

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Rajesh Mohan, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names of patients or any information that could disclose the names of patients referred to orally or in the exhibits filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the “Code”), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

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

- (a) in the case of an individual to a fine of not more than \$25,000 for a first offence and not more than \$50,000 for a second or subsequent offence; or
- (b) in the case of a corporation to a fine of not more than \$50,000 for a first offence and not more than \$200,000 for a second or subsequent offence.

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v.
Mohan, 2015 ONCPSD 37**

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

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the *Regulated Health Professions Act, 1991*,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. RAJESH MOHAN

PANEL MEMBERS:

**DR. P. GARFINKEL (CHAIR)
S. BERI
DR. M. DAVIE
P. PIELSTICKER
DR. R. MACKENZIE**

Hearing Date:	September 22, 2015
Decision Date:	September 22, 2015
Release of Written Reasons:	October 13, 2015

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the “Committee”) of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on September 22, 2015. At the conclusion of the hearing, the Committee stated its finding that the member committed an act of professional misconduct and delivered its penalty and costs order with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Mohan committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* (“O. Reg. 856/93”), in that he has failed to maintain the standard of practice of the profession; and
2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO THE ALLEGATIONS

Dr. Mohan admitted the allegations in the Notice of Hearing that he has failed to maintain the standard of practice of the profession; and that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

THE FACTS

The following facts were set out in an Agreed Statement of Facts and Admission that was filed as an exhibit and presented to the Committee:

1. Dr. Rajesh Mohan (“Dr. Mohan”) is a family physician who practises medicine in Etobicoke, Ontario at the Islington Medical Centre & Travel Clinic. He obtained his certificate of registration authorizing independent practice in 1986. His general practice includes family practice patients, walk-in patients, and travel clinic patients.
2. In February 2010, the College received information from a patient that she and her family had attended at Dr. Mohan’s clinic for travel medicine services, including hepatitis shots, where they had been seen by a man whom they believed to be a physician. On returning home, they viewed Dr. Mohan’s website and realized that although they had received a prescription signed by “Dr. R. Mohan,” the man whom they had seen was not Dr. Mohan. They later spoke to Dr. Mohan and he explained that the man they had seen was not “licensed” to practise medicine in Ontario and had signed Dr. Mohan’s name on the prescription.
3. As a result, the College began an investigation under section 75(1)(a) of the Health Professions Procedural Code into Dr. Mohan’s practice. When Dr. Mohan was made aware of the investigation in December 2010, he ceased to employ physician assistants in his general practice, and cooperated with the investigation.
4. The investigation showed that Dr. Mohan had employed two assistants in his general practice, Yaseen Ali Saiyed and Mitra Samiee.
5. Mr. Saiyed’s resume described him as being a medical doctor in Kyrgyzstan. He is not certified to practise medicine in Ontario. He worked as an assistant in Dr. Mohan’s clinic from October 2008 until Dr. Mohan learned of the College’s concerns. When Mr. Saiyed began working for Dr. Mohan, he job shadowed Dr. Mohan on a full-time basis for a period of time, during which Dr. Mohan did introduce him to patients as a foreign medical graduate and sought patient consent to have Mr. Saiyed treat them. There was no written employment contract between them and there were no written medical directives in place. After the period of job shadowing, Mr. Saiyed saw walk-in patients and travel clinic patients for Dr. Mohan. Any patients who were seen in the evenings were seen by Mr. Saiyed instead of Dr. Mohan. Dr. Mohan would be available by telephone to Mr. Saiyed. Mr. Saiyed

would provide the charts of patients whom he had seen to Dr. Mohan for review.

Mr. Saiyed's duties included taking patient histories, doing assessments, conducting physical examinations, and writing prescriptions. Dr. Mohan advised Mr. Saiyed that he could write prescriptions if he wrote 'for Dr. Mohan' on the prescription, but Mr. Saiyed failed to do so on at least one occasion, instead simply signing Dr. Mohan's name. Mr. Saiyed also requisitioned tests for patients.

6. Ms. Samiee described herself as an international medical graduate from Iran. She is not certified to practise medicine in Ontario. Ms. Samiee worked as an assistant in Dr. Mohan's clinic from July to December 2008. For the first three to four months of this time period, Ms. Samiee was observed by Dr. Mohan in providing care to patients, but for the last approximately three months, she saw patients on her own. During that time period, Dr. Mohan would be available to Ms. Samiee for consultation. Dr. Mohan advises that he reviewed patient charts and the care provided. On occasion, Dr. Mohan was not present at the clinic while Ms. Samiee saw patients and would only be available by cell phone. When Ms. Samiee saw patients while under observation by Dr. Mohan, Dr. Mohan would seek patient consent to have her treat them, but would introduce her to the patient as "Dr. Samiee." It was contrary to section 33 of the Regulated Health Professions Act to use the title 'doctor' in referring to Ms. Samiee, as she is not permitted to use this title in the course of providing or offering to provide health care. Ms. Samiee provided travel medicine services for patients by appointment, taking the patient's history, determining what vaccinations were required, writing prescriptions for vaccinations which she signed 'for Dr. Mohan,' and providing the vaccinations. Ms. Samiee also reviewed incoming lab reports and arranged follow-up, and conducted physical examinations on patients, including Pap tests. Ms. Samiee requisitioned tests for patients under Dr. Mohan's name. Ms. Samiee reported to Dr. Mohan on any concerns that she formed regarding a patient's presentation or care.
7. When asked by the College, some patients who had been treated by Mr. Saiyed advised that they were unaware that he was not a physician, while some patients confirmed that they had been advised of this information.

8. Delegation of care is permissible under College policy, if certain criteria are met and appropriate procedures are followed. However, Dr. Mohan failed to familiarize himself with his professional obligations in regard to delegation and supervision of patient care and other issues arising from his employment of assistants. Appropriate delegation requires a number of safeguards, including the establishment of a physician-patient relationship, the existence of a medical directive or direct order, appropriate evaluation of the delegate, informed patient consent, and quality assurance steps, including appropriate supervision.
9. Dr. Mohan screened applicants for assistant positions, provided a period of job shadowing, and subsequently reviewed care provided by his assistants after the fact. However, his supervision, delegation and ongoing quality assurance were inadequate.
10. The following deficiencies in Dr. Mohan's use of physician assistants were identified:
 - (a) Dr. Mohan delegated controlled acts in the absence of written medical directives or direct orders, and in fact did not have written medical directives in his office;
 - (b) Dr. Mohan inappropriately had his physician assistants provide care while he was out of the office, including during a period of time while he was on holiday, without ensuring that another physician was on the premises and would supervise them;
 - (c) Dr. Mohan did not ensure that there was a prior physician-patient relationship between himself and any patient seen by his physician assistants;
 - (d) Dr. Mohan did not adequately ensure that there was informed patient consent to care being provided by physician assistants in all cases;
 - (e) When introducing patients to his physician assistants, Dr. Mohan did not adequately ensure that patients were aware in all cases that physician assistants were not certified to practise medicine in Ontario;

- (f) Dr. Mohan did not adequately ensure that his physician assistants and office staff introduced the physician assistants appropriately to patients when he was not present;
 - (g) Dr. Mohan inappropriately permitted his physician assistants to write prescriptions and test requisitions; and
 - (h) Dr. Mohan inappropriately billed the Ontario Health Insurance Plan for services provided by his assistants in circumstances where it was not permitted for him to do so.
11. The College retained Dr. X, a family physician, to provide an expert opinion regarding Dr. Mohan's practice. As Dr. X opined, Dr. Mohan failed to meet the standard of practice of the profession with respect to delegation of controlled acts and appropriate supervision of his staff. Dr. Mohan also failed to maintain the standard of practice of the profession with respect to his medical record-keeping. His patient charts failed to indicate the care-provider where care was provided by an assistant, and there was inadequate documentation of follow-up management plans. In two cases the deficiencies in medical record-keeping resulted in patients' abnormal test results being missed.
12. After allegations against Dr. Mohan were referred to discipline, Dr. Mohan retained an expert, Dr. Y, a family physician. Dr. Y reviewed updated charts for some of the patients whose care had been reviewed by Dr. X. Dr. Y noted that since Dr. Mohan had moved to an electronic medical record-keeping system in 2013 there had been improvements, including in follow-up on test results and significant improvement in record-keeping. Dr. Y noted that in two cases Dr. Mohan should have monitored diabetes more closely and that there was overuse of broad templates, but overall opined that Dr. Mohan now met the standard of practice.
13. In his response to the College during the investigation, Dr. Mohan acknowledged that he did not properly delegate responsibilities to his assistants.

14. Dr. Mohan has been subject to an Order of the Inquiries, Complaints and Reports Committee since February 20, 2015, which has been effective on an interim basis pending the disposition of the allegations against him. It is attached at Schedule [1 to the Agreed Statement of Facts]. Among other things, Dr. Mohan's general practice has been under clinical supervision. The clinical supervisor has recommended some improvements, for example to the management of diabetic patients and to record-keeping. The clinical supervisor has also identified patient charts in which he found care to be well-documented, appropriate investigations ordered, and appropriate referrals made.

ADMISSION

15. Dr. Mohan agrees to the facts in paragraphs 1 to 14 above, and admits that they show that:
- (a) he failed to maintain the standard of practice of the profession under paragraph 1(1)(2) of Ontario Regulation 856/93 made under the Medicine Act, 1991, and has thereby committed an act or acts of professional misconduct under paragraph 1(1)33 of Ontario Regulation 856/93 made under the Medicine Act, 1991; and
 - (b) he engaged in disgraceful, dishonourable or unprofessional conduct and has thereby committed an act or acts of professional misconduct under paragraph 1(1)33 of Ontario Regulation 856/93 made under the Medicine Act, 1991.

FINDINGS

The Committee accepted as true all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Mohan's admission and found that he committed an act of professional misconduct in that he has failed to maintain the standard of practice of the profession and in that he has engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty and costs order.

A penalty must take into consideration the specifics of the misconduct and the circumstances of the case. The law is clear that when a joint submission is made the Committee should accept it unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

The proposed penalty, which the Committee accepts, includes a reprimand, a three month suspension, and terms, conditions and limitations on Dr. Mohan's certificate of registration. The public reprimand will serve to denounce Dr. Mohan's misconduct and express the Committee's strong disapproval of his actions. It will send a clear message to Dr. Mohan and the membership at large that, through the inappropriate delegation of controlled health acts, Dr. Mohan put his patients' health at risk and specifically, in this case, by being unaware of abnormal laboratory results. In addition, by allowing new patients to be seen and examined by unlicensed individuals in his absence, Dr. Mohan undermined the vital trust of the public that is at the very core of the doctor-patient relationship.

A three month suspension of Dr. Mohan's certificate of registration will serve as a specific deterrence for Dr. Mohan against recurrence of such unacceptable professional misconduct, as well as a general deterrence to the membership. The Committee was disappointed that Dr. Mohan delegated to practitioners that he knew were not licensed physicians and that he did so without the informed consent of his patients. His actions tarnish his reputation as well as that of the profession. Our health system operates on the honour system that patients will be fully informed and can trust that the professionals they are seeking advice from are who they say they are and are acting within the rules and regulations of the profession.

In addition, the proposed penalty includes terms, conditions and limitations on Dr. Mohan's certificate of registration which will serve to protect the public going forward

after his suspension. Dr. Mohan will be prohibited from delegating any controlled acts, which includes not permitting non-regulated health professionals to conduct histories or physical examinations of his patients. These terms, conditions and limitations will rebuild the public confidence in the profession's ability to regulate itself. The Committee does note that the investigation into the rest of Dr. Mohan's practice did not reveal any additional shortcomings in Dr. Mohan's patient care, but we must be assured that he will not continue to delegate controlled acts or histories and physical examinations. He must complete an educational program in medical record keeping, undergo a reassessment of his practice twelve months after he returns to practice post suspension, consent to unannounced inspections of his practice and consent to the College making appropriate enquiries of OHIP.

The Committee is of the view that the jointly proposed penalty is in the public interest and is just. As mitigating factors, the Committee notes that this was Dr. Mohan's first appearance before the Discipline Committee, and also that he has already started to take steps to improve his patient care by successfully completing the record keeping educational program before the hearing.

The Committee has the jurisdiction to award costs in appropriate cases and decided this is such a case. Dr. Mohan was cooperative and accepted responsibility for his actions and thus saved the time and resources required of a contested hearing, but none the less, a one day hearing was required and accordingly the Committee orders Dr. Mohan to pay the tariff rate of \$4,460.00, for one day of hearing costs.

ORDER

Having stated the findings of professional misconduct in paragraph 1 of its written order dated September 22, 2015, the Committee ordered and directed on the matter of penalty and costs that:

2. Dr. Mohan attend before the panel to be reprimanded.
3. the Registrar suspend Dr. Mohan's certificate of registration for a period of three (3) months, commencing from October 23, 2015 at 12:01 a.m.

4. the Registrar impose the following terms, conditions and limitations on Dr. Mohan's certificate of registration:
- (a) In his general practice, including with respect to care provided to his family practice patients, walk-in patients and travel clinic patients, Dr. Mohan shall not delegate controlled acts (as defined in the *Regulated Health Professions Act, 1991*), nor shall he permit individuals who are not regulated health professionals to conduct assessments, take histories, or conduct physical examinations of patients.
 - (b) Dr. Mohan shall successfully complete within three months of the date of this order an educational program in medical record-keeping that is satisfactory to the College, and shall provide proof to the College of his successful completion of the same.
 - (c) Approximately sixteen (16) months from the date of this order, Dr. Mohan shall undergo a reassessment of his general practice, including with respect to care provided to his family practice patients, walk-in patients and travel clinic patients, by a College-appointed Assessor. The assessment may include review of Dr. Mohan's patient charts, direct observations, and interviews with staff and/or patients. The Assessor shall report the results of the reassessment to the College.
 - (d) Dr. Mohan shall consent to sharing of information among the Assessor, the College and the provider of the educational program as any of them deem necessary or desirable in order to fulfill their respective obligations.
 - (e) Dr. Mohan shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order, and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location, until the report of the reassessment of his practice has been reported to the College.

- (f) Dr. Mohan shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.
 - (g) Dr. Mohan shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor his compliance with this Order.
 - (h) Dr. Mohan shall be responsible for any and all costs associated with implementing the terms of this Order.
5. Dr. Mohan pay to the College costs in the amount of \$4,460.00, within thirty (30) days of the date of this Order.

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

**Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v.
Mohan, 2015 ONCPSD 37**

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

IN THE MATTER OF a Hearing directed
by the Inquiries, Complaints and Reports Committee of
the College of Physicians and Surgeons of Ontario
pursuant to Section 26(1) of the **Health Professions Procedural Code**
being Schedule 2 of the *Regulated Health Professions Act, 1991*,
S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. RAJESH MOHAN

PANEL MEMBERS:

DR. P. GARFINKEL (CHAIR)
S. BERI
DR. M. DAVIE
P. PIELSTICKER
DR. R. MACKENZIE

Hearing Date:	September 22, 2015
Decision Date:	September 22, 2015
Reprimand Date:	September 22, 2015
Release of Written Reasons:	October 13, 2015

PUBLICATION BAN

TEXT of PUBLIC REPRIMAND
Delivered September 22, 2015
in the case of the
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
and
DR. RAJESH MOHAN

Dr. Mohan, public trust is fundamental to the practice of medicine. This trust has to be reinforced daily and can never be taken for granted. By misrepresenting the qualifications of your practice assistants, you have violated this public trust. You have exposed your patients to serious risk of harm by allowing them to be treated by unqualified individuals.

The autonomy of the medical profession is a privilege. Your actions have served to undermine this honour, and have tarnished the profession as a whole. We hope that this penalty serves the purpose of ensuring that you never again appear before this Committee.