NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Mohammed Asif Hameed Khan, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names of patients or any information that could identify the patients referred to orally or in the exhibits filed at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 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.

DISCIPLINE COMMITTEE
COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Citation: *College of Physicians and Surgeons of Ontario v. Khan,* 2021 ONCPSD 32

Date: June 25, 2021

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Mohammed Asif Hameed Khan

FINDING AND PENALTY REASONS

Heard: May 19, 2021 by videoconference

Panel:

Mr. J. Paul Malette, QC (chair)
Dr. Glen Bandiera
Mr. Jose Cordeiro
Dr. James Watters
Dr. Susanna Yanivker

Appearances:

Ms. Jessica Amey, for the College
Ms. Glynnis Burt and Ms. Jessica Laham, for Dr. Khan
Mr. Jesse Harper, Independent Legal Counsel to the Discipline Committee

Introduction

[1] Dr. Khan is a general practitioner who co-signed prescriptions from two British Columbia pharmacies without taking steps to ensure proper assessment and follow-up of the patients. In addition, Dr. Khan provided a patient with blank, signed prescription forms so that the patient could self-prescribe medication.

[2] The parties submitted an Agreed Statement of Facts and Admission. Accordingly, we found that Dr. Khan had committed professional misconduct in that he had failed to meet the standard of practice of the profession and had engaged in disgraceful, dishonourable or unprofessional conduct. The College withdrew the remaining allegation in the Notice of Hearing.

[3] We accepted the parties' joint submission on penalty and ordered that Dr. Khan be reprimanded, his certificate of registration be suspended for three months, he successfully complete an educational program in professional ethics and boundaries and that he pay $6,000 in costs to the College.

Issues to be Decided

[4] The issues for us were:

a. Did the acts of co-signing of prescriptions from BC pharmacies and giving blank, signed prescription forms to a patient constitute professional misconduct? Specifically, in doing so, did Dr. Khan:
    i. fail to meet the standard of practice of the profession; and/or
    ii. engage in disgraceful, dishonourable or unprofessional conduct?

b. If Dr. Khan did engage in professional misconduct, is the penalty that the parties have jointly proposed appropriate?

Agreed Statement of Facts

[5] The parties submitted an Agreed Statement of Facts and Admission which is summarized as follows.

Dr. Khan co-signed prescriptions from pharmacies in British Columbia

[6] Dr. Khan was contacted in early 2016 by two pharmacies in British Columbia to ask if he would co-sign prescriptions written by American physicians and other health professionals and by naturopaths in British Columbia who did not have prescribing privileges. The prescriptions were being filled at the two British Columbia pharmacies. Dr. Khan agreed.

[7] The pharmacies faxed the prescriptions to Dr. Khan, sometimes with supporting information from the original prescriber. Dr. Khan had no relationship with the patients. He did not assess or follow up with them. He did not obtain assessment information from the original prescribers or know the prescribers' qualifications.

[8] Dr. Khan was paid just under $32,000 (USD) for co-signing prescriptions over a two-year period.

[9] Health Canada and the College of Pharmacists of British Columbia contacted the College, and the College undertook an investigation.

Dr. Khan provided signed, blank prescriptions to a patient whom he also knew personally

[10] The Committee also considered the allegation that Dr. Khan had provided signed, blank prescriptions to a patient whom he also knew personally.

[11] This patient travelled frequently and had difficulty obtaining stimulant medication (Concerta) for management of his ADHD. Dr. Khan knew the patient both personally and professionally, describing him as a friend and professional colleague.

[12] Dr. Khan provided the patient with three or four signed, blank prescription forms or copies of his letterhead that the patient could use to write his own prescriptions and obtain short courses of Concerta as needed when travelling.

[13] Dr. Khan did not properly assess the patient, monitor his use of Concerta or maintain proper documentation.

[14] On November 25, 2017, the patient used a signed, blank prescription form to write a prescription for Concerta for himself, as well as a prescription for his girlfriend.

The pharmacist to whom he presented the prescriptions, in New Brunswick, refused to fill them because they were signed by Dr. Khan but otherwise written by someone else. The pharmacist contacted Dr. Khan and then the College.

[15] On November 25, 2017, Dr. Khan also wrote a prescription for the patient's girlfriend after the patient explained to him that the pharmacy would not fill the prescription that he (the patient) had written for her.

Independent report on Dr. Khan's actions

[16] The College retained a family physician, Dr. Marcus Law, to provide an independent opinion on whether Dr. Khan's actions met the standard of practice of the profession. Dr. Law's report was included in the Agreed Statement of Facts and Admission.

[17] In Dr. Law's opinion, Dr. Khan failed to fulfill a number of the requirements set out in the College policies relating to prescribing medication, medical records and providing care to someone with whom a physician has a close personal relationship.

[18] Dr. Law concluded that Dr. Khan had failed to meet the standard of practice of the profession in co-signing prescriptions from the BC pharmacies and in providing a patient with signed, blank prescription forms that allowed the patient to self-prescribe.

Co-signing prescriptions from pharmacies in British Columbia

[19] The *Prescribing Drugs* policy permits physicians to prescribe on the basis of an assessment done by someone else. However, other than in narrowly-defined circumstances which do not apply here, the physician must have reason to believe that the person who conducted the assessment had the appropriate knowledge, skill and judgment to do so and must evaluate the assessment and judge it to be appropriate.

[20] Dr. Law noted that, by co-signing prescriptions for these patients, Dr. Khan was actively engaged in their care. However, Dr. Khan did not assess the patients himself or receive sufficient information about the patients from the clinicians who

wrote the prescriptions through the pharmacies. Dr. Khan did not contact the original prescribers, nor did he take steps to ensure that he might reasonably rely on their assessments.

[21] The *Prescribing Drugs* policy also requires that a physician ensure that patients are appropriately monitored for complications arising from the drugs they prescribe. The physician must inform the patient about the patient's role in monitoring the drug's safe use and effectiveness, and the follow-up necessary to monitor whether any changes in the prescription are needed.

[22] Dr. Law pointed out that Dr. Khan did not know what follow-up arrangements may have been in place, if any, or what information may have been given to the patients, if any. Yet he prescribed up to 12 months' supply of medication for complex medical conditions.

[23] Both the College's *Medical Records* policy as well as O. Reg 114/94 require that a physician record, among other things, the date of each professional encounter, their assessment of the patient (including history and examination) and the disposition of the patient. A complete and accurate medical record is needed to enable a patient's physician to provide them with comprehensive, high-quality care, including prescribing.

[24] Dr. Law noted that Dr. Khan did not maintain medical records for the patients.

[25] Dr. Law concluded that Dr. Khan's failure to:

a. assess the patients or ensure that he could rely on others' assessments, and
b. ensure that the patients were appropriately informed about their medications and received appropriate follow-up

was likely to have exposed the patients to harm.

Providing signed, blank prescription forms to allow a patient to self-prescribe medication

[26] Dr. Law concluded that Dr. Khan failed to meet the standard of practice in his care of this patient in several ways.

[27] Dr. Law noted that Dr. Khan was engaged in the active treatment of this patient but, contrary to the *Prescribing Medication* policy, did not properly assess the patient or otherwise fulfill the prerequisites for safe and effective initial prescribing. Nor did Dr. Khan appropriately follow up with the patient or monitor the effects of the medication.

[28] Further, before prescribing narcotics and controlled substances, such as Concerta, the *Prescribing Medication* policy requires that the physician take reasonable steps to review the patient's prescription history as it relates to narcotics and controlled substances, develop a comprehensive treatment plan, inform the patient of the risks and benefits of the drug and obtain valid consent. There is no evidence that Dr. Khan met any of these requirements.

[29] As well, the *Prescribing Medication* policy requires that the physician document all relevant information about the medications they prescribe, either by keeping a copy of each prescription or by documenting the information in the patient's medical record. Dr. Khan failed to do this. He made no arrangement to have prescriptions completed by his patient copied back for the patient's medical record or record the information himself.

[30] Contrary to the requirements set out in the *Medical Records* policy, the only medical records Dr. Khan had for either the patient or his girlfriend are dated November 25, 2017. The entirety of Dr. Khan's medical record for the patient is a single incomplete note that lacks an assessment or treatment plan.

[31] In Dr. Law's view, it was dangerous for Dr. Khan to provide signed, blank prescriptions and allow the patient to write his own prescriptions for Concerta, a medication with the potential for addiction.

[32] Lastly, the College policy on *Physician Treatment of Self, Family Members or Others Close to Them* notes that when a physician provides care to such individuals, there is a real concern that the physician's objectivity and the standard of care they provide will be compromised. Dr. Law pointed out, as well, that the policy explicitly prohibits the prescribing of controlled drugs or substances such as Concerta.

Dr. Khan's Admission

[33] Dr. Khan admitted the facts set out in the Agreed Statement of Facts and Admission, and admitted that, on the basis of these facts:

a. he failed to maintain the standard of practice of the profession, and

b. his conduct constitutes acts or omissions relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional.

Analysis

[34] We accept as correct the facts in the Agreed Statement of Facts and Admission which includes Dr. Law's report and the relevant College policies. We accept Dr. Khan's admission and find that the facts constitute professional misconduct.

[35] The standard of practice is the standard that is reasonably expected of the ordinary, competent practitioner in the member's field of practice.

[36] We find that Dr. Khan failed repeatedly and in multiple ways to meet the standard of practice of the profession, both in his co-signing prescriptions from BC pharmacies and in his care of the patient with whom he had a personal relationship.

[37] In addition, Dr. Khan's actions reflect a serious and persistent disregard for his professional obligations and we conclude that they represent disgraceful, dishonourable or unprofessional conduct.

[38] Dr. Khan demonstrated very poor judgement – and put patients at risk – when he co-signed prescriptions despite having no reliable information about the patients' medical conditions, their understanding of their care or whether they had appropriate follow-up in place.

[39] When he provided signed, blank prescription forms so that his patient could self-prescribe a controlled substance, Dr. Khan demonstrated a severe lack of judgement, failed to establish or maintain appropriate boundaries, and put the

patient and others at risk of harm. He abdicated his responsibility to prescribe in a safe and effective manner for this patient and placed highly inappropriate trust in him. Dr. Khan had no control over how his patient might use the signed, blank prescription forms, either to prescribe medication other than Concerta for himself or medication of any kind for someone else. The patient's writing a prescription for his girlfriend illustrates how completely improper Dr. Khan's actions were.

Finding of Professional Misconduct

[40] We find that Dr. Khan has committed an act of professional misconduct in that:

a. he failed to maintain the standard of practice of the profession in his care of patients under paragraph 1(1)2 of Ontario Regulation 856/93; and

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

Penalty

[41] The parties jointly proposed that Dr. Khan receive a public reprimand, his certificate be suspended for three months, he successfully complete an educational program in professional ethics and boundaries and that he pay costs of $6,000 to the College.

[42] We accept the joint submission on penalty, detailed in the Order below, for the following reasons.

Agreed Statement of Facts on Penalty

[43] The parties submitted an Agreed Statement of Facts on Penalty which is summarized as follows.

[44] Dr. Khan stopped co-signing prescriptions for pharmacies in British Columbia in April 2018.

[45] Dr. Khan has not prescribed Concerta for the patient to whom he provided signed, blank prescription forms since November 2017. The patient has indicated he has not used the forms since then and has destroyed those that remained.

[46] In December 2018, following a patient complaint, Dr. Khan undertook to complete a set of remedial activities and did so successfully. These included Dr. Khan reviewing the *Medical Records* policy and the policy on *Physician Treatment of Self, Family Members, or Others Close to Them*, among other policies, as well as completing the *Safer Opioid Prescribing* workshop. Dr. Khan had taken the *Medical Record Keeping* course some months earlier.

[47] In addition, as part of Dr. Khan's December 2018 undertaking, he underwent an independent reassessment of his clinical practice, leading to a reassessment report in April 2020. The assessor found that Dr. Khan had made significant changes in his practice to correct concerns identified in 2018 and concluded that Dr. Khan's patient care now consistently met the standard of practice of the profession.

Analysis of Penalty

Penalty principles

[48] Although we have discretion to accept or reject a joint submission on penalty, the law provides that we should not depart from a joint submission unless the proposed penalty would bring the administration of justice into disrepute or is otherwise not in the public interest. *R. v. Anthony-Cook*, 2016 SCC 43

[49] A joint submission on penalty must satisfy the fundamental penalty principles. These include ensuring public protection and maintaining public confidence in the College's ability to regulate the profession in the public interest. The penalty should express our denunciation of the misconduct and act as a deterrent, both to the member and to the profession. As well, we should consider decisions in prior cases to the extent they are similar to the present case, although we are not bound by prior decisions. The penalty should be proportionate to the misconduct.

Aggravating Factors

[50] Dr. Khan's very poor judgement and failure to meet his fundamental responsibilities to the patients whose prescriptions he co-signed and to the patient to whom he gave signed, blank prescription forms mark the seriousness of his misconduct.

Mitigating Factors

[51] Dr. Khan accepted responsibility for his actions and made an early admission to the allegations. By cooperating with the College, Dr. Khan reduced the time and cost of the investigation and hearing process.

[52] Dr. Khan ceased his misconduct when the College investigation began.

[53] The balance of Dr. Khan's general practice is not at issue here. He recently completed a set of remedial activities. An independent assessment confirms that his practice currently meets the expected standard.

Prior Cases

[54] Although prior Committee decisions are not binding as precedent, we accept as a principle of fairness that, generally, like cases should be treated alike.

[55] We considered eight prior cases identified jointly by the parties. Each differed in significant ways from the present case but there were some useful comparisons, particularly in respect of co-signing prescriptions.

Co-signing on-line prescriptions

[56] In four cases, decided between 2004 and 2005, physicians co-signed prescriptions for US patients that were to be filled by Canadian pharmacies, without assessing the patients or contacting the original prescribers:

a. *College of Physicians and Surgeons of Ontario v. Katz*, 2004 ONCPSD 27

b. *College of Physicians and Surgeons of Ontario v. Robinson*, 2004 ONCPSD 29

c. *College of Physicians and Surgeons of Ontario v. Belda*, 2005 ONCPSD 6

d. *College of Physicians and Surgeons of Ontario v. Gore*, 2005 ONCPSD 1 (liability); 2005 ONCPSD 9 (penalty)

[57] The Committee made findings of disgraceful, dishonourable or unprofessional conduct in each case. Drs. Katz, Robinson, and Belda admitted their misconduct. The finding in *Gore* followed a contested hearing where the Committee also found that Dr. Gore was not a credible witness.

[58] In each case, the Committee accepted a joint submission on penalty which consisted solely of a reprimand. Relevant to the present case, in *Gore* the Committee wrote that, had there not been a joint submission, it would have considered a fine and a suspension.

[59] The cases are helpful in that physicians' failure to meet their professional obligations in co-signing prescriptions warranted intervention, but did not result in suspension, although that possibility was raised in *Gore*. However, these cases were all in the early days of on-line pharmacies, where physician obligations in respect of co-signing prescriptions were a novel issue. In addition, Dr. Khan's misconduct involved more than co-signing prescriptions.

Co-signing on-line prescriptions: professional misconduct in another jurisdiction

[60] In two prior cases, physicians working in upstate New York under restricted licences improperly co-signed on-line prescriptions without ensuring meaningful assessments, diagnoses or documentation.

a. *College of Physicians and Surgeons of Ontario v. Buckley*, 2012 ONCPSD 31

b. *College of Physicians and Surgeons of Ontario v. Cohen*, 2012 ONCPSD 22

[61] The New York State Board found both physicians failed to meet the standard of practice, had been negligent and had practised outside their restricted scope. It revoked Dr. Buckley's licence and imposed a $40,000 fine. Dr. Cohen received a reprimand and was fined. Following an administrative review of the Board's original

order, Dr. Cohen was suspended for three years and the fine was tripled to $30,000. All but three months of the suspension were ordered stayed.

[62] In the subsequent College proceedings, both physicians admitted the facts found by the New York State Board and that the facts constituted professional misconduct in Ontario.

[63] Mindful of the earlier penalties in *Katz*, *Robinson*, *Belda* and *Gore*, and of the penalties already imposed in New York, the Committee accepted joint submissions on penalty by which the physicians were reprimanded, pay costs of $3,650 and required to complete education in professional ethics.

[64] The nature of Dr. Buckley's and Dr. Cohen's misconduct is similar to Dr. Khan's co-signing practice although, unlike Dr. Khan, they practised outside the scope of their licences and Dr. Buckley co-signed far more prescriptions (approximately 75,000) than Dr. Khan.

[65] *Buckley* and *Cohen* are helpful as examples of the seriousness with which this misconduct was regarded and the more severe penalties that resulted in another jurisdiction, though the facts of those cases are not identical to those here.

Providing signed, blank prescription forms

[66] The parties were not able to identify any prior cases in which the physician had provided signed, blank prescription forms or letterhead to a patient to permit him to self-prescribe.

[67] The parties identified two cases in which physicians had self-prescribed and prescribed for family members (including narcotics and controlled substances in Guirguis) and forged the signatures of colleagues:

a. *College of Physicians and Surgeons of Ontario v. Guirguis*, 2018 ONCPSD 47

b. *College of Physicians and Surgeons of Ontario v. Raddatz*, 2020 ONCPSD 27

[68] *Guirguis* and *Raddatz* are of limited assistance. Loosely related, more serious misconduct was met with a six-month suspension (and remediation) in these two cases. The misconduct in those matters was substantially different from Dr. Khan's.

[69] In summary, there is no other case that is directly on point. However, taken together, the eight prior cases include misconduct that is more severe than Dr. Khan's in some instances and less severe in others. They provide some reassurance that the jointly proposed three-month suspension of Dr. Khan's certificate of registration falls within a reasonable penalty range.

Conclusion on penalty

[70] We find that the jointly proposed penalty is reasonable, appropriate, and proportionate to Dr. Khan's misconduct.

[71] In respect of public protection, Dr. Khan has ceased the activities that comprised his misconduct and Dr. Khan's general practice is not otherwise at issue here. He has shown himself willing and able to respond to identified practice deficiencies and we are reassured by the favourable results of his recent practice reassessment.

[72] The suspension of Dr. Khan's certificate for three months is a significant penalty. The suspension and reprimand will denounce his misconduct and should deter him from future misconduct. They will make the profession aware that such misconduct is wholly unacceptable and they should support public confidence in the ability of the College to regulate the profession in the public interest.

[73] Remediation is an appropriate objective in this case and will be served by Dr. Khan successfully completing an educational program in professional ethics and boundaries.

[74] We find that this is an appropriate case in which to award costs and accept the joint proposal that Dr. Khan pay costs to the College in the amount of $6,000.

Order

[75] On May 19, 2021, we ordered and directed:

- Dr. Khan to attend before the panel to be reprimanded.

- the Registrar to suspend Dr. Khan's certificate of registration for a period of three (3) months, commencing from June 1, 2021 at 12:01 am.

- the Registrar to place the following terms, conditions and limitations on Dr. Khan's certificate of registration commencing from May 20, 2021 at 12:01 am.

    i. Dr. Khan will participate in the PROBE Ethics & Boundaries Program offered by the Centre for Personalized Education for Professionals, by receiving a passing evaluation or grade, without any condition or qualification. Dr. Khan will complete the PROBE program within 6 months of the date of this Order, and will provide proof to the College of his completion, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it.

- Dr. Khan to pay costs to the College in the amount of $6,000 within 30 days of the date of the order.

Reprimand

[76] At the conclusion of the hearing, Dr. Khan waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand by videoconference.

In the matter of:

College of Physicians and Surgeons of Ontario

- and -

Mohammed Asif Hameed Khan

Reprimand delivered by the Discipline Committee
by videoconference on Tuesday, May 19, 2021 at 11:41 am

*****Not an official transcript****

Dr. Khan, by co-signing for prescriptions as you did, you have demonstrated that you put financial gain ahead of the well-being of patients. You did not know these patients. You did not obtain information from the persons who assessed the patients. You did not know who conducted the assessments or what their qualifications were. You did not follow up with the patients.

Over 5,000 times you put the well-being of patients at risk for your financial gain. This is just shocking. You compounded this conduct by violating patient-physician boundaries. Again, prescriptions were your undoing.

You provided a friend with signed blank letterhead to enable this friend to self-prescribe medication. Again, you did not take any of the expected steps to safeguard this friend, patient or the public. Your blank letterhead could have been used to prescribe any substance for anyone.

Prescribing is a very significant regulated medical act for which you have failed to meet the standard. A licence to practise medicine is a privilege. There are responsibilities that come with this licence. You chose not to assume these responsibilities. We hope that you will learn from this experience and that this committee will not see you again.

That is the end of the reprimand.