ms. E (patient substitute decision-makers), Andrea Boddy (a College compliance case manager), and Dr. Karen Yeates, who was qualified as an expert in the diagnosis and management of chronic kidney disease and end-stage renal failure.

[9] During the hearing, the College decided not to call two other nephrologists with hospital privileges at the WRH. While Dr. Kadri initially requested that one of these witnesses be compelled to testify, he subsequently withdrew this request. The possibility that Dr. Kadri's case might have to be split (as contemplated in our case management reasons in *College of Physicians and Surgeons of Ontario v. Kadri*, ONPSDT 44) never materialized and the hearing proceeded in the usual manner: the testimony of the College's witnesses followed by Dr. Kadri's testimony and his witnesses' testimony.

[10] Dr. Kadri initially indicated that he would call 53 witnesses (for which several summonses were refused in the case management reasons in *College of Physicians and Surgeons of Ontario v. Kadri*, 2022 ONPSDT 38). As well as his own testimony, Dr. Kadri eventually decided to call four witnesses even though the Tribunal had agreed to issue summonses for several additional witnesses. Dr. Kadri called Patients KL and WS and Dr. Vincent Cheung and Dr. Garth Hanson, who were qualified as experts in the clinical treatment of advanced chronic kidney disease.

[11] We entered 180 exhibits during the 22-day hearing. Dr. Kadri represented himself. A significant amount of time was spent on Dr. Kadri's cross-examination of the College's witnesses, Dr. Kadri's own evidence, and the College's cross-examination of his evidence. The panel often had to remind Dr. Kadri of our previous ruling that the merits of the model of care was not an issue before us (see *College of Physicians and Surgeons of Ontario v. Kadri*, 2022 ONPSDT 30). As part of our authority to manage the hearing process, the panel also had to occasionally curb the length of Dr. Kadri's cross-examination of some of the College's witnesses because of the number of irrelevant questions that he asked going to the merits of the model of care. We also had to repeatedly remind Dr. Kadri not to ask leading questions of his own witnesses.

BACKGROUND

[12] Dr. Kadri is a nephrologist in Windsor. Until June 2018, he held privileges at the WRH in addition to managing a private practice. He was the chief of medicine and director of the WRH renal program (and its predecessor) from around 2010 until he resigned these positions in June 2015.

The WRH's renal program

[13] The allegations originate in Dr. Kadri's objections to changes that the WRH made to its renal program.

[14] In 2015, the WRH commissioned an external review of its chronic kidney disease program and services. According to Mr. Foster, the reasons for seeking an external review included an insufficient number of nephrologists, the lowest rates of home dialysis in the province, fragmented care when the patients transferred from a private practice to hospital-based dialysis, and the inconsistent use of the program's resources, such as the hospital's multi-care kidney clinic (MCKC – also at times referred to as the chronic kidney disease (CKD) clinic). The external reviewers made recommendations, which included recruiting additional nephrologists, reorganizing the MCKC to reflect best practices in collaborative, interprofessional care including the direct participation of the nephrologists, requiring that patients admitted to the WRH dialysis program be seen by the MCKC team, and changing the nephrologist billing model.

[15] The WRH subsequently implemented the external reviewers' recommendations as part of its new model of care for renal patients. The salient features of the new model included: (1) the recruitment of two additional nephrologists; (2) the requirement that all nephrologists refer all patients who would eventually require dialysis or who required pre-dialysis care to the MCKC based on set criteria; and (3) a rotation of the on-call nephrologists for the management of patients receiving hemodialysis at a hospital or satellite site. According to this model, the on-call physician manages all professional aspects of chronic dialysis and end-stage renal failure in hemodialysis patients and, as the most responsible physician (MRP), bills the CDTF (the chronic dialysis team fee). The CDTF is an OHIP fee code that provides an all-inclusive benefit for the services of all physicians participating in the patient's dialysis treatment.

[16] The model was implemented in various stages. On March 4, 2016, the WRH sent a memorandum to the then three WRH nephrologists stating that effective April 1, 2016, all nephrologists holding privileges at the WRH “must” refer all WRH patients who require pre-dialysis care to the MCKC.

[17] The WRH medical advisory committee formally adopted the model of care on January 17, 2017, to take effect on March 1, 2017. The WRH medical advisory committee endorsed the following:

1. That with regard to the In Centre/Satellite Dialysis Patients:

    - the MRP will be the Nephrologist on-call who will bill for work done, with the work being equitably divided among the Nephrologists, including the fair integration of any new Nephrologists to the Program in accordance with the approved Professional Staff Resource Plan

    - Rounds will have standard schedules and blocked time with WRH multidisciplinary support

2. That with regard to the CKD Clinic:

    - there will be a trial of patients referred from private practice with all Nephrologists holding CKD Clinic time

    - Nephrologists will be MRP for those patients referred from their private practice

    - CKD Clinics will have standard schedules and blocked time with WRH multidisciplinary support

    - This recommendation is to be evaluated after 6 months time

3. That with regard to the Home Program:

    - there will be a trial for patients referred to the Home Program with all Nephrologists holding CKD Clinic time ·

    - Nephrologists will be MRP for those patients they have referred to the Home Program – this includes the CKD Clinic as well as other arms of the Program

    - CKD Clinics will have standard schedules and blocked time with WRH multidisciplinary support

    - This recommendation is to be evaluated after 6 months time

[18] In practice, this new model meant that once patients met the referral criteria for the CKD clinic, the nephrologist was to refer these patients from their private practice to the CKD clinic. While the patients would become patients of the CKD clinic and the WRH renal program, the referring physician remained the MRP for those patients and was to block time at the CKD clinic to see their patients with the other allied health professionals. Similarly, the referring nephrologist remained the MRP for the patients who opted for home dialysis, which was also managed through the CKD clinic. For the patients who opted or required in-centre or satellite hemodialysis, which is only offered in a hospital-based setting, the MRP became the on-call nephrologist, who rotated every two weeks. Most patients who require hemodialysis attend dialysis several hours at a time, three times per week.

[19] Dr. Kadri is against this model of care because he believes that it is neither safe nor in his patients' best interests. He believes that he can offer better multi-disciplinary care through his community practice and that patients should not be forced to attend the MCKC. Dr. Kadri believes that the MRP should, at all times, be the nephrologist to whom the patient was initially referred. He submits that such a model is important for continuity of care and consistent messaging. He also submits that the WRH's rotating physician model of care removes accountability in the event of errors and removes a patient's choice as to their treating physician. He is also of the view that the on-call physician does not have enough time to manage all aspects of a patient's dialysis care since they are also responsible for other duties while on call such as emergency room and ward consultations.

[20] Dr. Kadri prefers the model that is based on an agreement he drew up and signed in 2009 with the then two other Windsor nephrologists where the MRP was defined as the nephrologist who first saw the patient in consultation.

[21] The allegations to be addressed concern Dr. Kadri's actions in respect of his objections to the model of care.

<u>How the matter came to the College's attention and the ICRC order</u>

[22] The WRH suspended and then revoked Dr. Kadri's hospital privileges for his refusal to comply with the new model of care and what they viewed to be disruptive behaviour. Pursuant to its mandatory reporting obligations under s. 33(b) of the *Public Hospitals Act,* RSO 1990, c. P.40 (PHA) and s. 85.5(1) of the Health

Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c. 18 (Code), on June 1, 2018, the WRH advised the College that its medical advisory committee had recommended revoking Dr. Kadri's hospital privileges and had suspended his privileges on an interim basis effective June 1, 2018. The WRH subsequently revoked Dr. Kadri's hospital privileges on January 15, 2019.

[23] On June 29, 2021, the Health Professions Appeal and Review Board (HPARB) dismissed Dr. Kadri's appeal of the revocation of his hospital privileges: *Kadri v. Windsor Regional Hospital*, 2021 CanLII 57862. On July 18, 2022, the Divisional Court dismissed Dr. Kadri's appeal of the HPARB decision: *Kadri v. Windsor Regional Hospital*, 2022 ONSC 4016.

[24] Following the ICRC's approval, the College Registrar appointed investigators to investigate whether Dr. Kadri had engaged in professional misconduct or was incompetent. After obtaining an opinion from Dr. Yeates and reviewing the opinion of Dr. Levin (a nephrologist who had provided an opinion for the purposes of the HPARB appeal), on July 29, 2020, the ICRC issued an interim order under s. 25.4 of the Code, placing terms, conditions and limitations on Dr. Kadri's certificate of registration. The order prohibited Dr. Kadri from treating patients at high risk of developing end-stage renal disease and required him to transfer these patients to a regional renal centre. The order also required that Dr. Kadri maintain a log of patients that met transfer criteria, provide a specified signed OHIP consent form, and obtain an approved clinical supervisor by a certain date.

[25] Dr. Kadri sought judicial review of the ICRC order, which was dismissed on September 18, 2020: *Kadri v. College of Physicians and Surgeons of Ontario*, 2020 ONSC 5882. Because Dr. Kadri had not obtained an approved supervisor, he ceased practising on September 18, 2020, and has not practised since.

[26] The College subsequently initiated another investigation into allegations regarding Dr. Kadri's conduct in transferring patients and his non-compliance with the ICRC order.

[27] On May 7, 2021, the ICRC referred to the Tribunal the allegations addressed in this decision.

EVIDENCE AND ANALYSIS

[28] The College must prove the allegations against Dr. Kadri on a balance of probabilities.

Disgraceful, Dishonourable or Unprofessional Conduct

Legal framework

[29] According to s. 1(1)33 of O. Reg. 856/93 under the *Medicine Act, 1991*, SO 1991, c. 30, an act of professional misconduct includes 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 is. As noted in *College of Physicians and Surgeons of Ontario v. Rabiu*, 2020 ONCPSD 15, disgraceful, dishonourable or unprofessional conduct is often referred to as a broad catch-all provision and is intended to capture any improper misconduct that is not caught by the wording of the specific definitions of professional misconduct. The conduct does not have to be dishonest or immoral to fall within the definition. A serious or persistent disregard for one's professional obligations is sufficient (p. 26).

Allegations

[30] The College submits that Dr. Kadri engaged in disgraceful, dishonourable or unprofessional conduct in four main areas: (1) in his disruptive conduct with WRH staff and administrators regarding his persistent refusal to comply with the WRH model of care; (2) in his inappropriate communications and advocacy with patients; (3) in his inappropriate billing practices regarding the CDTF; and (4) in his inappropriate recruitment of Dr. Amin and his misrepresentations to Dr. Amin.

Refusal to comply with the WRH model of care

[31] The College submits that Dr. Kadri engaged in disgraceful, dishonourable or unprofessional conduct with WRH staff and administrators regarding his persistent refusal to comply with the WRH model of care. There is little factual dispute regarding Dr. Kadri's conduct. In his final submissions Dr. Kadri admitted that he "never followed" the model of care. The dispute centers on whether the conduct is disgraceful, dishonourable or unprofessional.

Failure to refer patients who met MCKC criteria to the MCKC

[32] As noted in the background section, the nephrologists with WRH hospital privileges were required to refer patients who met MCKC criteria to the MCKC as of April 1, 2016. We heard from various witnesses that the MCKC includes access not only to nephrologists but also to a variety of allied health professionals such as nurses (including a vascular access nurse), pharmacists, social workers, and dieticians. It is intended to coordinate dialysis and pre-dialysis care, including measures to avoid dialysis if possible.

[33] Dr. Kadri does not dispute that it was hospital policy that he refer patients to the MCKC and that he did not do so. Except for a brief period in 2016 when he referred patients to the MCKC as an "extra" visit in addition to visits with him, he did not refer patients to the MCKC. For example, in cross-examination, he agreed that between April 1, 2016, and July 1, 2016, he only referred one patient to the MCKC and that during this same period he bypassed the MCKC in respect of 53 patients whom he referred directly for vascular access surgical appointments. It was part of the MCKC's role to arrange for such procedures.

[34] Despite a follow-up request from the WRH chief of staff and the chief of the department of medicine in September 2016 that he comply with the MCKC referral and schedule clinic time in the MCKC, Dr. Kadri did not do so.

[35] Dr. Kadri explained that he never scheduled clinical time in the MCKC because to do so would mean that his patients would become patients of the MCKC and renal program and that he, as their individual nephrologist, would no longer have any say in their care. He stated that he "never stepped foot" in the MCKC beyond 2013. Furthermore, he believed that after the six-month trial period envisioned in the endorsed model of care (quoted earlier in the background section), the hospital would change the MRP to whichever nephrologist happened to be at the MCKC. He also agreed, however, that this belief did not in fact materialize and that no changes were made after the six-month trial period.

[36] In summary, Dr. Kadri agreed that other than a brief period in 2016 when he referred his patients to the MCKC for an additional visit, he never referred his patients to the MCKC. He also does not dispute that he continued not to refer his patients to the MCKC after his hospital privileges were suspended.

[37] Dr. Kadri said that one of his reasons for refusing to refer patients to the MCKC relates to a change in the MCKC criteria. He explained that shortly after the external reviewers issued their report, the MCKC criteria changed and became more restrictive. The more restrictive criteria excluded more patients such that Dr. Kadri felt that he could provide better multi-disciplinary care in his own private community clinic. We do not find this reason persuasive because Dr. Kadri never referred patients to the MCKC prior to the criteria change when those criteria were less restrictive. Furthermore, even if he felt that the MCKC criteria were too restrictive (thus depriving a certain renal population from access to it), nothing prevented him from offering a multi-disciplinary approach to his patients who met less restrictive criteria and then referring them to the MCKC once they met the criteria.

EPO referrals

[38] Another example of Dr. Kadri's circumvention of the MCKC relates to the prescription of erythropoietin (also known as EPO and Eprex). Erythropoietin is a very costly medication taken by some renal patients. Patients can receive the medication at no charge if prescribed by a physician with hospital privileges. Once he lost his hospital privileges, Dr. Kadri could no longer prescribe EPO for his patients in a cost-effective manner. He testified that he tried to find alternative ways to assist his patients. One of these attempts was an arrangement whereby his sister, who was a nurse practitioner at WRH, would prescribe the drug under the supervision of a physician in London through a medical directive. However, the WRH advised his sister on July 26, 2018, that a nurse practitioner cannot prescribe a drug covered under a special drug program. Dr. Kadri eventually made an arrangement with Dr. Callaghan, one of the WRH nephrologists, whereby he referred his patients to Dr. Callaghan for the limited purpose of obtaining an EPO prescription.

[39] We are struck by the fact that there was a much easier and more direct way for Dr. Kadri to ensure that his patients could receive this medication at no cost: a referral to the MCKC.

Failure to follow the vascular access pathway

[40] Patients who require dialysis first need to undergo vascular access surgery. Mr. Foster explained that the MCKC and the WRH body access nurse are part of the WRH renal program and the dialysis access procedure. Going through the MCKC and the body access nurse ensures that patients receive the appropriate pre and post-procedure care, which is an integral part of their dialysis care. Mr. Foster testified, however, that Dr. Kadri continued to refuse to refer patients to the MCKC, even after his hospital privileges were revoked. Instead, he referred patients directly to the vascular surgeon. Mr. Foster said that Dr. Kadri's circumvention of the hospital pathways resulted in suboptimal dialysis starts. Patients whom the WRH renal program had never met presented to dialysis and were unprepared to start dialysis. Mr. Foster explained that dialysis is life-changing and takes months of support planning to implement given the life disruption in attending the hospital three times per week, three to four hours per trip.

[41] Mr. Foster testified that the WRH had to send multiple memos to hospital staff to explain the appropriate vascular access pathway considering Dr. Kadri's repeated refusals to follow it. On December 8, 2017, the WRH administration sent a memo to the department of surgery and diagnostic imaging in which it explained that the care pathway for patients requiring a dialysis access procedure was for all referrals to be sent though the MCKC. The memo requested that referrals bypassing this care pathway be redirected to the referring physician with instructions to first refer to the MCKC. Mr. Foster said that Dr. Kadri continued to bypass the MCKC such that the WRH administration sent a further memo to the department of surgery and diagnostic imaging, as well as a letter to Dr. Kadri's counsel, reminding them of the need to coordinate access to surgeries through the MCKC.

[42] While Dr. Kadri was not always a direct recipient of these memos, he acknowledged that he was aware of the hospital policy that mandated that he refer patients requiring vascular access surgery to the MCKC rather than directly to the vascular surgeon's private office. He said, however, that the hospital was "overstepping their jurisdiction" such that he continued to bypass the MCKC and refer his patients directly to the vascular surgeon. He also testified that the vascular surgeons did not "deny" his referrals.

[43] Dr. Kadri also refused to follow the hospital pathway for laparoscopic access procedures, which were only offered in London. Despite being aware that such procedures had to come through the WRH renal program via the Windsor body access coordinator, Dr. Kadri continued to refer some patients directly to London.

Disputes about MRP and on-call schedule

[44] There was conflicting evidence on whether the new WRH on-call model of care for hemodialysis patients changed anything in respect of the clinical care of these patients. Dr. Bagga testified that there were no changes from a clinical care perspective since the on-call physician had always dealt with acute and chronic patient issues while on-call both before and after March 2017. Dr. Kadri, on the other hand, disagreed with Dr. Bagga's evidence and testified that he was available to his patients even when he was not the on-call nephrologist and that the renal staff called him for patient care matters. It is not necessary for us to determine whether the new model of care introduced clinical care changes. The relevant evidence, which is not disputed, is that the new WRH model of care became a formal hospital policy effective March 2017.

[45] In January 2017, in advance of the model's implementation, Dr. Kadri inserted a note in Nephrocare (the WRH renal patient electronic documentation system) for all his patients directing, "patient and/or staff to call MRP office to discuss and/or book appt for any concerns or chronic management issues esp when non-dialysis rounds days." In his testimony, Dr. Kadri agreed that he had never inserted such a notation before because he previously "never had to." While he understood that the hospital was going to be implementing the new model, which required that the on-call physician deal with all issues, he continued to maintain that the hospital should be calling him for his patients.

[46] Dr. Bagga was the on-call nephrologist for the first week of the model's implementation, the week of March 6, 2017. Nevertheless, on March 3, 2017, Dr. Kadri wrote to Mr. Foster to advise that he was going to "remain MRP for my patients and that status will not change regardless who is the on-call/service for nephrologist." He added that he would personally supervise the dialysis treatment for all his chronic dialysis patients. Mr. Foster replied in a memo addressed to the three nephrologists, including Dr. Kadri, reminding them that "ONLY the

Nephrologist on-call will be the [MRP] for all In-Centre and Satellite Dialysis Patients." Despite having received this memo, Dr. Kadri attended the hospital to round on his patients the week of March 6, 2017, even though Dr. Bagga was the scheduled on-call nephrologist.

[47] Mr. Foster testified that Dr. Kadri's presence alongside Dr. Bagga was extremely disruptive and that the nursing staff expressed concerns about receiving orders from multiple physicians.

Faxing hospital orders

[48] There is also no factual dispute that while he still had hospital privileges, Dr. Kadri faxed orders to the WRH hemodialysis unit that occasionally conflicted with orders made by the on-call nephrologist. Dr. Kadri explained that he wanted to ensure that the on-call physician received his assessment of his patients and what he felt was in their best interest but that he was not under any illusion that they had to follow his assessment instructions. He testified that he was not "forcing" the WRH renal staff to do anything.

[49] Dr. Kadri also does not deny that after the revocation of his hospital privileges, he continued to fax orders to the WRH for his patients. He again explained that he was sending information on what he thought needed to be done regarding his patients' care.

Conclusion regarding Dr. Kadri's refusal to follow the model of care

[50] In our view, Dr. Kadri engaged in disgraceful, dishonourable or unprofessional conduct in his disruptive conduct with WRH staff and administrators regarding his persistent refusal to comply with the WRH model of care. As indicated earlier, there was little disagreement on the facts of this allegation. Dr. Kadri agreed that he never followed the model of care.

[51] Both parties agreed that patients with end-stage renal disease are vulnerable patients with co-morbidities. Given the vulnerability of these patients, their co-morbidities, the fact that they are frequent users of hospital resources, and that they may require hospital-based dialysis treatment, the hospital, as an institution, is intimately involved in the treatment of these patients. In other words, while various aspects of care may be provided outside the hospital, some of the care by

necessity is provided in hospital. As a result, it is reasonable for a hospital to establish policies and procedures regarding the care of these patients and its expectations of the region's nephrologists. While it was open to Dr. Kadri to attempt to engage in constructive and respectful discussions with the hospital administration about his concerns regarding patient care, it was not appropriate for him to deliberately circumvent the hospital's model of care once implemented.

[52] As noted by the Ontario Divisional Court in rejecting Dr. Kadri's appeal of the revocation of his hospital privileges, "No proper health care system could run on the basis that where a doctor does not agree with hospital policy, he or she is free to act on his or her view of how things should be done." (para. 49). The court further held:

> On its face, behaviour directed at, having the object of, or effecting the disruption and undermining of established hospital policy by a physician, (a member of its Professional Staff) must be enough to withdraw his or her privileges. Pursuant to s. 19.02 of the By-Law of the Windsor Regional Hospital, Dr. Albert Kadri, as a member of its Professional Staff was obliged to adhere to its "rules, regulations, vision and strategic plan". Surely, this has to be accepted as fundamental to a physician's association with any hospital, especially when he or she does not agree. Without consistent acceptance of its rules and policies such a facility could not operate much less to the best advantage of its patients. (para. 67)

[53] In its conclusion, the court noted that, "The system of providing health care is an integrated one, where the hospital, its staff and doctors work together to provide a high quality and hopefully efficient and economically feasible level of care." (para. 132)

[54] We conclude that Dr. Kadri's persistent refusal to follow the model by bypassing the MCKC, by not following proper vascular access pathways, by showing up to round on his patients after being specifically told not to, and by sending orders when not the physician on-call, was disgraceful, dishonourable or unprofessional.

Patient communications

[55] The College alleges that Dr. Kadri inappropriately communicated with patients in two main ways: in respect of a written memo he sent to his patients on May 15,

2018, and in respect of his office's communications with patients after the ICRC had imposed terms, conditions and restrictions on his practice.

Correspondence to patients on May 15, 2018

[56] On May 15, 2018, Dr. Kadri sent a memo to all of his patients. When he sent this memo, Dr. Kadri was already aware of the WRH's medical advisory committee's decision to suspend his hospital privileges as of June 1, 2018. The memo stated:

> In the past year I have received many concerns from my patients who are receiving outpatient hemodialysis at Windsor Regional Hospital. These concerns range from who is making decisions about the amount of usual fluid removal, chronic medication adjustments, eligibility for site of treatment, to whether a patient is a candidate for a kidney transplant. In my opinion, these decisions are best made by the doctor who knows you most well and that you have a long-standing relationship with, however the hospital has taken steps to limit the involvement and interaction between you and your nephrologist. I have objected to this as I feel it does not represent best practice and this change was implemented without individual patient consent, leading to confusion in patient expectations. Given that your condition is quite serious, I have been personally advocating against this for more than one year.
>
> I have pointed out many cases of concern to the hospital administration. I do feel this will increase the potential for adverse outcomes to individual patients. The hospital's change in policy restricts your physician's access to manage and direct your chronic care issues and only allows nurses to contact or process orders from a constantly rotating on call physician who may not know you or your history well. As you are aware, I've been arranging visits in my outpatient private practice to oversee your care as I feel this is my obligation to you and your expectation of me. You deserve to know about these changes and you deserve the right to voice your opinion. I repeatedly asked the hospital administration who would be accountable to you in the event of an adverse outcome and they have declined to answer this question. You have a right to request that your nephrologist both manage and be accountable for your chronic care. Without direct accountability, quality of care will likely diminish.
>
> Our own College of Physicians and Surgeons have stated in guidelines regarding the care of dialysis patients that the Medical Director of the dialysis unit is responsible to ensure that: *"each patient is followed by a primary nephrologist, and ensures and documents that the (most responsible)*

> *Nephrologist is aware of any problems and is responding appropriately".* The Ontario Association of Nephrology has communicated a stance against hospital's dictating such policies and against breaking or diminishing physician-patient relationships.
>
> Due to previously identified patient care concerns, since 2009 the nephrologists unanimously agreed on a model of care that respected patient rights and ensured accountability to patients from their primary and most responsible physician. By being involved in your care continuously it allowed your nephrologist to advocate fully for you in accordance with your wishes based on an intimate knowledge of your history. I will not abandon my professional obligation to you as your primary nephrologist. You are always welcome to call my office and come to see me with any concerns at any time. I am sending this letter to you because I feel your rights as a patient should be respected and eroding relationships between patients and physicians built over many years is contrary to the premise of the good practice of medicine. There have been enough cases of concern that I feel it is my duty to you to inform you of these changes. If you would like your opinion heard, please contact any or all of the below:
>
> **David Musyj, CEO** – 1995 Lens Ave, Windsor, ON N8W 1L9; Email: david.musyj@wrh.on.ca
>
> **Lynne Watts, Board Chair** – 1995 Lens Ave, Windsor, ON NBW 1L9, Email: lynne.watts@wrh.on.ca
>
> **Patient Ombudsman for Ontario** – Box 130, 77 Wellesley St. W., Toronto, ON M7A 1N3, info@patientombudsman.ca

[57] Mr. Foster testified that the WRH had to send a letter to Dr. Kadri's patients to address the inaccuracies in this communication. Dr. Kadri had referred to an outdated College policy that was not relevant for a hospital-based program. Furthermore, he was erroneously indicating that the hospital was limiting interactions between patients and their nephrologist. Dr. Kadri's letter also made it more difficult to effectively transfer the patients who would need to be referred to the WRH renal program because of Dr. Kadri's upcoming loss of hospital privileges.

Correspondence with patients after the ICRC order

[58] The ICRC orders of July 29, 2020 and August 13, 2020, imposed terms, conditions and limitations on Dr. Kadri's certificate of registration. He was not to see any patients meeting certain criteria and was to transfer the care of patients meeting the criteria. Furthermore, he was not to practise without engaging a clinical supervisor

acceptable to the College. As described later in this decision in respect of the allegations concerning Dr. Kadri's non-compliance with the ICRC order, having not engaged a clinical supervisor, Dr. Kadri was no longer able to practise beyond September 18, 2020, and had to transfer his patients by September 30, 2020.

[59] There is no evidence that Dr. Kadri accurately communicated the reasons why he ceased practising to his patients or that he was transferring their care. On the contrary, the evidence was that the communications from his office were misleading.

[60] Ms. Boddy testified that on September 23, 2020, she asked two of her colleagues to attend Dr. Kadri's former practice location to ensure that he was not practising. The sign posted on his office door indicated that because of the global pandemic, Dr. Kadri and Dr. Yaseen (a physician then working with Dr. Kadri) would be reviewing patient care by telephone only and that all in-person clinic visits were cancelled for the time being and would instead be done by telephone. There was no indication on the sign that Dr. Kadri had ceased practising.

[61] Ms. Boddy also contacted Dr. Kadri's office after-hours on September 27, 2020. The office voicemail message essentially provided the same information as found on the office sign. There was no indication that Dr. Kadri was no longer practising.

[62] Dr. Kadri noted that the sign and voicemail messages were undated and reflected an old message relating to the pandemic. We find, however, that even if the messages were old, the fact remains that they had not been updated to reflect Dr. Kadri's new status.

[63] We also heard evidence from two substitute decision-makers for patients of Dr. Kadri regarding their communications with Dr. Kadri's office after he had to stop practising. One testified that around early October 2020, she received a phone call from Dr. Kadri's office informing her that she would be receiving a call from the WRH renal clinical transferring the care of her family member to the WRH but that Dr. Kadri would never "abandon" his patients.

[64] The second testified that around late December 2020 or early January 2021, she received conflicting information from the WRH renal clinic and from Dr. Kadri's office confirming upcoming appointments at their respective offices. When she

called Dr. Kadri's office to ask why she was receiving calls for appointments at multiple locations, the receptionist replied that there was a pending court case and that Dr. Kadri's office had not given permission for the patients to be transferred. The receptionist asked if she wanted the patient to remain at Dr. Kadri's office if the court case worked out and the substitute decision-maker said yes. She testified that she was not then made aware of any changes to Dr. Kadri's status or his ability to practise medicine.

[65] Dr. Kadri said that he believes that his receptionist spoke to most of his patients and was likely "truthful" with them. He denied directing her to tell patients that they were not abandoning them but acceded that his receptionist would not want to leave patients with the impression that it was "our choice" to abandon patients.

[66] While Dr. Kadri had his office receptionist on his witness list, he later advised that he was not calling her.

Conclusion regarding Dr. Kadri's communications

[67] We conclude that Dr. Kadri engaged in disgraceful, dishonourable or professional conduct in respect of his communications and advocacy with patients.

[68] As noted previously, patients with end-stage renal disease are vulnerable patients dependent on the care of their health professionals. It was highly inappropriate for Dr. Kadri to provide these patients with one-sided information about the hospital's model of care and insinuate that the care that they would receive would be unsafe. Dr. Kadri's letter of May 15, 2018, essentially asked that his patients advocate by contacting various individuals and organizations within and outside the hospital. Given that the memo was written just prior to the effective date of Dr. Kadri's suspension of his hospital privileges, we find that Dr. Kadri was advocating on his own behalf rather than on his patients' behalf.

[69] Furthermore, the communications Dr. Kadri's office had with his patients after he had to cease practising were misleading. Dr. Kadri's office sign, voicemail, and the conversations his office staff had with patients did not inform patients of the fact that he was no longer practising and that their care had to be transferred to the WRH renal program. It was Dr. Kadri's responsibility to ensure that his office staff communicated accurate information with his patients. The undisputed evidence

from two substitute decision-makers was that the information they received was erroneous, confusing, and misleading. It left them with the impression that the care was not being transferred and that Dr. Kadri would be able to continue treating patients.

Inappropriate billing practice

[70] The OHIP Schedule of Benefits provides for a CDTF (chronic dialysis team fee) defined as the "all-inclusive benefit per patient per week for professional aspects of managing chronic dialysis and end-stage renal failure in dialysis patients." The CDTF, as its name suggests, is a team fee that includes the services of all physicians routinely or periodically participating in the patient's dialysis treatment at "the patient's principal treatment centre."

[71] The CDTF is paid to the MRP. The Schedule defines MRP as, "the attending physician who is primarily responsible for the day-to-day care of a hospital in-patient." As found in the definition, the MRP refers to *in-patient* care. Dr. Coutinho, who testified about the OHIP schedule, acceded that the definition left something to be desired in respect of its application to non-in-patient settings such as in the case of patients receiving dialysis in home or satellite settings.

[72] Dr. Coutinho explained that OHIP generally respects the team's agreement as to who may submit the code so long as the submission of the fee is in keeping with the Schedule and that the patient received the care. He indicated that OHIP is not involved in whether and how the fee is subsequently divided up among various physicians.

[73] As noted earlier, the new model of care provided that the on-call nephrologist would be the MRP and bill the CDTF for all patients receiving dialysis for the weeks on call. Before March 2017, in accordance with a 2009 practice agreement among the then three nephrologists, the MRP was defined as the nephrologist who saw the patient first. While the three nephrologists participated equally in coverage for on-call duties, the CDTF was claimed and paid to the physician who first saw the patient.

[74] Dr. Bagga explained some of his concerns with the way in which the CDTF was billed until 2017. Even though the on-call nephrologist rounded on the dialysis

patients, assessed, and addressed concerns raised while on call that week, the CDTF fee went to the physician who was first referred the patient, even if that physician was not in the hospital, or even in the city that week. In other words, the first physician to have ever seen the patient captured the weekly fee, every week, whether or not they actually saw the patient that week.

[75] There is no dispute that the new model of care implemented in March 2017 changed who could bill the CDTF. In advance of changing the billing practice, the WRH sought an opinion about the proposed changes from Dr. Salisbury (senior medical advisor, negotiations and accountability management division) of the Ministry of Health and Long-Term Care.

[76] In his response of January 25, 2017, Dr. Salisbury indicated that while the Ministry does not approve or otherwise intervene in private agreements between physicians or a hospital, from what the WRH had described, the model of care appeared to be consistent with the Schedule. He explained that the WRH's description of the on-call nephrologist met the definition of MRP.

[77] Following receipt of Dr. Salisbury's letter, both Dr. Bagga and Dr. Callaghan agreed in writing to the WRH's CDTF model. Beginning on March 6, 2017, they would bill the CDTF for the patients seen on their rotation of duty for the hemodialysis therapy patient at the hospital and satellite clinic. They would continue to bill the CDTF for their individual patients on home dialysis.

[78] The hospital also recruited two additional nephrologists based on the new model of care and CDTF billing structure. Dr. Patel, one of these two new nephrologists, testified about his WRH offer letter, which specified that he would participate in the approved model of care, which involved serving as the MRP for in-centre and the satellite dialysis patients and billing the CDTF accordingly.

[79] Dr. Patel testified that he began practising at the WRH in December 2017. While he habitually submitted his CDTF OHIP billings at the end of the week, his submissions were periodically rejected until around June 2018. He estimated that his rejected billings totalled $2,000 to $5,000. He understood that the reason for the rejected billing was because another physician had billed the fee. Dr. Patel testified that he provided the care required under the CDTF when he billed the CDTF while

acting as the on-call nephrologist. He rounded on the patients and was responsible for and available to patients on a 24/7 basis during the weeks he was on call.

[80] Starting in March 2017, Dr. Bagga submitted billings to OHIP in accordance with the WRH model of care. He acceded that he did not generally rush to submit his billings and instead tended to submit them one or two months after providing the service. Relying on a document that he prepared concerning his refused billings, he testified that he was refused just over $150,000 for the CDTF claimed as the on-call nephrologist between March 6, 2017 and June 4, 2018. He also believes that these amounts were refused because another nephrologist, likely Dr. Kadri, had billed the CDTF.

[81] While Dr. Kadri attempted to avoid directly answering questions as to whether he had billed the CDTF for his patients when not on call after the model's implementation, he eventually conceded that he had billed the CDTF every week for "his" patients even when not on call. He explained that he continued to bill the CDTF for patients known to him for whom he felt he could provide the service encompassed in the CDTF. Conversely, he did not bill the CDTF where he did not feel that he had provided the service regardless of what the hospital mandated him to do. Dr. Kadri further explained that even when not on call, he was "available 24/7" to his patients through multiple means and that he had never taken a vacation in the five years prior to the implementation of the new model. He also agreed, however, that while he was always available to his patients, he might not necessarily see or talk to them every week.

[82] Dr. Kadri did not dispute that he was aware how the CDTF was to be billed as part of the new model of care. On October 10, 2017, the WRH's counsel advised Dr. Kadri's then counsel that the WRH was aware that OHIP had rejected Dr. Bagga's claims for the CDTF because Dr. Kadri had already submitted claims for the same patients. Referencing the letter from Dr. Salisbury, the WRH indicated that it expected that Dr. Kadri would refrain from billing the CDTF when he was not the on-call nephrologist. The WRH also indicated that it would consider action (in respect of his hospital privileges) if Dr. Kadri continued to fail to abide by the CDTF arrangement particularly if he billed the CDTF when either of the two new nephrologists were on call.

[83] Despite being aware of the WRH's letter of October 10, 2017, Dr. Kadri continued to bill the CDTF for his patients during the week of October 16, 2017, the first week that Dr. Walters, one of the two new nephrologists, was on call. On December 7, 2017, the WRH's counsel again wrote to Dr. Kadri's counsel. She noted that despite their previous letter of October 10, 2017, Dr. Walters' submission for payment from OHIP of $12,974.40 had been refused because Dr. Kadri had already submitted the same claims for the same period. The letter indicated that Dr. Kadri's ongoing effort to unilaterally enforce the 2009 "agreement" between the nephrologists regarding billing practice was unacceptable and provided no basis for Dr. Kadri billing this fee when Dr. Walters was not a party to the 2009 agreement. She further noted that Dr. Patel was going to be on call December 18, 2017 to January 1, 2018, such that the matter needed to be resolved prior to December 18, 2017. Furthermore, the WRH counsel asked that Dr. Kadri refund the money owing to Dr. Walters or provide written confirmation that he did not bill the CDTF when not acting as the nephrologist on call. There is no evidence that Dr. Kadri did either of these things.

[84] Again, despite acknowledging being aware of this letter, Dr. Kadri continued to submit the CDTF for his patients when Dr. Patel was on call. He explained that while he understood the hospital's position, in his view, the hospital was not part of the OHIP billing equation. He added that the WRH had "weaponized" the CDTF.

[85] Dr. Kadri's position is that the on-call nephrologist does not have the time to properly fulfill the services covered by the CDTF. They round on up to 350 hemodialysis patients per week while at the same time performing other duties in respect of the emergency, intensive care and ward units. He testified that in essence, the nephrologist only has one or two minutes per dialysis patient to perform all of the services covered by the CDTF. He also relied on the testimony of two patients who testified that the care received from the on-call nephrologist during rounds was fleeting and at various times inadequate.

[86] In summary, despite being aware of the hospital's model of care regarding the billing of the CDTF by the on-call physician, Dr. Kadri continued to bill the CDTF every week for his patients even if he was not the on-call nephrologist.

Conclusion regarding the billing of the CDTF

[87] It is possible, as Dr. Kadri suggests, that the care that the hemodialysis patients received from the on-call nephrologist was imperfect. It is not necessary for us to determine the adequacy of care provided by the on-call nephrologist. We simply note that the hospital's model regarding the billing of the CDTF did not prevent Dr. Kadri from continuing to provide care to his patients in a cooperative manner that was not inconsistent with the care the on-call nephrologist provided.

[88] We conclude that it was disgraceful, dishonourable or unprofessional for him to continue to bill the CDTF for his patients when he knew that the on-call nephrologist would be billing that fee in accordance with the hospital's model of care. Prior to implementing its new model in respect of the CDTF, the WRH obtained an opinion from the Ministry of Health and Long-Term Care to ensure that the model was in keeping with the OHIP Schedule of Benefits. While Dr. Kadri may have disagreed with the opinion and the changed CDTF billing arrangement, it was not open to him to continue to deliberately refuse to follow hospital policy. His actions not only affected his patients and the hospital but also his colleagues who relied on the new model of care for their billings. Dr. Kadri in effect stole hundreds of thousands of dollars from his colleagues. It was particularly disgraceful, dishonourable or unprofessional for him to bill the CDTF when the new nephrologists were on call. These nephrologists had not been signatories to the 2009 "agreement" and had accepted positions at the hospital based on the new model of care.

Dr. Amin

[89] Dr. Amin is a physician who obtained his medical degree outside of Canada in 2012. He also did most of his postgraduate training in internal medicine outside the country. He first met Dr. Kadri as a fourth-year medical student while on a three-month elective in Windsor, including one month with Dr. Kadri. The College alleges that Dr. Kadri made false representations to Dr. Amin in recruiting him and that he improperly directed him to send patient orders to the WRH where he did not hold hospital privileges.

Dr. Kadri's recruitment of Dr. Amin

[90] Dr. Amin and Dr. Kadri both testified that during a phone call in early December 2014, Dr. Kadri orally offered Dr. Amin a nephrology position in Windsor that would begin once he completed his training. In cross-examination, Dr. Amin agreed that one of the reasons why he was interested in practising in Windsor was related to his five-year return of service agreement with the Ministry of Health and Long-Term Care, which requires him to practise in an underserviced area.

Dr. Amin's testimony

[91] Dr. Amin explained that when Dr. Kadri offered him the position, Dr. Kadri was then the WRH chief of medicine and the medical director of the renal program. Therefore, Dr. Amiri understood that he was being offered a position by the WRH. There was no signed written agreement at this time. Dr. Amin testified that he had multiple conversations with Dr. Kadri over the next two years during which Dr. Kadri reiterated that he was the chief of medicine and medical director of nephrology and recruited him within the powers of his leadership position. According to Dr. Amin, Dr. Kadri advised him not to disclose the position to anyone except his immediate family.

[92] In January 2017, Dr. Amin testified that he went to Windsor and Dr. Kadri presented him with a written offer on WRH letterhead from Dr. Kadri as "Medical Director Renal Program" and "Chief of Medicine" at the WRH. It is dated December 6, 2014, and provides that, "given your continual interest in our program and our prior experience in working directly with you, I would like to formally offer you a position within our division upon completion of your training." The written offer includes a handwritten notation at the bottom stating that the offer was "accepted December 2014." Dr. Amin testified that in January 2017, Dr. Kadri handwrote the statement and he then signed underneath it. Dr. Amin testified that at this time, he continued to believe that Dr. Kadri was the chief of medicine and director of the renal program. Dr. Kadri had not disclosed to him that he no longer held these positions.

[93] Dr. Amin testified that he assumed that he was being recruited by the WRH's nephrology division, which includes the entire scope of nephrology including dialysis patients at the hospital. Dr. Amin also explained that his previous experience with hospital privileges as a trainee were that they were rather

seamless such that he did not then understand the hospital credentialing process necessary to obtain hospital privileges.

[94] At one point, he could not recall when, Dr. Amin said that he saw a posting for a medical director at the WRH nephrology unit and asked Dr. Kadri if he should concern himself with the posting. According to Dr. Amin, Dr. Kadri responded that Dr. Amin was not qualified to be a medical director and that in any event he had already been recruited to the unit.

[95] Dr. Amin and his family moved to Windsor in May 2017. Dr. Amin completed a two-month elective with Dr. Kadri in his clinic. Following his move to Windsor, Dr. Amin testified that Dr. Kadri advised him to apply for hospital privileges. On May 10, 2017, he wrote to Ms. Bennett, director of medical affairs, to express his desire to apply for hospital privilege and to obtain an application form. Ms. Bennett replied on May 16, 2017. While she attached an application form, she also advised that she did not anticipate that the application would proceed because they had just concluded the nephrology recruitment and filled the advertised positions. Given the implications of possibly having an application for appointment for privileges at a hospital refused, she suggested that he contact the Canadian Medical Protective Association (CMPA) to seek advice prior to applying.

[96] Dr. Amin discussed the email with Dr. Kadri who responded that he had done everything in his power to recruit him when he was the chief of medicine and that the hospital would have to grant him privileges. He encouraged Dr. Amin to continue with the hospital application process. Dr. Amin also explained that once he arrived in Windsor, Dr. Kadri started painting a picture of the WRH as a “big bad wolf” who wanted to take away his patients.

[97] Dr. Amin submitted his application to the hospital on July 18, 2017. In her written response, Ms. Bennett acknowledged receipt of the application but once again advised that she did not think the application would proceed and again suggested he contact the CMPA for advice. She asked that he advise her no later than August 28, 2017, if he wished to withdraw his application. Dr. Amin responded that he wished to proceed with the application. From the email exchange, it also appears that Ms. Bennett forwarded Dr. Amin’s response to Dr. Ing, the then chief of

medicine, who responded to Ms. Bennett but also copied Dr. Amin, stating that they would proceed, “and let him have an experience which he might regret.”

[98] Dr. Amin said that he immediately discussed Dr. Ing’s response with Dr. Kadri who responded that it was good news because it showed a bias against him. He recommended that Dr. Amin continue with his application and that Dr. Ing would have to recuse himself because of his bias.

[99] On September 29, 2017, the WRH’s counsel sent Dr. Amin a letter advising that the WRH medical advisory committee had denied his application for hospital privileges for two main reasons: his appointment would not be consistent with the need for service and he had not demonstrated an ability to work and cooperate with others in a collegial and professional manner. This second reason related to the fact that he had sent orders to the hospital for some patients despite not having hospital privileges, a matter that we address in the next allegation.

[100] Dr. Amin testified that he had looked up to Dr. Kadri as a mentor and trusted him. However, after he received the letter denying him privileges, he began questioning Dr. Kadri about his lack of authority to recruit him unilaterally. Eventually, their relationship became more strained. Whereas they had previously jointly retained counsel in respect of several matters including Dr. Amin’s hospital privileges, Dr. Amin decided to seek his own legal counsel. Based on the advice he received, he decided to terminate his relationship with Dr. Kadri and left Windsor at the end of 2017. While he was able to pursue training in Ottawa because of a previous relationship with his mentors there, he testified that his experience with Dr. Kadri set him back two to three years as he had not applied to other positions on the understanding that he had a position in Windsor and also because he had to explain what had transpired with Dr. Kadri whenever he sought opportunities.

[101] In cross-examination, Dr. Amin admitted that he had essentially come to an agreement with the WRH whereby he was permitted to withdraw his application for hospital privileges and write a letter of apology to Dr. Ing for his disruptive behaviour and that he would cooperate in investigations into Dr. Kadri’s conduct upon being summonsed. Dr. Kadri submitted that Dr. Amin’s testimony was therefore biased.

Dr. Kadri's evidence

[102] Dr. Kadri testified that he recruited Dr. Amin in December 2014 in his position as the chief of division. While he did not send Dr. Amin a written offer, he testified that he drafted the offer in December 2014 and submitted written proof of this. Other than mailing this document to himself, Dr. Kadri did not send it to anyone else, either Dr. Amin or anyone at WRH. Dr. Kadri agreed that at the time of his 2014 offer, it was his hope, wish and expectation that Dr. Amin would be granted hospital privileges.

[103] When he resigned his positions of chief of medicine and director of the renal program in June 2015, he did not tell the hospital administration that he had recruited another nephrologist. He explained that Dr. Callaghan had approached him in 2014 expressing a desire to retire over a two to three-year period, asked Dr. Kadri to recruit, but to keep his retirement confidential. He also did not tell anyone of the recruitment when the external reviewers identified the need for new nephrologists.

[104] Other than possibly informing Dr. Bagga in August 2016 of his recruitment efforts, Dr. Kadri did not tell the WRH administration that he had recruited a nephrologist until a meeting in November 2016 with Dr. Bagga, Dr. Callaghan, Mr. Foster, and Dr. Saad (the chief of medicine). He informed them in response to the hospital's own recruitment efforts for additional nephrologists. He agreed that at that time, the hospital did not agree with him that he had the authority to recruit. He testified that the hospital told him to tell Dr. Amin and Dr. Yaseen (another nephrologist Dr. Kadri recruited) not to come. They also told him that Dr. Amin and Dr. Yaseen could apply for the posted position if they wanted to come. Dr. Kadri, however, explained to us that he wanted to honour his word regarding the offers he had made. He also testified that even though the hospital ultimately recruited two nephrologists, it only advertised for a renal director. According to Dr. Kadri, neither Dr. Amin nor Dr. Yaseen, both junior physicians, had the qualifications for a director position.

[105] Dr. Kadri testified that, contrary to Dr. Amin's testimony, Dr. Amin was aware in January 2017 that he no longer held the positions of chief of staff and director of the renal program. He also testified that he told Dr. Amin of the hospital's direction in November 2016 to tell him not to come.

Directing Dr. Amin to send orders to the hospital

[106] Dr. Amin also testified about his experience in Dr. Kadri's nephrology office. Dr. Amin said that Dr. Kadri maintained that the hospital had no jurisdiction over the patients they saw in their private office and that they could see any patient they wanted including patients on hemodialysis and peritoneal dialysis. Dr. Kadri recommended that Dr. Amin see these patients and send orders to the hospital regarding these patients so that the hospital would have to come to terms with his recruitment. Dr. Amin therefore sent orders to the hospital.

[107] While Dr. Kadri testified that he was aware that Dr. Amin sent orders to the hospital and that the hospital wanted this practice to stop, Dr. Kadri explained that it was their "duty" to share information on the patients with the hospital. Furthermore, he testified that the hospital had no jurisdiction over their private practice.

Conclusion regarding Dr. Kadri's behaviour with Dr. Amin

[108] There was conflicting testimony between Dr. Amin and Dr. Kadri as to whether Dr. Kadri apprised Dr. Amin around the time that the written agreement was signed in January 2017 whether he no longer held the positions of chief of medicine and director of the renal program. There was also conflicting evidence as to whether Dr. Kadri apprised Dr. Amin that the hospital wanted him to tell him not to come. Dr. Amin's testimony was that when he saw the advertisement for the new positions, Dr. Kadri told him he did not have to apply because he had already been recruited.

[109] We prefer the evidence of Dr. Amin. In our view, Dr. Amin would not have moved his family to Windsor if there were questions about his recruitment, at least not without making further inquiries. Dr. Kadri's evidence suggested that much of what he did in respect of Dr. Amin's recruitment was done secretly without full disclosure to either Dr. Amin or to the hospital. For example, he did not advise the hospital of his December 2014 offer to Dr. Amin until the fall of 2016. He did not disclose it when he resigned from the positions of chief of medicine and director of the renal program in 2015 nor when he became aware of the external reviewers' recommendation to hire more nephrologists. The written document he presented to Dr. Amin in January 2017 continued to refer to himself as the chief of medicine and director.

[110]We conclude that Dr. Amin was a pawn in Dr. Kadri's ongoing battle with the hospital. Dr. Kadri misled him by continuing to represent himself as the chief of medicine and director of the renal program, by not informing him of the hospital's advice that he not come to Windsor, by discouraging him from applying to the posted nephrology position, and by encouraging him to send patient orders to the WRH, where he did not hold hospital privileges. This last fact was uncontested. It was disgraceful, dishonourable or unprofessional for Dr. Kadri to mislead Dr. Amin, a junior nephrologist who considered Dr. Kadri to be a mentor.

Standard of practice of the profession and incompetence

Legal framework

[111]A failure to maintain the standard of practice of the profession is an act of professional misconduct under para. 1(1)2 of O. Reg. 856/93 (a regulation under the *Medicine Act, 1991*). The standard of practice has been defined as the standard which is reasonably expected of the ordinary, competent practitioner in the member's field of practice. It is not necessary to find that there has been harm to conclude that there has been a failure to maintain the standard of practice (*College of Physicians and Surgeons of Ontario v. Depass*, 2009 ONCPSD 27).

[112]To make a finding of incompetence under s. 52(1) of the Code, a panel must be satisfied that the member's professional care of a patient displayed a lack of knowledge, skill, or judgment of a nature or to an extent that demonstrates that the member is unfit to practise or that the member's practice should be restricted. Thus, to make out an allegation of incompetence, the College must establish that: (i) the alleged incompetence relates to the member's professional care of a patient; (ii) in his professional care of a patient, the member displayed a lack of knowledge, skill or judgment; and (iii) the lack of knowledge, skill or judgment was of a nature or to an extent that demonstrates that the member is unfit to practise or that the member's practice should be restricted.

[113]Incompetence differs from professional misconduct in that a finding of professional misconduct will be based purely on events that occurred in the past. Incompetence is assessed based on the member's care of patients in the past, but the panel must be satisfied that the member is presently incompetent in order to make a finding of incompetence (*Depass* at pp. 24-25).

Expert evidence

[114] We heard evidence from three experts: Dr. Yeates, called by the College, and Drs. Cheung and Hanson, called by Dr. Kadri. We briefly summarize their reports and evidence below. All three physicians were qualified as experts in the treatment of patients with advanced chronic kidney disease.

Dr. Yeates

[115] Dr. Yeates is currently a professor of the Department of Medicine, Division of Nephrology, at Queen's University. In addition to her research and academic roles, Dr. Yeates has clinical experience in the diagnosis and management of chronic kidney disease and end-stage renal failure. She works in an academic nephrology group practice that manages patients and teaches medical students, residents and fellows on end state and chronic renal disease. Furthermore, Dr. Yeates runs a nephrology clinic in James Bay where she sees patients in general nephology as well as through a multi-disciplinary care kidney clinic. She estimated that 50 to 60% of her time is currently spent in clinical practice.

[116] Dr. Yeates provided an opinion regarding Dr. Kadri's care of each patient in response to the following three questions:

- Does the care Dr. Kadri provided to the patient meet the standard of practice of the profession?
- Does Dr. Kadri's care display any or all of the following: a lack of knowledge, a lack of skill, or a lack of judgment?
- Does Dr. Kadri's clinical practice, behaviour or conduct expose or is likely to expose patients to harm or injury?

[117] Dr. Yeates was first asked to review the clinical records of 28 patients. She provided a first report on May 1, 2020, followed by a clarification report on June 3, 2020. In her testimony, Dr. Yeates explained that about one month after submission of her initial report, she realized that she had made a few mistakes, which she attributed to cutting and pasting and spending so many hours on the report such that some of the cases became inadvertently jumbled. For example, in the case of Patient BH, while the body of her opinion (in the report of May 1, 2020) referred to

several deficiencies in the care and information Dr. Kadri provided to the patient, the report's conclusion erroneously stated that Dr. Kadri had met the standard of practice for the care of this patient. Dr. Yeates corrected this conclusion in her report of June 3, 2020, such that the conclusion corresponded with the opinion.

[118] While Dr. Kadri raised concerns about Dr. Yeates' clarification report of June 3, 2020, in our view, the required clarifications are explained by the quantity of information Dr. Yeates had to review and assess. The patient charts numbered thousands of pages. Dr. Yeates' report of May 4, 2020 is extremely comprehensive and numbers 238 pages such that it would not be surprising to find a few errors of a typographical nature. We note that the confidentiality provisions Dr. Yeates had to adhere to as a College assessor would not have provided her with the opportunity to have a second pair of eyes review the report for any obvious errors. In our view, the need to clarify certain aspects of her report is reasonable and does not negatively affect the quality of her opinion.

[119] Dr. Yeates also provided another report on June 30, 2020, regarding her review of two additional patient records. Dr. Yeates thought that these patients may have been missed in her initial review.

[120] Dr. Yeates' reports of May 1 and June 3, 2020, were prepared based on extensive information, which included patient charts obtained from the WRH and Dr. Kadri's office, information the WRH lawyer provided, and information obtained during Dr. Yeates' in-person interview with Dr. Kadri in September 2019. The patient charts total thousands of pages. Similarly, the report of June 30, 2020, regarding two additional patients, was prepared based on extensive written records from the WRH and Dr. Kadri's office.

[121] The report of September 4, 2020, however, was provided on a rush basis without access to complete information. The College requested the report on August 30, 2020, and Dr. Yeates provided her report five days later. While Dr. Yeates had access to patient records from the WRH, she did not then have access to Dr. Kadri's clinical files for these five patients because of the short turnaround time. She only obtained Dr. Kadri's clinical files after having submitted her report of September 4, 2020. It became apparent during the hearing that the absence of Dr. Kadri's records was significant because of some misleading information found in

the WRH records of one particular patient, which was clarified upon a more in-depth review of the records from Dr. Kadri's office. Dr. Yeates changed her opinion at the hearing once the error was discovered. We have decided not to rely on Dr. Yeates' report of September 4, 2020, because the report was based on incomplete patient charts resulting in at least one significant error. We therefore do not rely on her opinions in respect of Patients PR and KG.

[122] Dr. Kadri also raised a concern about the case summaries from the WRH's lawyer that were provided to Dr. Yeates in respect of some of the patients. He submitted that these summaries biased Dr. Yeates. Dr. Yeates maintained that while she read these summaries, she made her own assessment of the information from the patient records and did not rely on the summaries from the WRH's lawyer. We first note that the WRH lawyer did not provide patient summaries for each patient. More significantly, however, it is apparent, in our view, from Dr. Yeates' lengthy summaries of each case that she personally reviewed each patient's entire chart and did her own case summaries. It is also evident, in our view, that Dr. Yeates kept an open mind throughout her multiple reports based on her willingness to change her opinion in respect of Dr. Kadri's care of three patients after reviewing Dr. Cheung's report. For example, after reviewing Dr. Cheung's report and realizing that she had inadvertently missed some information, she changed her opinion in respect of Patient HH, one of the patients for whom the WRH lawyer had provided a summary. Dr. Yeates also gave Dr. Kadri the benefit of the doubt when the records did not specifically indicate if required patient conversations had occurred (as in the case of Patient JK).

[123] Ultimately, after reviewing 30 patient charts (the 28 patients covered in the first group of patients with the additional two patients covered in the report of June 30, 2020, together with any changes to her opinion after reviewing Dr. Cheung's report), Dr. Yeates concluded that Dr. Kadri failed to meet the standard of practice in the management of patients with chronic kidney disease in 15 of the 30 patients.

[124] For these 15 patients, Dr. Yeates' opinion was for the most part based on Dr. Kadri's decisions regarding patients with advanced chronic kidney disease who also required multi-disciplinary care or who were already receiving dialysis care from the WRH renal program where Dr. Kadri no longer held hospital privileges. Having his hospital privileges suspended made Dr. Kadri's continued care of patients with

advanced chronic kidney disease or requiring dialysis completely unmanageable with the risk of likely harm to these patients.

[125] The College summarized the three themes in respect of Dr. Yeates' criticisms of Dr. Kadri's care:

> 1) Dr. Kadri's refusal to refer patients who would eventually require dialysis or who required pre-dialysis care to the MCKC thus depriving the patients of coordinated care and hospital health professionals of relevant medical information. This was the case for patients WB, CB, AD, MH, CT, VK, DL, and DD.
>
> 2) Dr. Kadri's faxing of orders to the hospital after he no longer held privileges, at times on an urgent basis, without also phoning the nephrologist on call. This was the case with patients RP, JQ, TL, YZ, DL, and MH.
>
> 3) Dr. Kadri's undermining of the patients' relationship with the hospital by giving them advice that conflicted with the hospital nephrologist such as in the case of patient YZ.

[126] For example, because of Dr. Kadri's refusal to refer his patients to the MCKC, he bypassed that clinic and directly referred his patients for dialysis access surgery followed by dialysis initiation. According to Dr. Yeates, bypassing the MCKC meant that the patients were at times ill-prepared for dialysis initiation because they had received insufficient information and/or training. At other times, the delay in referring patients for dialysis and bypassing the MCKC resulted in an urgent referral for access surgery and dialysis initiation. This meant that patients started dialysis at a renal program where they did not know the physicians who would be providing them with care.

[127] Similarly, because the patients had not previously been seen at the MCKC, the renal program nephrologists had limited information regarding their health history. In one case, according to Dr. Yeates, the late referral of a patient who was seen on an urgent basis by the nephrologist on call led to a series of events that culminated in the patient's death. In order to preserve this patient's identity, we refer to him as the "deceased patient." Dr. Yeates was of the opinion that Dr. Kadri should have referred this patient earlier to the renal program physicians who would be responsible for his care such that they would have had more information about his medical history in order to provide better care to him.

[128] Furthermore, Dr. Yeates expressed the opinion that where an urgent referral was necessary, the standard of care would be for Dr. Kadri to phone the nephrologist who would be assuming care for the patient, which Dr. Kadri did not do.

[129] In other cases, Dr. Kadri, who often continued to see his patients who were undergoing dialysis at the WRH, provided contradictory advice and orders to those given by the renal program nephrologists, which created confusion for the patient and health providers at the renal program.

[130] Essentially, according to Dr. Yeates, many of the standard of care failures were related to Dr. Kadri's refusal to follow the WRH established pathways for care resulting in urgent surgeries, patients who were ill prepared, and the initiation of dialysis by a team of nephrologists who had never previously been involved in the patient's care and who had limited information about the patient.

Dr. Cheung

[131] Dr. Cheung is a nephrologist with hospital privileges at the Peterborough Regional Health Centre. He has practised nephrology for over 20 years and is engaged in all aspects of nephrology care except acute transplantation care. In addition to his hospital privileges, Dr. Cheung practised nephrology in a community private clinic from 2002 to 2015, at which time the clinic closed. Since 2015, all his nephrology care has been hospital based.

[132] Dr. Cheung provided two reports in response to Dr. Yeates' reports. Dr. Cheung only reviewed the patients for whom Dr. Yeates had concluded that Dr. Kadri failed to meet the standard of practice. In his first report, dated May 7, 2021, Dr. Cheung provided an opinion as to whether any harm occurred and if so, whether it was because of Dr. Kadri's actions or clinical management. In his second report, dated February 16, 2022, Dr. Cheung provided an opinion in response to the same questions that Dr. Yeates had addressed: (1) Does Dr. Kadri's care expose or is likely to expose patients to harm or injury; (2) Did the care provided by Dr. Kadri meet the standard of practice of the profession; and, (3) Did Dr. Kadri's care display a lack of knowledge, skill or judgment.

[133] We have mainly considered Dr. Cheung's second report, in which he answered the same questions that Dr. Yeates answered. In the aggregate, Dr. Cheung reported

that he did not feel that Dr. Kadri's clinical care exposed or was likely to expose patients to harm or injury. He also did not believe that Dr. Kadri displayed a lack of knowledge or skill in any of the cases reviewed.

[134] In respect of whether Dr. Kadri displayed a lack of judgment and whether he met the standard of practice, Dr. Cheung's opinion was, in our view, more nuanced. He indicated that "from a clinical perspective" he did not believe that Dr. Kadri displayed a lack of judgment and believed that he was fit to continue to practise. He indicated that, "with regards to clinical management and decision making, I believe that Dr. Kadri met the standard of care of the profession in these cases." However, he also indicated that the practice of sending orders while under suspension was outside of standard practice:

> Dr. Kadri's practice of sending in orders for dialysis and requisitions for access placement while under suspension [patients DL, JQ, MH, RP and TL] was outside of standard practice, but in all cases his clinical decision was appropriate and his action effective at alerting the on-call nephrologist and the renal program to an urgent need for intervention. It seems to me that communication between Dr. Kadri and the renal program was so poor that this was the best way to convey crucial information and avoid further conflict. In all cases his plan was endorsed by the on-call nephrologist and in no case was there any documented effort to contact Dr. Kadri in return.

[135] In cross-examination at the hearing, Dr. Cheung agreed that sending orders to a hospital where one does not hold privileges would be viewed as an "offence." He agreed that instead of or in addition to sending orders, it would be in a patient's best interest for the physician to pick up the phone to have a nephrologist-to-nephrologist call, particularly in the case of an urgent referral for dialysis (as occurred with Patient DL).

[136] In respect of the non-referrals to the MCKC, in cross-examination, Dr. Cheung agreed that he had not been provided with the WRH pathways, policies and procedures. He indicated that his opinion was focused on Dr. Kadri's *clinical* care of patients. He agreed that the benefits of MCKC included access to various supports such as social work, dietician, body access coordination and education. He also agreed that effective coordination was necessary to provide safe patient care particularly since patients with advanced chronic kidney disease are frequent users of the health care system.

[137] Dr. Cheung also agreed at times that Dr. Kadri allowed patients to progress too far before making a referral. In respect of Patient CT, in his report he indicated that while "on the surface" it appeared that the patient was allowed to progress too far before access creation and referral, there were other factors to consider. These included the patient's deliberate delaying of the access surgery, the patient's non-disclosure of certain symptoms, and the fact that even when referred to the hospital dialysis team, the attending nephrologist did not find compelling indications to start hemodialysis emergently.

Dr. Hanson

[138] Dr. Hanson has practised nephrology for 16 years at the Peterborough Regional Health Centre. He also has associate professor status at Queen's medical school. Dr. Hanson's report is undated; he testified that his report was drafted in 2021. His report only addressed one patient, the deceased patient. He indicated that he was, "asked to assess the clinical care delivered by Dr. Kadri regarding [this patient]."

[139] Dr. Hanson's opinion was that there were no deficiencies in Dr. Kadri's care of the patient. He adequately followed him and when it became clear dialysis may become necessary, referred him for peritoneal dialysis catheter insertion, the patient's preferred modality of care. Dr. Hanson indicated that Dr. Kadri did not have access to the subsequent hospital-based lab work which indicated an abrupt progression of the patient's chronic kidney disease. The patient was then seen by another physician at the MCKC. Dr. Hanson felt that Dr. Kadri was not responsible for the patient's tragic outcome as he was not aware of the abrupt rise in his creatinine[1] level nor was he the assessing physician at the time of the patient's acute presentation.

[140] As with Dr. Cheung, in cross-examination, Dr. Hanson acceded that he was unaware of any hospital policies requiring nephrologists to refer patients who met MCKC criteria to that clinic or how patients who required peritoneal dialysis catheters should access these services.

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[1] A creatinine level is a measure of how well the kidneys are performing their job of filtering waste out of the blood.

Conclusion regarding the standard of practice

Faxing orders to the hospital

[141] Firstly, we note that both Dr. Yeates and Dr. Cheung agree that Dr. Kadri did not meet the standard of practice for a number of patients when he faxed orders to the hospital, at times on an urgent basis, at a hospital where he no longer held privileges. They both agreed that the standard of practice in these situations required that Dr. Kadri pick up the phone and talk to the on-call nephrologist to ensure that they were aware of the needed care.

[142] Dr. Cheung seemed to excuse this behaviour on the basis that communications between Dr. Kadri and the hospital-based nephrologists had become strained. In our view, a strained relationship does not change the standard of practice required for the professional and safe care of patients. Unless Dr. Kadri spoke with someone at the hospital, he had no way of knowing that orders he was faxing were received, reviewed by the appropriate person and being acted upon. Relying on the opinions of both Dr. Yeates and Dr. Cheung, we conclude that Dr. Kadri failed to meet the standard of practice in respect of Patients DL, JQ, MH, RP and TL.

Late or non-referral to the MCKC

[143] Another main theme of Dr. Yeates' reports was the late or non-referral of patients to the MCKC. She concluded that Dr. Kadri failed to meet the standard of care because patients were not introduced to the program and to the physicians and the allied health providers who would be involved in overseeing their care. Moreover, the physicians who would be caring for these patients were introduced to them late and with inadequate knowledge of their medical history or ongoing management to be able to provide optimal care.

[144] Dr. Cheung had a different view than Dr. Yeates in respect of the late or non-referrals to the MCKC. While he did not dispute that referrals were tardy or not done, he questioned the "superiority" of the MCKC. In his general comments at the outset of his report, he indicated that Dr. Kadri preferred to provide educational and multi-disciplinary care in his community nephrology clinic. Dr. Cheung wondered what problems or deficiencies in the hospital MCKC led Dr. Kadri to seek an alternate model of care. While Dr. Cheung acknowledged that hospital-based MCKC care for patients with chronic kidney disease is *presumed* to be the standard

care, he questioned whether this was true as community-based kidney care was not a model that had been adequately developed to make a comparison. He added:

> If the superiority of WRH's hospital-based MCKC over Dr. Kadri's community-based care cannot be proven beyond doubt, then one must challenge the primacy of MCKC referral.

[145] Firstly, we note that the standard of proof that applies in this proceeding is beyond Dr. Cheung's expertise. Additionally, as noted previously, the issue before us is not whether the WRH model of care was superior or inferior to another model. The question to be answered is whether Dr. Kadri failed to maintain the standard of practice of the profession in deliberately refusing to refer patients to the hospital-mandated MCKC pathway.

[146] We conclude that Dr. Kadri failed to meet the standard of practice of the profession by not referring patients or referring them late in their disease process to the MCKC particularly after he had lost his hospital privileges.

[147] For example, the late referrals to the MCKC included three patients (CT, VK and WB) who had apparently chosen home peritoneal dialysis but were not referred to the home therapies program via the MCKC. Dr. Cheung did not dispute that Dr. Kadri did not refer these patients to the MCKC in advance of referring them for access surgery. He indicated that it was Dr. Kadri's established practice to refer his patients to the peritoneal dialysis clinic after access had been secured.

[148] Dr. Yeates indicated that Dr. Kadri was not meeting the standard of practice when directly referring patients for peritoneal dialysis catheter insertion and bypassing the MCKC. In respect of Patient WB, she explained that assessments must take place *prior* to initiating peritoneal dialysis including a home assessment as to the suitability and needs of the patient in their home environment. The patient must also undergo training and have supplies and equipment ordered prior to initiating dialysis. Dr. Yeates indicated that in the case of WB, there was no documentation that this referral or these steps had taken place, which was concerning and could lead to sub-optimal initiation of peritoneal dialysis.

[149] In cross-examination, Dr. Cheung agreed that once a patient chooses peritoneal dialysis as a preferred modality, the patient must be followed by a home dialysis clinic to receive equipment and oversight from a nephrologist. He seemed to think,

however, that it was satisfactory for the referral to be done after rather than before access surgery. Yet, in the case of CT, he agreed that that on the surface, it appeared that the patient was allowed to progress too far before access creation and MCKC referral were made. After having been directly referred for peritoneal dialysis catheter placement (bypassing the hospital-mandated MCKC pathway prior to access surgery), the patient's bloodwork came to the attention of the renal program which alerted the on-call nephrologist, who then asked the patient to go to the emergency department. The patient required bridge hemodialysis and subsequently successfully started on peritoneal dialysis. Dr. Yeates again noted that peritoneal dialysis requires training the patient and another family member where possible. There was no documentation in Dr. Kadri's records of these discussions or plans including how the patient would receive his equipment and supplies.

[150] In respect of the late or non-referral to the MCKC, we prefer the opinion of Dr. Yeates who examined the standard of practice holistically rather than Dr. Cheung who agreed that his focus was on Dr. Kadri's clinical care of the patients. Dr. Cheung did not consider Dr. Kadri's care in the context of a renal program where patients by necessity required hospital-based programs and nephrologists. It makes sense to us than an earlier rather than late referral to the MCKC is necessary for the patient to become familiar with the treatment and treatment team and, for the treatment team to become familiar with the patient.

[151] We conclude that Dr. Kadri failed to meet the standard of practice of the profession in his late or non-referral to the MCKC in respect of Patients AD, CB, CT, DL, MH, VK, WB and DD.

The deceased patient

[152] We wish to address the case of the deceased patient, given the time and attention spent at the hearing on this particular patient who unfortunately died shortly after Dr. Kadri's hospital privileges were suspended.

[153] Dr. Kadri treated this patient in respect of his renal function from 2016 onwards. According to Dr. Yeates' interview with Dr. Kadri, the patient's first language was not English, and he had a significant language barrier. There is no dispute that Dr. Kadri's care was adequate until at least March 2018. It was at that time that the

patient's creatinine level significantly elevated. In Dr. Yeates' opinion, Dr. Kadri should have referred the patient to the MCKC in March 2018. Dr. Kadri, however, continued to treat the patient and in early May 2018, referred him for a peritoneal dialysis catheter insertion, bypassing the usual pathway through the MCKC and instead referring the patient directly to the vascular surgeon. The surgeon saw the patient in mid-May 2018 and booked him for surgery on June 20, 2018. On June 15, 2018, the patient had pre-operative bloodwork at the WRH, which showed a marked worsening in his renal function. The bloodwork had not been ordered by Dr. Kadri and Dr. Kadri was not informed of the results. It is not clear that any nephrologist saw this bloodwork.

[154] Despite not having been referred to the MCKC, the patient was seen at the MCKC on June 20, 2018, just before his surgery. There is no indication in the MCKC records of June 20, 2018, that the previous bloodwork records of June 15, 2018 were available or reviewed. The patient underwent the surgery and was again seen at the MCKC on June 22, 2018, with worsening symptoms. The MCKC nephrologist prescribed treatment and sent the patient home with follow-up in one to two months. On June 23, 2018, the patient suffered a cardiac arrest and subsequently died.

[155] Dr. Yeates provided the opinion that the events that took place prior to the patient's cardiac arrest appear to be related to his lack of prior referral to the MCKC such that when the MCKC nephrologist assessed the patient, they had limited information on the patient. Without this information, the attending nephrologist was unable to decide whether the patient required dialysis imminently. It was her opinion that the late referral to the MCKC and the renal care program led to a barrier in care that the renal program could provide to the patient due to the lack of patient records/information that were available to the physicians and health care team in the MCKC.

[156] Dr. Cheung's view was that the patient's two encounters at the MCKC in June 2018 could have possibly altered his course. In both instances the patient demonstrated concerning clinical signs and symptoms such that the treatment prescribed was unreasonable. He was of the view that it was unreasonable to think that the patient could be safely reviewed after an absence of one to two months. Given that the need for urgent dialysis was unrecognized on two MCKC visits, it was difficult to

accept Dr. Yeates' opinion that an earlier referral to MCKC would have changed the patient's outcome.

[157] Dr. Hanson's view was also that the patient's signs and symptoms at the MCKC suggested that urgent hemodialysis needed to be initiated. He testified that even if the MCKC did not have access to Dr. Kadri's previous patient notes, the decision to initiate dialysis in this patient did not hinge on his prior history given his creatinine level.

[158] In our view, there was at the very least a breakdown in communication since the bloodwork was not necessarily reviewed by the requisite physicians at the appropriate time. As with most communication breakdowns, a multitude of factors likely contributed to this patient's outcome. As expressed by all experts, given the vulnerabilities of these patients and their co-morbidities, it is important to have coordinated care. It is clear that Dr. Kadri did not follow the recognized pathway by not referring the patient to the MCKC earlier: in March 2018 when the patient met MCKC criteria. His medical history would then have been available to the attending MCKC health professionals as his condition took a turn for the worse. It is possible, as Dr. Kadri submitted, that other physicians made errors in respect of this patient and/or that the patient's outcome would have been the same with an earlier referral to the MCKC. Nevertheless, by not referring the patient to the MCKC in accordance with the hospital's renal program, Dr. Kadri deprived the patient of the coordinated care of the MCKC and in so doing failed to meet the standard of practice of the profession.

Undermining the patients' relationship with the hospital

[159] We are of the view that the evidence is insufficient to prove on a balance of probabilities that Dr. Kadri undermined the patients' relationship with the hospital by giving them advice that conflicted with the hospital nephrologist. The College relied on the case of Patient YZ.

[160] Patient YZ sought to reduce his dialysis from twice to once weekly. After Dr. Patel advised him not to do so, Patient YZ sought an opinion from Dr. Kadri who then suggested a trial of dialysis once weekly. While Dr. Patel had concerns about the once weekly dialysis, the patient eventually began a trial of once weekly dialysis. After the trial, the patient returned to his twice weekly dialysis schedule.

[161] In our view, it was open to this patient to seek a second opinion and to opt for once per week dialysis treatment despite medical advice from Dr. Patel to the contrary. The more problematic aspect in respect of this case, in our view, was for Dr. Kadri to order a trial of once per week dialysis without discussing this with the attending hospital nephrologist, Dr. Patel, given that at this time, Dr. Kadri no longer held hospital privileges.

[162] The College did not call any other evidence, such as direct patient evidence, to substantiate Dr. Kadri's undermining his patients' relationship with the hospital. We note, however, our previous conclusion that Dr. Kadri engaged in disgraceful, dishonourable or professional conduct in respect of his communications and advocacy with patients.

Conclusion regarding incompetence

[163] As noted earlier, to make a finding of incompetence under s. 52(1) of the Code, a panel must be satisfied that the member's professional care of a patient displayed a lack of knowledge, skill, or judgment of a nature or to an extent that demonstrates that the member is unfit to practise or that the member's practice should be restricted.

[164] There are no allegations that Dr. Kadri did not have the requisite knowledge or skill to care for his patients. Rather, this case centers on Dr. Kadri's judgment. We are of the view that Dr. Kadri displayed a lack of judgment in his professional care of patients by his persistent refusal to abide by hospital policies, to the detriment of his patients. Dr. Kadri showed no remorse for any of his actions during the hearing. On the contrary, at various times, he indicated that he was "proud" of his actions and that he wished that he had done more. In our view, Dr. Kadri's lack of judgment is of such an extent that at the very least, his practice should be restricted.

ICRC Orders

[165] The College submits that Dr. Kadri failed to comply with three aspects of the ICRC orders: he failed to provide the College with a signed OHIP consent form within the timelines set out in the orders, he failed to maintain and submit a patient log as set out in the orders, and he failed to transfer his patients' care in a timely and orderly manner.

[166]As noted in the background section, on July 29, 2020, the ICRC issued an order directing the College to impose terms, conditions and limitations on Dr. Kadri's certificate of registration pursuant to s. 25.4(1) of the Code. Further to Dr. Kadri's submissions on August 13, 2020, the ICRC issued a revised order, which amended some of the timelines found in the initial order.

[167]Under s. 1(1)1 of O. Reg. 856/93 under the *Medicine Act, 1991*, contravening a term, condition or limitation on the member's certificate of registration is an act of professional misconduct includes.

Patient transfers

[168]Some of the most significant provisions of the ICRC order of July 29, 2020, related to Dr. Kadri's care of patients at or at risk of developing end-stage renal disease. The order provided that Dr. Kadri not see patients who met any of the following criteria (the Criteria for Transfer):

a. Patients at a very high risk of developing end-stage renal disease, including but not limited to patients who have received a blood test result showing an eGFR[2] of less than 30;

b. Patients who have been prescribed, or require the prescription of erythropoiesis-stimulating agents;

c. Patients undergoing dialysis;

d. Patients receiving pre-dialysis care from a Regional Renal Program.

[169]Dr. Kadri was required to complete a full transfer of care for the patients who met any of the Criteria for Transfer by referring these patients to the WRH regional renal program. Dr. Kadri was to complete the transfer of care within seven days of a patient first meeting the Criterial for Transfer or more quickly if clinically necessary. For patients who already met the Criteria for Transfer on the date of the order, Dr.

[2] The eGFR is the estimated glomerular filtration rate, an estimated number that measures kidney function based on a blood test. A low number suggests that the kidneys are not working well.

Kadri was to complete the transfer of care within 14 days of the date of the order or more quickly if clinically necessary.

[170] On August 7, 2020, Dr. Kadri wrote to Ms. Boddy to advise that it may be difficult if not impossible for him to meet the transfer timelines. He explained that he could not just refer the patients electronically without speaking to each patient as they deserved an individual explanation of what had prompted the situation. Additionally, he explained that the hospital required that he complete a hospital referral form that was extremely time consuming.

[171] On August 10, 2020, Dr. Kadri's then recently retained counsel, Ms. Stephenson, requested an extension of time for the patient transfer and asked that the ICRC revise the transfer criteria such that patients be transferred with an eGFR of less that 15 rather less than 30 as found in the order's transfer criteria. She explained that Dr. Kadri had advised that approximately 500 to 700 patients were impacted by the transfer selection criteria and that only four physicians would be able to receive these patients. She submitted that it would be impossible to transfer hundreds of patients to four receiving physicians by the order's timeline of August 13, 2020.

[172] On August 13, 2020, the ICRC issued a revised order, requiring that Dr. Kadri complete the transfer of care of the patients who already met the Criteria for Transfer by September 30, 2020. The order did not amend the Criteria for Transfer.

[173] Dr. Kadri sought judicial review of the ICRC orders. On August 26, 2020, Ms. Ainsworth, counsel for the College, advised that the College agreed on a without prejudice basis not to enforce the interim order of August 13, 2020, pending the judicial review application hearing given that it would likely be held during the week of September 14, 2020.

[174] The judicial review application was heard and denied on September 18, 2020. Ms. Boddy wrote to Dr. Kadri's counsel on September 18, 2020, to advise that Dr. Kadri must cease to practise until he had obtained a College-approved clinical supervisor (another requirement of the order). Dr. Kadri was also to comply with the other requirements of the order including making the appropriate referrals in a timely manner and maintaining a log of the patients who met the transfer criteria as well as the referral information.

[175] Since Dr. Kadri was unsuccessful in his judicial review application, the deadline of September 30, 2020, for the patient transfers remained. There is no dispute that Dr. Kadri did not transfer any patients until September 28, 2020. The vast majority of patients were transferred between September 28 and 30, 2020. A handful of patient transfers were received after September 30, 2020, some as late as October 16, 2020. Dr. Kadri acknowledged that a minority of patient transfers were *received* by the WRH after September 30, 2020, but testified that they were all sent by the deadline.

[176] Given the number of patient files involved, we do not find it surprising that a handful of patient files were mistakenly either not transferred or their transfers were not received by the WRH until after the deadline. The more significant issue, in our view, is that Dr. Kadri waited until September 28, 2020, to start the patient transfer when he knew as early as August 7 and August 10, 2020, that the order affected hundreds of patients who could not be transferred in a short period of time.

[177] Dr. Kadri provided several explanations for the delay in starting to transfer patients. Firstly, after receiving the first order, he obtained a revised ICRC order that extended the transfer timeline. He then sought judicial review of that order and testified that based on advice received from his lawyer, he believed that the judicial review would be successful. If successful, the order, including the patient transfer provisions, would not be enforceable. Dr. Kadri explained that it would be disruptive to patients to reverse a referral. As a result of the possible patient disruption, he waited for the results of the judicial review prior to beginning the transfer process.

[178] Dr. Kadri relied on the College counsel's letter of August 26, 2020, that the terms of the order would not be enforced until after the judicial review disposition, in support of his argument that he could wait until after the judicial review to comply with the order.

[179] Dr. Kadri testified that he complied with the order as soon as he found out that the judicial review was unsuccessful. He said that he spent every hour of every day complying with the order. He explained that he dedicated one staff member to this task. He also testified that his office had only one fax machine, which was used to send 599 referrals - some with hundreds or thousands of pages. While he did not dispute that his office did not start faxing referrals until September 28, 2020, he

testified that the work preparing these fax referrals began before September 28, 2020.

[180]While Dr. Kadri believed the best way of referring patients was to have an in-person meeting with them first, he testified that the time frames did not allow for such.

[181]Mr. Foster testified about the disruptive way in which Dr. Kadri referred his patients to the WRH renal program. He testified that “overwhelming” information arrived in a short time frame. As a result, he created a spreadsheet including the name of 591 patients, to help organize the information. The date of referral from Dr. Kadri for the most part covers the period from September 28 to October 5, 2020. Mr. Foster indicated that the renal team had to organize urgent clinics to set up patient appointments.

[182]Mr. Foster testified that none of the patients that the WRH renal clinic contacted were aware of what was transpiring. They were hearing of the transfer of care for the first time during the WRH’s renal team’s phone calls. Mr. Foster described the patients as stressed and confused. As a result, some opted not to book an appointment or failed to attend their booked appointment.

[183]Mr. Foster described this period as one of the most disruptive in the renal program’s history. He testified that the hospital had asked Dr. Kadri through his counsel in advance of the transfer date to collaborate and cooperate to effectively transfer the patients’ care. The hospital never received a response until the transfer deadline had passed, and it was unaware of the number of patients being transferred. Mr. Foster testified that the hospital had to redeploy staff amid the COVID-19 pandemic to help organize the information, ensure that no patient was missed, contact the patients, and book them for appointments within two months. The biggest impact was on the patients, because of the confusion and distress, and at times, the delays in their care.

[184]As noted earlier, there was also testimony from two substitute decision-makers that they were not advised of the circumstances leading to the patient transfer; on the contrary they were given misleading information that Dr. Kadri would never abandon his patients.

OHIP consent

[185] The ICRC order of July 29, 2020, required that Dr. Kadri provide his irrevocable consent for the College to make inquiries of OHIP to monitor his compliance with the order's terms. The order attached the required consent form, which stipulated that Dr. Kadri consent to the release of billing information by OHIP to the College for the time period of 2020 onward. Dr. Kadri was to provide his signed consent within 14 days of the order.

[186] The revised ICRC order of August 13, 2020, stated that Dr. Kadri was to provide the College with the signed OHIP form by August 14, 2020. In other words, the revised ICRC order essentially maintained the 14-day deadline from the time of the initial order.

[187] There is no factual dispute that despite multiple requests made by Ms. Boddy, Dr. Kadri only provided the College with the required OHIP consent form on February 8, 2021, just less than six months after the ICRC-imposed deadline.

[188] Ms. Stephenson, the lawyer then representing Dr. Kadri in respect of his compliance with the ICRC order, wrote to the College on September 30, 2020, about the OHIP consent form. She asked that since Dr. Kadri had ceased practising, he be permitted to provide a direction to the Ministry of Health directing it to suspend his billing number rather than provide the signed OHIP consent form. Alternatively, she submitted that the consent form was overly broad and should be limited to only permit access to billing information as of September 18, 2020, the date of the unsuccessful judicial review decision of the ICRC order and only for the purposes of monitoring Dr. Kadri's compliance with the order.

[189] Ms. Boddy replied on September 30, 2020, and stated that the consent from must be the one included in the ICRC order. She further explained that the form provided for OHIP monitoring of Dr. Kadri's compliance with all aspects of the order, not only that relating to the cease to practise as a result of not having a clinical supervisor.

[190] On September 30, 2020, Dr. Kadri, through his counsel, provided the College with a signed OHIP consent form but modified the consent to state that it was only for the specific purposes of monitoring compliance with the interim order and only for the period commencing September 18, 2020. Ms. Boddy responded on October 1,

2020, that Dr. Kadri's consent was not acceptable. She again explained that the data from 2020 onwards could be used to monitor Dr. Kadri's compliance with the terms that were in effect after July 31, 2020.

[191] Having still not received the OHIP consent form, on October 8, 2020, Ms. Ainsworth wrote to Dr. Kadri's counsel regarding the OHIP order. She explained that OHIP data pre-dating the order is one of the tools used to select charts in spot-checking the required patient transfers. She again asserted the expectation that Dr. Kadri provide the signed consent form as required by the ICRC order. Ms. Stephenson replied on October 8, 2020, thanking her for the explanation and advising that she would send the explanation to Dr. Kadri. On October 9, 2020, Ms. Stephenson wrote to advise that she hoped to forward the consent to the College shortly. Despite Ms. Boddy's further requests for the signed OHIP consent and indications that Ms. Stephenson was following up with Dr. Kadri regarding the signed OHIP consent form, Dr. Kadri did not return the required OHIP consent form to the College until February 2021.

Log

[192] The ICRC order of July 29, 2020, required that Dr. Kadri maintain a log in the form set out in the order with specified information regarding patients who met any of the transfer criteria:

a. The name of every patient who met any of the Criteria for Transfer;

b. The patient's date of birth, OHIP number and chart number;

c. The specific Criteria for Transfer fulfilled by the patient;

d. The date on which the patient first fulfilled one of the Criteria for Transfer;

e. The patient's most recent eGFR and the date of that result;

f. The name of the physician and/or Regional Renal program to which the patient has been referred;

g. The date of the referral.

[193] The order also required that Dr. Kadri cooperate with College representatives for the purpose of monitoring his compliance with the order, including providing the College with any requested documentation within specified guidelines. The revised ICRC order of August 13, 2020, made no changes to the log.

[194] On July 31, 2020, Ms. Boddy sent Dr. Kadri the ICRC order and advised that he should start preparing the log of patients currently meeting any of the transfer criteria. On August 7, 2020, she requested submission of the log by August 13, 2020. She made multiple repeated requests for the log, which went unanswered.

[195] Dr. Kadri first provided a log on September 30, 2020. However, the information in the log was incomplete. The log did not include the date on which the patient first met one of the Criteria for Transfer. Dr. Kadri provided the missing information in another log on October 14, 2020. The College compared the information found in Dr. Kadri's log with information obtained from the WRH. After noting some inaccuracies, Dr. Kadri provided an updated log on October 19, 2020.

Conclusion regarding the ICRC order

[196] In our view, Dr. Kadri failed to comply with the ICRC order by failing to provide the College with the required OHIP consent in a timely manner, by failing to maintain and provide the College with a patient log in a timely manner, and by effecting the patient transfers in the most disorderly way possible. In so doing, he contravened a term, condition or limitation on his certificate of registration, which is an act of professional misconduct.

[197] While Dr. Kadri may initially have had some honestly held concerns about the scope of the OHIP consent, it was clear by at least October 8, 2020, when Ms. Ainsworth explained the purposes of the requirement that the College expected Dr. Kadri to submit an OHIP consent in the form prescribed by the order. Dr. Kadri then waited another four months before sending the completed consent form to the College in February 2021.

[198] While the patient transfer timelines were extended in the ICRC revised order, no changes were made to the log. The initial order required that Dr. Kadri cooperate with the College, including providing the College with any requested documentation within specified guidelines. Ms. Boddy first requested submission of the log by

August 13, 2020, before the College agreed on August 26, 2020, to temporarily not enforce the order pending the outcome of the judicial review. Dr. Kadri should have submitted a log to Ms. Boddy in accordance with her request well before August 26, 2020. Furthermore, even when he submitted a log on September 30, 2020, it was incomplete. As became clear with the patient transfers, the log was important to ensure that the WRH renal program was receiving all the patients found in the log. Had Dr. Kadri submitted the log as requested, these comparisons could have been made earlier than the deadline for the patient transfer.

[199] Finally, after having asked the College for more time to complete the patient transfers because he could not just refer the patients without speaking to each one individually, Dr. Kadri did precisely that. He transferred the patients by fax without any communication to them (either in person, by phone or in writing) about the transfer. Furthermore, he waited until September 28, 2020, to start faxing thousands of pages to the WRH despite the deadline of September 30, 2020. Even if Dr. Kadri wanted to wait until the outcome of the judicial review prior to sending the patient transfers, he should have been preparing the documentation well in advance given the hundreds of patients involved. Furthermore, it was completely unreasonable for him to begin faxing the patient transfers on September 28, 2020, when his office only had one fax machine. We can only conclude that at this stage, Dr. Kadri was not trying to do what was in his patients' best interests but was purposefully trying to thwart the ICRC order in making the patient transfers as late and disorderly as possible. Ultimately, not all the patients were transferred by the deadline.

[200] As discussed in *College of Physicians and Surgeons of Ontario v. Botros*, 2015 ONCPSD 16, the public and members of the profession have a right to expect that members will abide by any orders that are made by the ICRC (p. 15).

CONCLUSION SUMMARY

[201] In summary, we conclude that the College has proven the allegations against Dr. Kadri on a balance of probabilities.

[202] Dr. Kadri engaged in disgraceful, dishonourable or unprofessional conduct: (a) in his disruptive conduct with WRH staff and administrators regarding his persistent refusal to comply with the WRH model of care; (b) in his communications and

advocacy with patients; (c) in his billing of the CDTF contrary to the model of care; and, (d) in his inappropriate recruitment and misleading of Dr. Amin.

[203] Dr. Kadri failed to meet the standard of practice of the profession by continuing to fax orders (at times on an urgent basis) to a hospital where he no longer held privileges instead of directly speaking to the on-call nephrologists and by his late or non-referral of his patients to the MCKC contrary to the model of care and to the detriment of his patients.

[204] Dr. Kadri is incompetent because he displayed a lack of judgment in his professional care of patients and continues to view his actions as defensible.

[205] Dr. Kadri failed to comply with ICRC orders by not providing the College with the required OHIP consent form in a timely manner, by not maintaining and providing the College with a patient log in a timely manner, and by effecting patient transfers late and in a disorderly way.

[206] In response to a new model of care and hospital policies and procedures introduced to implement that model, Dr. Kadri engaged in a campaign of disgraceful, dishonourable or unprofessional behaviour whereby he deliberately refused to follow the model of care. When the ICRC imposed terms, conditions, and limitations on his certificate of registration, Dr. Kadri's response was again to refuse to follow some of its terms. Dr. Kadri's deliberate circumvention of the model of care detrimentally affected the care he provided to his patients. Dr. Kadri's poor judgment in respect of patient care and continuing failure to recognize he did anything wrong resulted in our finding that he is incompetent.

[207] Even if Dr. Kadri held an honest belief that the new model of care was worse than other alternatives, it was inappropriate for him to engage in a campaign of disruption regarding care that was being provided to a vulnerable patient population. It is not an acceptable defence to the allegations to assert that his way was the better way. In this respect, we quote and adopt the Divisional Court's comments in its dismissal of Dr. Kadri's appeal of the HPARB decision:

> The system of providing health care is an integrated one, where the hospital, its staff and doctors work together to provide a high quality and hopefully efficient and economically feasible level of care. If a doctor is unable to or unwilling to work with

> and respect the policies and program properly approved and implemented by the hospital the choice is not to undermine the service being offered. It is to find another way or place to practice. (para. 132)

[208]A penalty hearing will be scheduled.

OPSDT Ontario Physicians and Surgeons Discipline Tribunal TDMCO Tribunal de discipline des médecins et chirurgiens de l'Ontario

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Kadri,* 2023 ONPSDT 15
Date: July 13, 2023
Tribunal File No.: 21-010

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Albert Kadri

PENALTY REASONS

Heard: June 7, 2023, by videoconference

Panel:

Ms. Sophie Martel (chair)
Dr. Stephen Hucker
Mr. Shahab Khan
Dr. Roy Kirkpatrick
Ms. Linda Robbins

Appearances:

Ms. Amy Block, for the College
Dr. Albert Kadri, self-represented

RESTRICTION ON PUBLICATION

The Tribunal ordered, under ss. 45-47 of the Health Professions Procedural Code, that no one may publish or broadcast the names or any information that would identify patients referred to during the Tribunal hearing or in any documents filed with the Tribunal. There may be significant fines for breaching this order.

Introduction

[1] In *College of Physicians and Surgeons of Ontario v. Kadri*, 2023 ONPSDT 10, we found that Dr. Kadri committed professional misconduct and that he was incompetent. The allegations originated in Dr. Kadri's objections to changes the Windsor Regional Hospital (WRH) made to the model of care for its renal program and in his failure to comply with orders made by the Inquiries, Complaints and Reports Committee (ICRC).

[2] Dr. Kadri continues to view his actions as defensible on the basis that the new model of care was unsafe. Even if he honestly holds this belief, it was inappropriate for him to engage in a campaign of disruption regarding care that was being provided to a vulnerable patient population. There is no evidence that remediation is possible or that Dr. Kadri will not engage in the same disruptive behaviour despite our conclusions that his conduct affected patients in a negative way. Given the extent of the misconduct and the absence of any possibility of remediation, the appropriate penalty is revocation of Dr. Kadri's certificate of registration and a reprimand.

[3] We order Dr. Kadri to pay the College $250,510 in costs, calculated under the Tariff in the Tribunal's Rules of Procedure.

The Parties' Positions

[4] Neither party presented additional evidence at the penalty hearing. The parties agreed to stipulate that Dr. Kadri's certificate of registration expired on August 9, 2022, because he did not renew it.

[5] The College's position is that Dr. Kadri's certificate of registration should be revoked. It submits that the misconduct was widespread, far reaching, egregious and touched every aspect of Dr. Kadri's role as a physician. He persisted in a campaign of disruption rooted in his intractable belief that he did not have to follow the rules. He did as he pleased without any regard to the consequences to patients. According to the College, the incompetence finding together with the other misconduct, including the multiple contraventions of the ICRC orders, warrant revocation.

[6] Dr. Kadri did not present an alternative penalty. He argued instead that we should defer ordering a penalty until we know the outcome of a "whistleblower complaint," which he allegedly filed with the Auditor General regarding several aspects of the model of care and why it was implemented. He is of the view that a full investigation and public inquiry into the model of care is necessary prior to considering an appropriate penalty in this case.

[7] Dr. Kadri argued that none of the previous cases the College submitted are analogous to this case because none have "system" issues at play. In essence, as with his position at the hearing regarding the allegations, Dr. Kadri's submission is that his actions are defensible because he was "standing up" for renal patients.

Penalty Principles

[8] Dr. Kadri's certificate of registration expired on August 9, 2022, because he did not renew it. As a result, he is not presently a member of the College. Notwithstanding his expired status, the College and the Tribunal continue to have jurisdiction over Dr. Kadri for all stages of the disciplinary process including penalty. See s. 14 of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, SO 1991, c. 18 (Code) and *College of Nurses of Ontario v. Dumchin*, 2016 ONSC 626.

[9] The most important goal of a penalty order is the protection of the public. Protection of the public has two components. The public must be protected from further misconduct by the physician and the public must have confidence in the ability of the College, and the Tribunal, to govern the profession effectively and maintain public trust. Other penalty purposes include specific and general deterrence and rehabilitation where a safe return to practice is appropriate.

[10] Given the overriding consideration of protecting the public, the Tribunal is not required to consider the least restrictive penalty. The most serious penalty of revocation is not reserved for the most serious misconduct by the most serious offender. See *College of Physicians and Surgeons of Ontario v. McIntyre*, 2017 ONSC 116 at paras. 45-53.

[11] The Tribunal recently summarized the factors to consider when deciding penalty: the seriousness of the misconduct, the physician's discipline history, the physician's

actions since the misconduct, and the physician's personal circumstances. See *College of Physicians and Surgeons of Ontario v. Fagbemigun*, 2022 ONPSDT 22 at paras. 12-18; aff'd *Fagbemigun v. College of Physicians and Surgeons of Ontario*, 2023 ONSC 2642.

[12] The seriousness of the misconduct is usually the most significant factor to consider. The Tribunal will examine what the physician did, the physician's motivation, the number of times the misconduct happened, how long it lasted and the effects or potential effects of the misconduct on others. See *Fagbemigun* at para. 13.

Application to this Case

The Seriousness of the Misconduct

[13] The misconduct in this case was serious, multi-faceted, occurred on many different occasions, and lasted several years. It was also deliberate rather than based on ignorance. Furthermore, the misconduct affected patients with end-stage renal disease who are vulnerable patients with co-morbidities.

[14] Dr. Kadri engaged in disgraceful, dishonourable or unprofessional conduct in multiple ways: in his disruptive conduct with WRH staff and administrators regarding his persistent refusal to comply with the model of care, in his misleading patient communications while he was still practising and after he ceased practising, in his billing of a team fee to the Ontario Health Insurance Plan where he in effect stole from his colleagues, and in his recruitment and misleading of a junior physician whom Dr. Kadri used as a pawn in his battle with the WRH.

[15] Dr. Kadri was also found to have failed to meet the standard of practice of the profession by faxing orders (at times on an urgent basis) to a hospital where he no longer held privileges instead of directly speaking to the on-call nephrologist and by the late or non-referral of his patients to the multi-care kidney clinic (MCKC). Dr. Kadri deprived his patients of the coordinated care of the MCKC. As set out in Dr. Yeates' expert opinion, Dr. Kadri's refusal to follow the WRH-established pathways for care, which included referral to the MCKC, resulted in urgent surgeries, patients who were ill-prepared, and the initiation of dialysis by a team of nephrologists who had never previously been involved in the patients' care and who had limited information about the patients.

[16] Dr. Kadri displayed a lack of judgment in his professional care of patients by his persistent refusal to abide by hospital policies to his patients' detriment. He showed no remorse for any of his actions during the hearing. Dr. Kadri's lack of judgment led to our finding of incompetence.

[17] Dr. Kadri not only failed to abide by hospital policies, but he also then failed to comply with ICRC orders. Most significantly, after being mandated to transfer the care of his patients, he effected the patient transfers in the most disorderly way possible. He left the transfers to the last minute such that some patients were not transferred within the required timeline and he did not advise his patients of the transfers; instead, on some occasions he gave his patients and their families misleading information. Ultimately, the late and disorganized patient transfer resulted in patient confusion, distress, and delays in their care.

[18] Dr. Kadri's failure to comply with the terms of the ICRC order is a very serious matter. An order of this nature is put in place to protect the public and must be honoured. Dr. Kadri's failure to do so demonstrates disrespect for the authority of his governing body, undermines the College's authority, and compromises the College's ability to fulfill its primary mandate, the protection of the public. See *College of Physicians and Surgeons of Ontario v. Mossanen*, 2018 ONCPSD 54.

Discipline History

[19] There is no prior discipline history.

Physician's Actions since the Misconduct or Personal Circumstances

[20] Dr. Kadri did not present any evidence of any mitigating factors relating to his personal circumstances or his actions since the misconduct. There is no evidence or submission that he accepts that the way in which he acted constitutes professional misconduct and incompetence. Dr. Kadri is of the view that future investigations and inquiries could ultimately demonstrate that his actions are defensible.

Revocation and Reprimand

[21] We are of the view that the only penalty that will protect the public is revocation.

[22] It was open to Dr. Kadri to defend the allegations and his decision to do so cannot be viewed as an aggravating factor. His lack of insight, however, must be taken into account when considering whether rehabilitation is likely. See *College of Physicians and Surgeons of Ontario v. Wales,* 2017 ONCPSD 37 and *Kamermans, R.J. (Re)*, 2014 CanLII 99715 (ON PSDT), aff'd *Kamermans v. The College of Physicians and Surgeons*, 2018 ONSC 529 (unreported).

[23] Dr. Kadri is entrenched in his belief of the propriety of his actions. He has no insight into how his actions impacted not only his patients but also his nephrology colleagues, hospital staff, and a young physician who considered him his mentor. Dr. Kadri did not present any evidence that he would make changes or would abide by terms, conditions or limitations on his certificate of registration. On the contrary, he has already shown that he is not prepared to abide by terms, conditions or limitations, as evidenced in his failure to comply with the ICRC orders. If a physician has no insight into his deficiencies and is not willing to change, remediation is not possible. See *College of Physicians and Surgeons of Ontario v. Hill,* 2017 ONCPSD 21; aff'd *Hill v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 5833. In such cases, nothing short of revocation will protect the public.

[24] Considering the seriousness of the misconduct and the absence of any insight that could serve as the foundation for remediation, we order the revocation of Dr. Kadri's certificate of registration.

[25] We also order a reprimand, which will express our denunciation of Dr. Kadri's actions. Given the seriousness of the misconduct and our finding that Dr. Kadri was incompetent, we have decided not to depart from the common practice of ordering a reprimand. The public nature of the reprimand will assist in general deterrence and promote public confidence in the integrity of the profession and the College's ability to regulate in the public interest.

Costs

[26] The College asks for a costs order of $250,510. The costs represent one full day and one half day to orally argue two motions (*College of Physicians and Surgeons of Ontario v. Kadri*, 2022 ONPSDT 30 and *College of Physicians and Surgeons of Ontario v. Kadri,* 2022 ONPSDT 17), 21 full days and one half day for the merits

hearing,[1] and one full day for the penalty hearing. The Tariff is $10,370 for a full day of hearing and $6,000 for a half day hearing. We agree that $250,510 is the proper costs order in accordance with the Tariff.

Order

[27] We order:

a. The Registrar to revoke Dr. Kadri's certificate of registration effective immediately.

b. Dr. Kadri to appear before the panel to be reprimanded.

c. Dr. Kadri to pay the College costs of $250,510 within 30 days of the date of this order.

[1] The hearing was held over the course of 22 days but one half day of hearing was lost for Tribunal-related reasons.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Tribunal File No.: 21-010

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Albert Kadri

The Tribunal delivered the following Reprimand by videoconference on Monday, October 30, 2023.

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

Dr. Kadri – This panel found that you committed professional misconduct and that you were incompetent.

We found that you engaged in disgraceful, dishonorable or unprofessional conduct. These findings arose as a result of disruptive conduct in which you engaged with staff and administration at Windsor Regional Hospital, as a result of inappropriate billing, as a result of inappropriate and misleading recruitment of a junior colleague, and as a result of communication issues with your patients.

We found that you failed to meet the standard of practice of the profession and that you were incompetent because of a lack of judgement in the professional care of your patients. We found that you failed to comply with orders from the ICRC.

You defended your actions based on your concerns with respect to the “model of care” for renal patients at Windsor Regional Hospital. While physicians have a responsibility to advocate on behalf of their patients to advance policies that promote the health and well-being of the public, they must do so professionally. Behaving professionally requires adhering to values such as integrity, honesty, altruism and humility. You did not demonstrate these values in your advocacy against the model of care. On the contrary, you aggressively attempted to undermine the model of care and the Inquiries, Complaints and Reports Committee orders to the detriment of your patients.

As stated by the Divisional court in dismissing your appeal of a previous ruling against you, you failed to work within an integrated health care system:

> “The system of providing health care is an integrated one, where the hospital, its staff and doctors work together to provide a high quality and hopefully efficient and economically feasible level of care. If a doctor is unable or unwilling to work with and respect policies and programs properly approved and implemented by the hospital the choice is not to undermine the service being offered. It is to find another way or place to practice.”

Dr. Kadri – You refused to abide by these principles and you refused to act professionally with the hospital, your colleagues and the College. The multi-faceted serious misconduct and the absence of insight that could serve as the foundation for remediation have resulted in the revocation of your license to practice in the Province of Ontario.