NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Gabriel Nicola Attallah, this is notice that the Discipline Committee ordered that no person shall publish or broadcast the names of patients and their family members or any information that could disclose the identity of these individuals 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. Attallah, 2020 ONCPSD 12

DISCIPLINE COMMITTEE
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**
which is Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. GABRIEL NICOLA ATTALLAH

PANEL MEMBERS:

DR. MELINDA DAVIE (Chair)
DR. J. WATTERS
MR. M. KANJI
DR. DEBORAH HELLYER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. C. SILVER
MR. K. MAIJALA

COUNSEL FOR DR. ATTALLAH:

MR. J. KOZIEBROCKI (November 4-6 and December 18, 2019)
MS. L. YERMAKOUA (November 4-6, 2019)
MS Z. HOUNTALAS (November 4-6, 2019)
MR. N. ABRAMSON (September 4-6, 2019)
MR. R. BARBIERO (September 4-6, 2019)

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE: MS J. MCALEER

Hearing Dates: **September 4-6, November 4-6, December 18, 2019**
Decision Date and Release of Reasons Date: March 12, 2020

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 4 to 6, 2019; November 4 to 6, 2019; and December 18, 2019. At the conclusion of the hearing, the Committee reserved its finding.

ALLEGATION

The Notice of Hearing alleged that Dr. Attallah committed an act of professional misconduct under paragraph 1(1)33 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that 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.

RESPONSE TO THE ALLEGATION

Dr. Attallah denied the allegation in the Notice of Hearing.

BACKGROUND

The allegation of disgraceful, dishonourable or unprofessional conduct relates to Dr. Attallah's billing practices and record keeping from 2006 to 2010. Dr. Attallah is a family physician who had his own clinic in St. Catharines during that time.

At issue are Dr. Attallah's collecting of health card numbers of family members accompanying seven of his patients (Ms B, Mr. C, Ms D, Ms E, the children of Ms G, and Ms M) to their appointments with him, Ontario Health Insurance Plan ("OHIP") claims he made using the health card numbers of 11 patients and/or family members (Ms B,

Mr. C, Ms D, Ms E, the children of Ms G, and Ms M), and the medical records supporting these claims.

The College received a letter from the Ministry of Health and Long Term Care ("the Ministry") in October 2012 regarding Dr. Attallah's having asked family members accompanying patients to appointments for their health card numbers. The Ministry subsequently forwarded provider complaint reports, OHIP service verification letters and OHIP billing reports to the College.

THE ISSUES

The issues in this case are:

1. Did Dr. Attallah collect, with no proper purpose, the OHIP numbers of family members who attended his office only to accompany their relatives to appointments?

2. Did Dr. Attallah submit improper claims to OHIP

    a. for interviews with relatives (code K002 in the OHIP Schedule of Benefits)?
    b. for other services which he failed to render or for which he failed to spend sufficient time to justify his time-based claims?

3. Did Dr. Attallah create false or inaccurate medical records? Did he create charts for individuals who were not his patients?

4. To the extent such actions occurred, were they intentional and did they reflect a larger pattern or policy, or were they administrative errors that do not rise to being professional misconduct?

5. Did Dr. Attallah engage in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional?

THE EVIDENCE

The College's case depends in large part on Dr. Attallah's billing records, the corresponding notes in his office charts, and witness testimony, particularly insofar as it was inconsistent with Dr. Attallah's clinical notes.

The Committee heard testimony from 15 witnesses on behalf of the College. All were fact witnesses.

Dr. Anweiler is a medical advisor from OHIP. She testified in respect of, among other matters:

- the requirements that must be met in order for certain fee codes to apply, as set out in the Schedule of Benefits;
- the expectation that physicians understand the requirements for the fee codes which they bill to OHIP; and
- how the Ministry notified the College of concerns about Dr. Attallah's billing practices.

Five witnesses were family members who accompanied patients (Ms A, Mr. C, Ms D, Ms E, Ms M). Three witnesses were patients (Mr. H, Ms I, Ms K) and two were both family members of patients and patients themselves (Ms B, Ms F). One witness was the mother of a patient but whether she had accompanied her daughter, and whether she was a patient herself, were in question (Ms L).

Two witnesses were former employees in Dr. Attallah's office. A receptionist, Ms Barbara Cochrane, testified about the collection of health card numbers from

family members accompanying patients and about her interactions with Dr. Attallah in this regard. The other former employee, Ms Sharon Stitt, had done OHIP billing in the office. She testified about the billing of fee code K002 and direction she received from Dr. Attallah.

Dr. Attallah did not testify and his counsel called no witnesses on his behalf.

A joint book of documents of selected office charts and billing records of Dr. Attallah (Exhibit 2) was admitted on consent.

Other documents admitted in evidence include:

- Schedule of Benefits for Physician Services Under the *Health Insurance Act* (October 1, 2005)
- OHIP Provider Complaint Reports based on five telephone calls received by the Ministry between January 20 and April 18, 2006;
- OHIP Service Verification letters sent in October 2007, relating to OHIP billings by Dr. Attallah for services in July and August 2007
- Education letter from the Ministry to Dr. Attallah on May 12, 2008, regarding billing code K002.

Summary of the Evidence

Witnesses

Credibility and reliability

The Committee recognizes the importance of assessing each witness's credibility and reliability. Credibility refers to the witness's honesty and willingness to speak the truth as he or she believes it to be. Reliability relates to the witness's ability to accurately

observe, recall and recount the events at issue which, for the most part in this case, took place some years ago. The Committee appreciates that an honest witness can be mistaken and, consequently, his or her evidence is unreliable. A witness whose testimony is not credible on a particular point will also not be a reliable witness on the same point. However, the Committee may find a witness's evidence to be reliable and credible on one point while, at the same time, finding that the same witness is unreliable or not credible on another point.

When assessing credibility and reliability, the Committee should look to the totality of the evidence and assess the impact of any inconsistencies. Inconsistencies in the witness's evidence on minor matters of detail are to be expected and do not generally affect the credibility of the witness. When inconsistencies are of a material nature about which an honest witness is unlikely to be mistaken, such inconsistencies may demonstrate carelessness with the truth.

College Counsel drew the Committee's attention to *R. v Sanichar*, 2012 ONCA 117, which was reversed in 2013 SCC 4; *R. v Sidhu*, 2004 BCCA 59; and *R. v François* 1994 CanLII 52 (SCC); in regard to the assessment of inconsistencies, credibility and reliability.

Assessing credibility is ultimately a matter of judgment. There are a number of factors relevant to assessing credibility, including: Did the witness seem honest? Did the witness have an interest in the outcome? Did the witness seem able to make accurate and complete observations? What were the circumstances of the observations? Were they unusual or routine? Did the witness seem to have a good memory? Did any difficulty that a witness had in recalling seem to be genuine or made up? Did the witness seem to be reporting what they saw or heard, or simply putting together an account from other sources? Was the testimony reasonable or consistent? Did they say something different on an earlier occasion? Did any inconsistencies make the evidence more or less reliable and believable? Was there an honest mistake? Is there an explanation for the

inconsistency? What was the witness's manner, recognizing that appearance and demeanor can be highly unreliable in assessing credibility?

DR. LAURA ANWEILER (OHIP medical advisor)

Dr. Anweiler is a former family physician, now full-time medical advisor in the Provider Audit and Adjudication Unit of the Ministry. The unit reviews OHIP claims paid to physicians when concerns arise.

The Committee found Dr. Anweiler to be clear and impartial in her testimony. She was careful to understand the questions put to her. She is obviously familiar with the Schedule of Benefits for Physician Services. Her testimony was consistent with the Schedule and other documentary evidence and the Committee found it helpful.

Fact vs. opinion evidence

The Committee considered the nature of Dr. Anweiler's evidence as Dr. Attallah's counsel submitted that the College was endeavouring to elicit opinion evidence from her, despite her being brought as a fact witness. College counsel submitted that their questions sought factual responses based on Dr. Anweiler's knowledge and experience of the mechanics of the OHIP payment system.

Both counsel referred to an excerpt of the chapter Opinion Evidence, in Sopinka, Lederman, and Bryant*, The Law of Evidence in Canada,* fifth edition. At 12.2, the authors write: "As a general rule, a witness may not give opinion evidence but may testify only to facts within her or his knowledge, observation and experience…" Counsel for Dr. Attallah pointed as well to 12.3: "…A lay witness will be permitted to give an opinion only with respect to matters that do not require special knowledge and in circumstances

where it is virtually impossible to separate the facts from the inferences based on those facts."

College counsel cited *Eco-Zone Engineering Ltd. v. Grand Falls – Windsor (Town)* 2000 NFCA 21 ("*Eco-Zone*") where, in regard to the interpretation of a construction contract, the appeal court wrote:

> "There are two aspects to the evidence of the expert. The first is the expert's explanation of the mechanics of the GST, how it works in practice, which is more in the nature of a factual description than the rendering of an opinion. The second is the characterization of the GST as a sales tax or an excise tax…I would place such evidence [overview of the mechanics of the GST] within the factual matrix which may be considered in interpreting the contract. While the source of information is an expert, it is not opinion evidence and it is not the evidence to which the rules of admissibility of expert evidence are directed." (Paragraph 14)

In summary, the question for the Committee was not whether Dr. Anweiler was entitled to give opinion evidence, but whether questions to her about how the OHIP system works, how OHIP pays physicians, how the Schedule of Benefits is administered and what are the payment rules in the Schedule of Benefits, sought to elicit facts or opinion. The Committee found that these are questions of fact. They are facts that are within Dr. Anweiler's knowledge, observation and experience. The questions seek responses analogous to the witness's explanation of the mechanics of the GST in *Eco-Zone,* and are facts that are likely to assist the Committee in determining this matter.

How a physician is paid for providing a medical service to a patient

Most physicians bill OHIP on a fee-for-service basis. The physician selects a fee code that reflects the service from the list in the Schedule of Benefits and electronically submits a

claim to OHIP. The Ministry stores claims electronically in the usual and ordinary course of business.

Claims are checked electronically to ensure that the physician's billing number and patient's health card number are valid and that certain medical rules are met. If claims pass these checks then they are generally paid to the physician on a good faith basis. However, payment does not imply that the claim was in fact eligible for payment.

Expectation that physicians know the requirements for fee codes they bill

Dr. Anweiler testified that physicians are expected to have learned how to bill correctly when they submit claims to OHIP. Physicians are provided with educational materials, including the Schedule of Benefits, when they register for a billing number. The Ministry publishes bulletins with updates on how to bill correctly and whether there have been any changes to the Schedule, new fee codes or changes to existing fee codes. The Ministry also provides billing advice to physicians who contact the Claims Services Branch.

Dr. Anweiler identified the Ministry form titled "Registration for Regulated Health Professionals" completed by Dr. Attallah. Such documents are maintained by the Ministry in the usual and ordinary course of business. On the form's last page, above the signature and date lines, is acknowledgment of responsibility for having read and understood the Schedule of Benefits, Claims Submission Manual, and Ministry bulletins relating to payment policy. As well, there is acknowledgment that the physician bears sole responsibility for compliance with the provision of services in accordance with the Schedule of Benefits, and for the veracity of claims submitted to OHIP.

How concerns about Dr. Attallah's billing came to the College's attention

Dr. Anweiler identified a letter that she wrote on October 5, 2012, referring a concern about possible professional misconduct to the College. The letter reports that the Ministry had received a number of complaints about Dr. Attallah's having made requests for health card numbers of individuals accompanying patients to appointments.

In April 2013, Dr. Anweiler provided the College with Provider Complaint Reports, representing five calls made between January and April 2006 to the Ministry's toll-free number for anyone with concerns about OHIP claims. As well, she forwarded copies of responses to OHIP Service Verification letters sent October 11, 2007. The letters seek to verify that persons whose health card numbers had been used had received the services claimed.

The Provider Complaint Reports, other attachments to Dr. Anweiler's April 9, 2013 letter, and OHIP Service Verification letters are documents maintained by the Ministry in the usual and ordinary course of business. They were not admitted for the truth of their contents but as information provided to the College by Dr. Anweiler.

Dr. Anweiler also identified an email response to the College investigator on January 11, 2016, in which she states that she had found a document dated December 4, 2012, her understanding of which is that Dr. Attallah made restitution to the Ministry of $9,214.85 in respect of inappropriate claims as the amount was equivalent to the "fraud loss."

Schedule of Benefits for Physician Services

Dr. Anweiler identified the Schedule of Benefits, dated October 1, 2005. She was aware of no meaningful changes since that time in the definitions of services or fee codes. The Schedule contains a complete list of insured services that are payable by OHIP to physicians, and sets out payment rules and requirements that need to be met in order for fee codes to be eligible for payment.

Required documentation of services in the patient's medical record

The Schedule quotes the *Health Insurance Act* requirement that physicians have a record to support every claim that they make to OHIP (page GP8). The record has to demonstrate that the service claimed was the service rendered and that the service was medically necessary.

Intermediate and general assessments

Discussion with and providing advice and information to the patient or their representative(s) on matters related to the assessment, service provided, and test results are among the constituent elements that are included within patient assessments (page GP15).

In an intermediate assessment (A007 fee code), a physical examination is required if the patient's condition is physical in nature, or examination of the patient's mental health; otherwise a minor assessment would be the appropriate assessment to claim (GP23).

A general assessment (A001) requires a full history, and, except for breast, genital or rectal examination where not medically indicated or refused, an examination of all body parts and systems (page GP18).

Time-based services: individual psychotherapy (K007), primary mental health care (K005), and individual counselling (K013)

Most fee codes in the Schedule are not time-based. However, fee codes for psychotherapy, counseling, and primary mental health care, among other services, are billed in time units that are calculated and payable in 30-minute increments.

All psychotherapy, counselling and primary mental health care services specifically include discussion with and providing advice and information to the patient or the patient's representative on matters related to the service and, where appropriate, assessment or test results (page GP36).

For time-based services, the physician must document the time when the service started and ended (GP6) or else the service is not eligible for payment. Dr. Anweiler testified that the insured service is the actual rendering of the service, and that the basis for calculating the time units to be billed is the time spent in direct patient contact (GP37).

The payment rules for these services set out the minimum number of minutes the physician needs to be in direct patient contact to bill certain numbers of time units (20 minutes for 1 unit, 46 minutes for 2 units, 76 minutes for 3 units etc.) (page GP37).

Certain claims cannot be made together for the same patient on the same day. K013 (individual counselling) cannot be billed with an assessment or one of the claims will be automatically rejected (GP39). Counselling must be done at a pre-booked appointment or else is payable at a lower "assessment" fee code. Neither K007 (individual psychotherapy) nor K005 (primary mental health care) can be billed with an assessment unless the diagnosis for each is different (GP37, GP39).

The definitions, eligibility requirements and payment rules for individual psychotherapy (K007), primary mental health care (K005), and individual counselling (K013) are set out in the Schedule at pages A13, GP36, GP37, and GP39 and summarized below (Analysis).

Time-based services: interview with a relative (K002 fee code).

K002 is a time-based fee code, claimed using the patient's health card number and diagnosis (page A18). The interview must be a booked separate appointment lasting at least 20 minutes (page A18). K002 applies to an interview with a relative or person authorized to make a treatment decision on behalf of the patient, conducted for a purpose other than to obtain consent (page A18). Eligibility requirements are summarized below (Analysis).

Dr. Anweiler testified that computerized OHIP payment rules would reject claims for both K002 and an assessment of the same patient on the same day, regardless of whether different diagnostic codes are used. However, there is no computerized rule that would prevent a physician billing K002 using a relative's health card number instead of the patient's, although such a service would not be eligible for payment as it is to be claimed using the patient's health card number.

Education letter to Dr. Attallah about K002 billing

Dr. Anweiler identified a letter sent by the Ministry to Dr. Attallah in May 2008 in relation to a program aimed at reminding and/or educating physicians who were billing higher volumes of certain fee codes than their peers about the requirements for billing those codes. Dr. Attallah was selected to receive the letter because his billings for K002 placed him in the top 5% of physicians billing this code in the calendar year 2007.

The Ministry's letter to Dr. Attallah sets out the eligibility requirements and payment rules for K002 claims.

Witnesses who were patients of Dr. Attallah, family members, or both

The testimony of the witnesses who were patients of Dr. Attallah, family members, or both is summarized individually below. For each, the specific allegations to which their

testimony may be relevant are set out. A summary of their testimony is accompanied by evidence from the office charts and billing records.

MS A

In respect of claims made using Ms A's health card number on 29 occasions between May 2006 and January 2010, the College alleges that:

- Dr. Attallah improperly claimed the fee code K002 for "interview with a relative" 18 times
- Dr. Attallah did not provide the services to Ms A for which he claimed various fee codes (intermediate assessment, A007, general assessment, A001, and primary mental health care, K005) on 11 occasions
- Dr. Attallah did not spend at least 46 minutes (i.e. two time units) providing time-based services (K002 and K005) claimed on three occasions
- Dr. Attallah's documentation in Ms A's medical chart is false or inaccurate.

Ms A lives in Welland. She has a disability and testified by video link.

Ms A's mother saw Dr. Attallah as a patient between 2006 and 2010. Her mother stopped seeing him because travelling to St. Catharines was too difficult for them, particularly in winter. Ms A had her own family doctor in Welland at the time, who had been her doctor for thirty years.

Ms A's mother had had a stroke a number of years earlier, and had difficulties with comprehension. As a result, Ms A would always accompany her to appointments with Dr. Attallah "to be an extra ear to understand everything", and to enable her mother to get to the appointments. Ms A had no concerns with Dr. Attallah's medical care of her mother.

Ms A and her mother would typically wait from one-half to two hours in the waiting room and then five to 15 minutes in a treatment room before Dr. Attallah came in. They would usually spend 15 to 20 or 25 minutes with Dr. Attallah. Ms A accepted the possibility that some of the appointments might have been as long as 30 minutes, but didn't think they ever were. She testified that she knew how long the appointments were because she had a watch and cell phone and checked them.

Ms A could not clearly recall the details of many appointments. She also acknowledged the possibility that some of her recollections might be in error given the time that has passed. However, Ms A was very clear in her testimony that:

- she never saw Dr. Attallah alone without her mother; her role in visits with Dr. Attallah was solely to assist her mother with her care
- Dr. Attallah never talked to her about her health, prescribed medication for her or physically examined her
- Dr. Attallah never provided her with medical services such as a flu shot, and would have recalled a physical examination or medical services from Dr. Attallah as she had her own family doctor
- she never talked to Dr. Attallah about counseling or therapy ("it never happened") and would never have done so, as she had her own family doctor
- she was upset when she learned that Dr. Attallah had billed OHIP for services to her "because it wasn't true"; she had never seen him for herself "in any way, shape or form"
- she never had a separately-booked appointment with Dr. Attallah to discuss her mother's health.

Ms A identified the October 2007 OHIP Service Verification letter addressed to her and confirmed the truth of her response to it, including the explanation she wrote on the

back of it. She recalled that she checked the response box indicating that Dr. Attallah had not provided her with "individual care – at least 46 minutes" on a specific date in 2007 because she was not a patient of Dr. Attallah's and was simply accompanying her mother.

Ms A did not recall Dr. Attallah ever having told her he was maintaining a patient chart for her. Ms A testified that, in general, where Dr. Attallah's notes might say that he counseled her about anxiety on other occasions, "it never happened". Further, OHIP claims indicating that Dr. Attallah conducted an assessment of her on four occasions were "not true". Ms A had no recollection of Dr. Attallah interviewing, counseling her about her mother, or providing her with mental health care, for at least 20 minutes on seven occasions or for at least 46 minutes on three occasions.

Dr. Attallah's full chart note supporting each of the 29 OHIP claims at issue, and a summary of Ms A's testimony, if any, are set out in date order below.

Date	Fee code	Dr. Attallah's complete chart notes for Ms A	Ms A's testimony
September [date], 2006	K002, 1 time unit	[blank]	[none]
October [date], 2006	K002, 1 time unit	[blank]	[none]
November [date], 2006	A007	She has asthma. Declined flu shot consult. If she changes her mind, she will f/u. GA/lm (append by USER1 on 07-Apr-2007 at 12:25) AD: interviewed with regards to her mother.	Ms A did not recall ever talking to Dr. Attallah specifically about her asthma but might have said something in general. She denied that Dr. Attallah had ever physically examined her and was confident that she would have remembered.

May [date], 2007	K002, 2 time units	Interviewed and counselled re: mother's medical condition x 46 mins 1:15-2:01pm	Ms A testified that she did not have a separately booked appointment with Dr. Attallah on that day. She did not remember whether she spoke with him for 46 minutes on that day, but didn't remember ever speaking to him that long.
July [date], 2007	K002, 2 time units	S: multiple questions about her relative interviewed and counselled x 46 minutes from 2:30 to 3:16 pm counselled re importance of an abnormal potassium she seems to understand the seriousness of this now	[none]
August [date], 2007	K005, 2 time units	[blank]	Ms A denied with some vehemence that Dr. Attallah had provided her with primary mental health care for 46 minutes on that day or that he had ever counseled her or provided primary mental health care to her for 46 minutes.
November [date], 2007	A007	Interviewed and counselled she understood the importance of getting immunized now, promises to make an appointment with her family physician for consideration of the flu shot and the meningitis flu shot vaccine, etc. Getting up to date on all her immunizations.	Ms A denied that she had been assessed or that he had physically examined her or that she received a flu shot that day. She testified that, had Dr. Attallah asked her if she had had a flu shot, she would have told him that she would call her own doctor and have it done.

December [date], 2007	K002, 1 time unit	Interviewed and counselled with regards to her mom all her questions were answered, she was wondering what medications she should be on. And I explained this is probably due to dimentia [sic] that she has been prescribe different medications by three different doctors. We'll have to reassess in the new year. Interviewed and counselled for 20mins. From 1:30-1:50pm.	[none]
January [date], 2008	K002, 1 time unit	[blank]	[none]
September [date], 2008	K002, 1 time unit	Pt of Dr….is convinced mother is taking her meds and that that should not be cause for elevated BP. She is going to return to mother's home and investigate the situation. A: anxiety P: interviewed and counselled x 20 mins 1:41-2:01pm	Ms A had no recollection of telling Dr. Attallah that she had anxiety and stated that she never talked to him about herself. She testified that she had never talked to Dr. Attallah about anxiety, nor did Dr. Attallah ever tell her that he thought she had anxiety or interviewed or counseled her about anxiety.
October [date], 2008	K002, 1 time unit	Here with her mother, questions were answered	[none]
November [date], 2008	A007	1) Declined flu shot. 2) [blank] A: [blank] P: Interviewed and counselled re: questions about her mother	[none]

February [date], 2009	A001	1. here with her mother	[none]
March [date], 2009	K002, 1 time unit	1. here with some questions about her mother	[none]
April [date], 2009	K002, 1 time unit	1. some questions about her mother answered	[none]
May [date], 2009	K002, 1 time unit	1. here with some questions about her mother - answered	[none]
June [date], 2009	K002, 1 time unit	Some questions about her mother these were answered	[none]
July [date], 2009	K002, 1 time unit	questions about her mother were answered	[none]
July [date], 2009	K005, 1 time unit	1. couns with regards to her mother's condition	[none]
August [date], 2009	K002, 1 time unit	some questions about her mother these were answered	[none]
September [date], 2009	A007	some c/o her mother especially re her BP A: anxiety P: explained normal BP readings and her mom's situation	[none]
September [date], 2009	A007	c/o her mom's medications I stressed the importance to her of FU with her blister pack etc	[none]
September [date], 2009	K005, 1 time unit	1. explained her mother's condition to her	[none]
September [date], 2009	A007	1. some questions about her mother.	[none]

		Couns re: receiving the flu vaccine this year A; anxiety P: int/couns	
October [date], 2009	K002, 1 time unit	Couns re her mother's medical condition	[none]
October [date], 2009	K002, 1 time unit	1. int/couns re: her mother and flu shot was recommended 2. Patient presents for discussion of benefit/risk consideration for influenza vaccine. After reviewing these issues and giving written/verbal information about the composition, mode of action, benefits and possible side effects, the patient has decided to receive the influenza vaccine this season He/she is not allergic to eggs. 0.5 cc, IM, Deltoid administered by GA/mg	[none]
December [date], 2009	A007	1. councelled [sic] with regards to getting a blood test done for [mother]	[none]
December [date], 2009	K002, 1 time unit	1. couns re: [mother]'s health condition	[none]
January [date], 2010	K002, 1 time unit	1. some questions about her mother, these were answered	[none]

Credibility and reliability. The Committee finds Ms A credible and her evidence reliable and relevant. She stated that she could not recall details of specific appointments that she attended with her mother, which is reasonable after many years in that there were no unusual events that might have made any one of them stand out to her. However, Ms A was clear in her testimony on a number of significant points, as specified above. and the Committee found her explanations reasonable. Further, her testimony was consistent with the information provided in the October 2007 OHIP Service Verification letter.

In respect of the length of time spent with Dr. Attallah at her mother's appointments, Ms A's testimony was that this was 15 to 20 or 25 minutes, possibly 30 minutes on occasion, and that she could recall none that were longer. It is reasonable that she would offer a range of times, and also that she could relate the time spent with Dr. Attallah to the time she and her mother spent in the waiting room and in the treatment room waiting for him.

There is an inconsistency between Ms A's testimony that she never received a flu shot from Dr. Attallah, and his note of October [date], 2009 in which he records the outline of a comprehensive discussion and administration of a flu shot. The content of the note is non-specific to Ms A (e.g. "He/she is not allergic to eggs…") and very similar to text in notes in other individuals' charts. It is possible that Ms A received the flu shot and no longer recalls since it was ten years ago. The Committee, however, for the reasons provided below, found Dr. Attallah's clinical records to be inaccurate and unreliable in several respects. Given this finding, the Committee puts little weight on the content of Dr. Attallah's notes and prefers the evidence of Ms A that she did not receive the flu shot from Dr. Attallah.

MS B

In respect of the claim for individual psychotherapy to Ms B on February [date], 2006, for which he claimed fee code K007 (2 time units, at least 46 minutes), the College alleges that:

- Dr. Attallah did not provide this service
- Dr. Attallah's documentation in her medical chart is false or inaccurate.

Ms B lives in St. Catharines. Dr. Attallah was her husband's and children's family doctor in 2005 and 2006. Ms B had her own family doctor in Hamilton at that time, and had had for many years. When her family moved to St. Catharines, she saw Dr. Attallah on a few occasions for "small things" such as sinus problems and removal of moles. She told him of some of her health background at their first appointment. She denied ever seeing Dr. Attallah for or receiving from him any kind of counselling or therapy. She explained that she was on Effexor at that time, prescribed by her family doctor, and that her family doctor was providing her with counseling.

Ms B had no concerns with Dr. Attallah's medical care apart from one occasion when her husband saw him about a back problem. This appointment, however, was not at issue.

The appointment at issue is when Ms B took her 5-year old son to see Dr. Attallah on February [date], 2006 about a bad cold or sinus problem from which he was not getting better over a period of three months. Later, another physician diagnosed her son with pneumonia. Ms B testified that she did not have an appointment that day for herself, and was there simply because of her son. She recalled that she and her son "…were not in the room very long. It was just another check-up appointment…", "…we were in and out fast…", and that Dr. Attallah had checked her son's ears and listened to his chest.

Dr. Attallah's entire note for February [date], 2006 in Ms B's chart is:

> She has multiple questions about [her son]'s, condition. She has anxiety and has not noticed any improvement
> Anxiety counselled extensively re: [son]'s condition and her anxiety x 46 min from 2:00 to 2:46 pm.

Ms B agreed that the (limited) contents of Dr. Attallah's note for her son on that day were the substance of what was discussed with Dr. Attallah.

Ms B recalled the appointment very well, and testified that it was impossible that she and her son were with Dr. Attallah for 46 minutes, and that it was impossible that she simply doesn't remember being there that long.

She testified that she recalled that day very clearly because of what happened with the receptionist as she and her son were leaving. Ms B testified that the receptionist asked her for her health card number as they were leaving Dr. Attallah's office. Ms B asked why her health card number was needed as there had been no time spent with her that day. The Committee permitted Ms B to continue her testimony in respect of what the receptionist said to her, as part of the narrative of events and to explain why Ms B had a distinct memory of this appointment. The Committee recognizes that what Ms B reports someone else said to her is hearsay and not admissible for the truth of the contents of the statement made by the receptionist.

Ms B went on to state that the receptionist told her that OHIP was being billed $103.00 for her [Ms B's] appointment. Dr. Attallah's billing records show that he claimed $103.40 for services to Ms B on that day. Ms B testified that she felt at the time that there was no reason for a claim to be made for her as she had received no service. She testified that she was enraged and flabbergasted because she did not have an appointment and there was no discussion of anything about herself that day. Ms B said that, as a result,

she called the Ministry a day or two later and was directed to call the College. As well, she and her family stopped seeing Dr. Attallah at that point.

Ms B was shown the Provider Complaint Report dated February [date, two days after the appointment], 2006, and affirmed that its contents were true.

In cross-examination, Ms B acknowledged that she had mistakenly not provided her son with an antibiotic that Dr. Attallah had prescribed at a previous visit, as Dr. Attallah recorded in his note for her son that day. However, she consistently denied the suggestion that Dr. Attallah had been critical of her at the February [date], 2006 appointment for this failure and criticized her parenting, and that as a result Ms B was angry and lodged a complaint. Rather, her evidence was that Dr. Attallah was a "good, decent doctor", very nice, never rude, never "put her down". She denied that Dr. Attallah had been critical of her and that this was the reason she made a complaint.

Credibility and reliability. The Committee found Ms B to be credible and reliable. It is reasonable that she would recall the visit well because of the health issues with her young son and because of the request for her own health card number. Further her testimony is consistent with her call to the Ministry two days later, reflected in the Provider Complaint Report.

In respect of the length of the appointment, Ms B was able to recount the substance of the physical examination of her son. In terms of what may have been discussed, Dr. Attallah's note for the child provides little detail.

It was alleged that Ms. B was inconsistent in her testimony when she stated, "It was no big deal", followed shortly by, "I take that back. It's a big deal". This occurred during vigorous cross-examination and appeared to reference the unfilled antibiotic prescription in the first instance and ''your seriously unwell five-year old son with

breathing problems" in the second. The Committee is not persuaded that this was an inconsistency that should reflect negatively on the veracity or reliability of Ms B's evidence. These statements were made during vigorous cross-examination and Ms B quickly corrected herself when she understood that what was being suggested was that she was indifferent with respect to her son's condition and his proper care.

With respect to the suggestion in cross-examination that Dr. Attallah had criticized her parenting and she had become angry, there was no reference to this in the clinical notes and Dr. Attallah did not testify to this effect. There was no evidence to support this assertion and it was one that Ms B denied forcefully. The Committee was not persuaded that Ms B's complaint was in any way motivated by any ill will or anger towards Dr. Attallah for making any such suggestion or comment to her with respect to her parenting or care of her child as there was absolutely no evidence to support this theory.

MR. C

In respect of nine claims made using Mr. C's health card number between April 2006 and December 2009, the College alleges that:

- Dr. Attallah collected Mr. C's health card number with no proper purpose
- Dr. Attallah improperly claimed the fee code for "interview with a relative" (K002) on four occasions
- Dr. Attallah did not provide the services to Mr. C for which he claimed various other fee codes (individual counseling, K013, intermediate assessment, A007) on five occasions.

Mr. C lives in Orton, Ontario. He testified that Dr. Attallah was his father's doctor and that he himself never was a patient of Dr. Attallah's. He stated that Dr. Attallah never

provided him with any medical services other than a flu shot, for convenience, when he happened to be in Dr. Attallah's office accompanying his father. Mr. C had his own family doctor in Brampton at the time, who had been his family doctor since 1987.

Mr. C attended his father's appointments because his father had progressive dementia and would not remember what was discussed. As well he had a problem with alcohol abuse and other issues. He has had power of attorney for personal care decisions for his father for many years. His father stopped seeing Dr. Attallah in 2007 or 2008. Mr. C said that this was because he [Mr. C] had concerns about Dr. Attallah's "ethics" and, more importantly, the amount of time wasted in Dr. Attallah's waiting room, which was difficult with the travel involved and his work schedule. By "ethics", Mr. C meant that he was asked at the front desk for his health card number at every visit and he felt that this was not appropriate.

Mr. C had no issues with Dr. Attallah's medical care of his father.

Mr. C recalled his first contact with Dr. Attallah as a fairly long telephone conversation. He was concerned that his father hadn't been providing accurate information about his health conditions at prior visits on his own. At that point, it was decided that he should accompany his father at appointments. Mr. C testified that they did not discuss family counseling on that call or ever.

Mr. C testified that whenever they checked in at Dr. Attallah's office for his father's appointments, they would be asked for their health card numbers. He tried to avoid giving his own but was sometimes told that he needed to provide it.

Mr. C testified that he asked Dr. Attallah why he needed to provide his health card to Dr. Attallah, and that Dr. Attallah responded to him that "any time that he [Dr. Attallah] had an opportunity to speak with me [Mr. C], then he [Dr. Attallah] has the right to charge".

Mr. C testified further that:

- He never had a separately-booked appointment to discuss his father's health
- His father's health was what was discussed at every appointment
- Given his father's condition, much of the conversation taking place during his father's appointments was between himself and Dr. Attallah
- He never saw Dr. Attallah alone without his father present
- He spent virtually no time ever discussing his own health with Dr. Attallah
- Dr. Attallah never physically examined him, prescribed medication for him, or told him he was keeping a separate medical chart for him

Mr. C testified that Dr. Attallah did ask him about his own health at one of his father's first appointments he attended. Mr. C testified that he was very guarded in what he shared as Dr. Attallah was not his doctor and he already had a family doctor. He mentioned that he had high cholesterol. Mr. C didn't know why Dr. Attallah was asking about his health and thought perhaps he was just trying to be friendly.

Mr. C recalled it was not uncommon to spend more than an hour in the waiting room. Most appointments with Dr. Attallah were in the range of 20 minutes long but some were quite a bit longer, perhaps 45 minutes, given the concerns with his father they were dealing with.

To the extent that Dr. Attallah's notes state that Dr. Attallah counselled or interviewed him about his father and performed an examination or assessment of him for which he billed OHIP, Mr. C responded, "Did not happen."

Dr. Attallah's entire chart note supporting each of the nine OHIP claims at issue, and a summary of Mr. C's testimony, if any, are set out below.

Date	Fee code	Dr. Attallah's full chart note for Mr. C	Mr. C's testimony
April [date], 2006	K013, 1 time unit	Patient of Dr. … , [xx]-year-old…, married 26yrs, 3 children. High cholesterol. He is here with his Dad. His father has given permission for his file to be discussed with his only son. He has also acted in a similar way for his mother when she passed away approx 1 yr ago. Counselled with regards to his dad getting bubblepacks. Following through with his tests and issues in regard to how much of confusion is related to delerium [sic] from UTI, and how much from possible other cause and how much is due to dementia or alcohol. f/u in one to two weeks. Counselled x 46 mins 4-4:46pm	Mr. C testified that he recalled this appointment, that Dr. Attallah did not counsel him about his own health, did not spend 20 minutes with him in addition to any time spent talking to or assessing his father. He stated that Dr. Attallah asked him for his health card number. The discussion during the appointment was in regard to Mr. C's father.
August [date], 2006	K002, 1 time unit	Counselled re: diagnosis of his father multi infarct dementia x 20 mins 4:30-4:50pm	[none]
October [date], 2006	K013, 2 time units	Father with dementia. See fathers [sic] chart. Counselled for 46 minutes, 4:22-5:08pm. Reassurance given. I explained that he should not driven a [sic] he needs to be placed	Mr. C testified that he recalled this appointment and that he was present throughout. Further, Dr. Attallah did not counsel him about his own health, nor did he counsel him for 46

		with CCAC on emergency basis and he fully understands.	minutes in addition to any time he spent talking to his father, and Dr. Attallah did not spend over 90 minutes talking to Mr. C and his father that day.
March [date], 2007	K002, 2 time units	S: Interviewed with regards to father counselled 46 minutes from 12:50 to 1:36 pm	Mr. C testified that he recalled this appointment. Dr. Attallah did spend 46 minutes talking to Mr. C about his father's health. He also performed an examination or assessment of his father. Mr. C did not have a separately-booked appointment to discuss his father's health with Dr. Attallah. His father was present throughout the appointment.
June [date], 2007	K002, 2 time units	S: interviewed and counselled with regards to his father x 46 minutes from 8:30 to 9:16 pm	Mr. C did not specifically recall this appointment and did not know whether Dr. Attallah spent 46 minutes counselling him about his father or not. His father's appointments were typically in the morning. Mr. C had no recollection of attending an evening appointment from 8:30 to 9:16 pm.
August [date], 2007	K002, 2 time units	S: interviewed and counselled with regards to his dad x 46 minutes from 3:15 to 4:01 pm. I disagreed with him that if he is not monitored on a daily basis it was safe to leave him at home, however he agreed	[none]

		to reassess the situation frequently and will reassess whether or not he is competent to stay at home. Unfortunately he can do a lot for himself at this time and CCAC does not feel that he would qualify to be forced to live somewhere else.	
February [date], 2008	A007	[Mr. C] is [patient]'s son. A copy of his note was pasted in [Mr. C]'s chart at Dr. Attallah's request. S: here for follow-up of dementia, alcoholism …[continues with balance of the note from patient's chart]	Mr. C testified that he recalled this appointment. Dr. Attallah did not physically examine or assess him that day. Mr. C was present throughout his father's appointment. The appointment may have taken 76 minutes although he didn't believe that it had.
March [date], 2008	A007	some questions about his dad. interviewed and counselled for 7 minutes	[none]
March [date], 2008	A007	here concerned about his dad, interviewed and counselled with regard to the results.	[none]

Credibility and reliability. The Committee found Mr. C to be credible and his evidence reliable. He recalled several but not all of the visits in question and freely acknowledged when he did not remember details. There were no inconsistencies in his testimony.

With respect to the length of time he and his father spent with Dr. Attallah, Mr. C had some specific recollections. He was sensitive to the time spent because of his need to travel to be with his father and because of his work schedule. Mr. C tried scheduling early morning appointments, hoping that the waiting time would be less.

MS D

In respect of the claims for "interview with a relative" (K002) using Ms D's health card number on July [date] and July [date], 2007, the College alleges that:

- Dr. Attallah collected Ms D's health card number with no proper purpose
- Dr. Attallah improperly claimed the K002 fee code
- Dr. Attallah did not provide these services to Ms D
- Dr. Attallah did not spend at least 46 minutes providing this time-based service, as required to support his claim for July [date], 2007
- Dr. Attallah's documentation in Ms D's medical chart is inaccurate and self-serving in that it documents an encounter that did not occur.

Ms D lives in St. Catharines. She testified by video link. Ms D had her own family doctor at the time in question, in St. Catharines, and had been a patient of his since 1965.

Ms D knows Dr. Attallah from having taken her sister who has schizophrenia to some of her appointments in 2007. Ms D and her sister have an older sister, Ms E, who testified as well.

Ms D stated that she drove her sister to Dr. Attallah's office on four or five occasions and went in with her two or three times. She denied being involved in making decisions about her sister's health care and said that her sister did not need anyone with her in her appointments. Ms D denied that Dr. Attallah ever told her that patients with mental health issues should attend appointments with a family member.

Her recollection was that she did not go into the treatment room with her sister on the day in question or other occasions.

Ms D had no concerns with Dr. Attallah's care of her sister apart from how he managed the administration of her medication, which she received as an injection every two weeks.

Ms D testified that, on the first occasion she accompanied her sister, her sister checked in with the receptionist. The receptionist then called her [Ms D] to the desk and asked her for her health card number. Ms D's recollection was that she declined to give it. The receptionist asked again later for her health card number as they left the office. She initially declined again, but then did give it.

Ms D believed, although was not certain, that it was at this first visit that, when her sister was taken to a treatment room, Ms D was taken to a small room with a desk where Dr. Attallah asked her questions about her sister's health history. She spent 15 to 20 minutes with Dr. Attallah discussing her sister. She was adamant that such a discussion took place only once. She denied that she had a separately-booked appointment or that he spent 46 minutes with her. Ms D said that Dr. Attallah did not "go on and on with questions", and that "he [Dr. Attallah] couldn't leave [the patient] there for 46 minutes by herself in a room…waiting for him to give her needle".

Dr. Attallah's entire chart notes for the two visits at issue are set out below.

Date	Fee code	Dr. Attallah's complete chart note for Ms D	Ms D's testimony
July [date], 2007	K002, 2 time units	S: interviewed and counselled with regards to her sister x 46 minutes from 12:00 to 12:46 pm	[see above]
July [date], 2007	K002, 1 time unit	S: Interviewed and counselled with regards to her sister x 20 minutes from 2:00 to 2:20 pm	[see above]

Credibility and reliability. The Committee found Ms D to be a credible witness and her evidence reliable. She acknowledged when she was not fully certain of her recollections, but was clear and consistent about several key points. Her comments about why she recalled how long she had spent alone with Dr. Attallah discussing her sister's health made sense. It would not have been reasonable for Dr. Attallah to see her for 46 minutes while her sister sat in a treatment room waiting for a needle.

MS E

In respect of Ms E, the College alleges that Dr. Attallah collected Ms E's health card number with no proper purpose. There are no specific OHIP claims at issue but the Committee found her evidence relevant to the general allegation that Dr. Attallah improperly collected health card numbers.

Ms E is the older sister of Ms D, who also testified, and of the sister who was Dr. Attallah's patient. Ms E lives in St. Catharines and is retired. She had her own family doctor at the time and told Dr. Attallah this.

Ms E testified that she accompanied her sister on her visits with Dr. Attallah, but that she herself was never his patient. She stated that she did not make health care decisions for her sister, and was involved only in that she wanted to be sure her sister had a doctor. She agreed that accompanying her sister to appointments meant that she would miss work.

Ms E accompanied her sister twice. On the first occasion, Dr. Attallah asked her questions about her sister and then asked her for her health card number. Ms E declined, saying that she wasn't his patient. She testified that Dr. Attallah said, "If [your sister] is my patient, her whole family has to be my patient". She told him, "That wasn't

going to happen". Ms E testified that she never provided her health card number to Dr. Attallah or his office staff and continued to accompany her sister to appointments.

Ms E did not recall writing a note to Dr. Attallah to the effect that her sister was capable of going to appointments on her own, but accepted the suggestion by Dr. Attallah's counsel that Dr. Attallah had called her afterward. She could not recall the date of the call but agreed that Dr. Attallah's note in her sister's chart for September [date], 2007 reflected the substance of her note to him. Ms E testified that during his call to her, Dr. Attallah told her that she had a month to decide whether or not to provide her health card number and that if she did not then her sister would no longer be his patient.

Credibility and reliability. The Committee found Ms E to be a credible witness and her evidence reliable on the key issue of whether or not she was asked to provide her health card. She acknowledged that her recollections of dates and details of visits was limited, but was confident about the substance of what Dr. Attallah said to her about her health card number and her becoming his patient. Ms E did not recall having written a note to Dr. Attallah regarding her sister's ability to be independent, although she recognized the note as hers when shown it. The issue of her sister's independence is not significant in itself but was obviously a concern for Ms E (and Ms D) whose view differed from Dr. Attallah's. The Committee did not find that the fact that Ms. E did not recall this note to have a negative impact on the reliability of her evidence regarding being asked for her health card number. It was the fact that she was told that her sister could no longer be a patient if she (Ms E) did not provide her health card which was unusual and that is what stuck in her mind.

MS F

In respect of five OHIP claims using Ms F's health card number between January 2007 and November 2007, the College alleges that:

- Dr. Attallah improperly claimed the fee code for “interview with a relative” (K002) on three occasions
- Dr. Attallah did not provide the services to Ms F for which he claimed the fee codes for individual psychotherapy (K007) and individual counselling (K013)
- Dr. Attallah did not spend at least the minimum time providing time-based services he claimed using Ms F’s health card number on any of five occasions
- Dr. Attallah’s documentation in Ms F’s medical chart is false or inaccurate.

Ms F lives in St. Catharines. She, her husband and her mother became patients of Dr. Attallah in January 2007. She stopped seeing Dr. Attallah about two years later, mainly because she found the wait too long when she went to see him. Her mother died in April this year. She had no concerns about Dr. Attallah’s care of her or her family.

Ms F testified that she accompanied her mother to all of her appointments solely to translate for her and denied that she was an advocate for her mother. She was very consistent in this evidence through vigorous cross-examination. Her mother had no major health problems and was capable of making her own decisions and managing her own care. She denied ever having a separate appointment with Dr. Attallah to discuss her mother’s health, and said that she was always with her mother during her mother’s appointments. Ms F testified that she never spent 20 or 46 minutes discussing her mother’s health with Dr. Attallah. Nor was there ever an appointment when Dr. Attallah spent 46 minutes talking to her about her mother’s health and 46 minutes talking to her mother about her mother’s health, for a total of more 90 minutes.

Ms F often had appointments for herself with Dr. Attallah on the same days as her mother’s. She denied ever seeing Dr. Attallah for counselling or therapy or talking to him about her mental health. She denied ever seeing him to talk about her own health at an appointment without some kind of examination. She may have spent as much as 20

minutes discussing or being counselled with respect to her own health, but never 46 minutes.

Ms F described a typical appointment as lasting 20 to 30 minutes, and longer if for an annual assessment. However, she also went on to state that the longest time she spent in the treatment room with Dr. Attallah was "maximum" 20 minutes, and 30 minutes for an annual assessment. She said that she knows how long her appointments were because she wears a watch and checked it all the time, but acknowledged that many years later she could not clearly remember whether appointments were 20 or 30 minutes. She did not accept that Dr. Attallah could ever have spent 46 minutes with her but later acknowledged that it was possible, but did so at least partly in reference to later visits that are not at issue here.

A summary of Dr. Attallah's chart note for Ms F for each visit and a summary of her testimony are set out.

Date	Fee code	Dr. Attallah's chart notes for MS F	Testimony of Ms F
January [date], 2007	K007, 1 time unit	[A detailed medical history including past history, social history, family history, medications, allergies, lifestyle factors…] A: New pt she does c/o stress from work, moving, some mild anxiety symptoms, no depression, no suicidal ideations. Hypertension, hypothyroidism P: Fu for complete physical. Counselled x 20mins 3:17-	Ms F testified that this was her first appointment with Dr. Attallah. She did not remember it well but said it was possible that the appointment was 20 minutes. She denied that she received psychotherapy. She agreed that it's possible that she talked about moving and that moving can be unpleasant and stressful. She denies that she complained that she was stressed from work.

		3:27pm re: orientation to practice	
February [date], 2007	K002, 1 time unit	Interviewed in regards to her mother x 20 min 5:25-5:45pm. Will book Physical. W: 61.2 kg	Ms F testified again that she never had a separately-booked appointment to discuss her mother's health. She did not spend 20 minutes that day talking about her mother's health as she was there simply to translate for her mother. She acknowledged the possibility that her mother's appointment that day may have been as long as 20 minutes, being for a full physical examination and that she would have interacted with Dr. Attallah during that period of time, but as her mother's translator.
May [date], 2007	K002, 2 time units	Interviewed and counselled re: her mother x 46 mins 10:30-11:16am […note detailing follow-up of Ms F's hypertension, hypothyroidism, rhinitis-sinusitis, and counselling re: removing her dog.]	Ms F testified that her mother saw Dr. Attallah about cold symptoms that day and that her role was as a translator. She denied that she had ever spent 46 minutes with Dr. Attallah discussing her mother's health.
June [date], 2007	K002, 2 time units	S: Interviewed and counselled with regards to her mother x 46 minutes from 12:00 to 12:46 pm language barrier 2: she requires some prescription repeats 3: counselled re: smoking cessation again prescription for Champix given	Ms F recalled an appointment at which she was given a prescription for Champix and that she had sinus problems. She testified, however, that she did not have a separately-booked appointment to talk about her mother's health that day, and stated that it was not

		4: rhinitis did not notice any improvement with Nasonex P: discontinue or use prn will check TSH T4 and T3	possible that Dr. Attallah spent 46 minutes discussing her mother's health with her.
November [date], 2007	K013, 2 time units	[A note outlining, where appropriate, the history, exam, assessment and plan for four issues: lesion on her cheek, smoking cessation, rhinitis-sinusitis, and "continue with adalat"….] Counselled for 46mins from 12:10pm-12:56pm with regards to the importance of following through with Tx, she seems to understand this now, will hold off on any avelox Tx until then.	When asked if she recalled this visit, Ms F stated that it was "very possible." She attended because she needed some medication and denied that Dr. Attallah spent 46 minutes that day counselling her about following through on treatments. She agreed that she would likely have talked with Dr. Attallah about the various issues. She testified that she did not recall ever spending as long as 46 minutes discussing her health with Dr. Attallah. She did not recall ever having an appointment at which she simply went in to talk to Dr. Attallah about her health but was not examined.

Credibility and reliability. The Committee found Ms F to be credible and reliable. Her testimony was clear and consistent. She acknowledged when she was uncertain. Her recollection of detail and times seemed reasonable. She acknowledged when she was uncertain about specific recollections. The thrust of her evidence in respect of the lengths of appointments was that they were typically 20 minutes at most, and occasionally 30 minutes.

MS G

In respect of Ms G's visit on March [date], 2010, the College alleges that:

- Dr. Attallah collected health card numbers of Ms G's children with no proper purpose
- Dr. Attallah did not provide primary mental health care to Ms G for which he claimed the fee code K005
- Dr. Attallah did not spend at least the minimum time providing a time-based service (K005, 1 time unit, at least 20 minutes) required to support his claim.

Ms G lives in St. Catharines. She has two children, now aged 10 and 12.

Ms G testified that she was a patient of Dr. Attallah around the time in question and had been for some years but is no longer a patient. She saw him about hypothyroidism and periodic visits as needed. Ms G testified that she would answer questions from Dr. Attallah such as, "How are things?", but denied ever seeing him for counselling.

Ms G's children regularly saw a pediatrician. Ms G also took her son to see Dr. Attallah when he was a newborn. She acknowledged her signature on a form enrolling her and her daughter in Dr. Attallah's family practice, dated the day prior to the visit at issue. She had not taken her daughter to see Dr. Attallah previously.

Ms G had no concerns with Dr. Attallah's care of her or her son.

Ms G recalled the appointment in question. She had made it for herself because she needed a renewal of her prescription for thyroid medication. She testified that she brought her children with her because she had no babysitter that day.

Ms G stated that the receptionist asked her, when she arrived to register, to provide her children's health card numbers as well. She was surprised by this request, and objected to the receptionist that the appointment was only for her. She then recounted that the

receptionist told her that her children could not accompany her to the treatment room unless she provided their health card numbers. Ms G did so as she needed her thyroid prescription.

Ms G testified that, when she and her children went into the treatment room, Dr. Attallah first assessed her [Ms G] and then examined her nine-month old daughter. She said that she questioned him about this and told him that her daughter had seen her pediatrician the day before. She recalled "stopping him" but then, as Dr. Attallah explained that it didn't hurt to be checked twice and they were allowed to have a family doctor as well as a pediatrician, she let him continue. Ms G had no concerns about Dr. Attallah examining her two or two-and-a-half year old son that day, with respect to the resolution of his cough and possible H1N1 vaccination by his pediatrician.

Ms G described feeling angry after the appointment about being asked to provide her children's health card numbers. She made a complaint to the College and began looking for another family doctor. Ms G identified the College document and her narrative in the complaint, which is date-stamped September 3, 2010. In it, Ms G stated that she waited to make her complaint until she found a new family doctor because she "feared retribution".

Ms G denied that Dr. Attallah provided her with mental health care or counselling for 20 minutes on March [date], 2010. She said that he had asked her general questions such as, "How are things going at home? Have things improved?", and she answered but thought he was simply being nice.

Dr. Attallah's chart note for Ms G's visit on March [date], 2010 describes details of the current state of issues with her husband and marriage initially, and an assessment of her thyroid status including physical examination.

Credibility and reliability. It is reasonable that the events of the encounter on March [date], 2010 would be memorable for Ms G as she stated that she was upset by the request for her children's health card numbers. However, Ms G's evidence that she brought her two children because she didn't have a babysitter and was surprised to be asked for their health card numbers is not fully consistent with other evidence. In particular, in respect of her son, Ms G testified that she had made an appointment for her son with Dr. Attallah about H1N1 vaccination, although she gave no evidence about the date of the appointment. Ms G also testified that part of the advice she was seeking that day from Dr. Attallah was whether her son had recovered from a cold or not, in order that he could receive H1N1 vaccination from his pediatrician. Dr. Attallah's chart note for her son supports this. This evidence is not consistent with the statement in her complaint, where she said that her son "was not here for anything."

In respect of her daughter, Ms G did not recall signing the form enrolling her daughter in Dr. Attallah's practice on the day in question (presumably this did not occur the day before, as dated).

There is also an inconsistency in the reasons Ms G gave for waiting six months to make her complaint. In the complaint itself she stated that she waited until she had found a new family doctor because of concern about how Dr. Attallah might react. In her February 2017 response to a College email, she stated that the delay was because she didn't know that the public could make a complaint about a physician and that she went ahead as soon as she knew.

The Committee finds that Ms G's recollection of the circumstances and expectations around her visit with her children to Dr. Attallah's office on March [date], 2010 is not reliable as there are too many inconsistencies in her evidence.

MR. H

In respect of 10 claims for services to Mr. H made using his health card number between November 2006 and February 2008, the College alleges that:

- Dr. Attallah did not provide the psychotherapy (K007), counselling (K013), or primary mental health care (K005) services for which he submitted OHIP claims,
- Dr. Attallah did not spend at least the minimum time providing time-based services (K007, K013, K005) required to support his claims
- Dr. Attallah's documentation in Mr. H's medical chart is false or inaccurate.

Mr. H lives in Niagara Falls. He is a retired.

Mr. H was a patient of Dr. Attallah from 2006 to 2008. He saw him because he needed his pain medication prescription renewed every month, forms filled out, flu shots, and "anything relating to a family doctor." Mr. H was taking Percocet for chronic pain and had been for many years. Mr. H testified that Dr. Attallah never refused to prescribe Percocet to him.

Mr. H testified that he would typically spend "10 minutes tops" in a treatment room with Dr. Attallah, saying that it doesn't take too long to get a prescription and talk for five minutes. The longest he said he ever spent with any family doctor was 20 minutes for a general physical. He stated that it was not true that Dr. Attallah spent 20 minutes with him providing counselling, psychotherapy or mental health care on ten occasions as claimed. He denied consistently that Dr. Attallah ever spent 46 or 76 minutes talking to him.

Mr. H could not remember if Dr. Attallah ever talked to him about anxiety or depression but acknowledged that Dr. Attallah had prescribed medications to help with his mood. Mr. H had found them unhelpful and stopped taking them. He acknowledged that he

had had symptoms of depression from at least 2006. He stated that he didn't need counselling and that he would have seen another health professional, who he had seen after a car accident many years before, if he were going to see anyone for counselling about anxiety and depression.

Mr. H testified about each of the ten visits with Dr. Attallah in question although his recollections were not very specific. A summary of Dr. Attallah's chart note for each visit or the note in its entirety, and a summary of Mr. H's testimony, are set out below.

Date	Fee code	Dr. Attallah's chart note for MR. H	Testimony of Mr. H
November [date], 2006	K007, 1 time unit	The note appears to be a reasonably detailed history for a new patient, records a plan for a complete physical examination later, and a flu shot. The note contains the passage: "Counselled re: orientation to practice nad [sic] Narcotic use etc. Apparently he is feeling 7/10 today. Previous suicidal ideation but non [sic] presently. Some mild symptoms of depression and anxiety which have been persistant [sic]. Counselled x 46 mins 10:15-11:01am."	Mr. H did "not really" recall this visit or whether it was the first time he saw Dr. Attallah. He thought that they had probably talked about what is described in the note. Asked whether he may have spent 46 minutes in the appointment, Mr. H responded, "I don't know. But, what I do remember, I was never there long." He reiterated this in later testimony but allowed that the visit might have been as long as 15 minutes.
January [date], 2007	K013, 1 time unit	Dr. Attallah's note identifies multiple issues including discussion of bloodwork (hepatitis status, cholesterol), EKG, suggestion for dietitian,	Mr. H did not recall this appointment but was sure that if it had been 20 minutes long, he would have remembered.

		counselling, sinus symptoms, back pain, pain medication, depression, counselling re narcotic use.	
March [date], 2007	K013, 1 time unit	Dr. Attallah's note comments on the symptom of bright red blood per rectum and related examination, inguinal hernia, enlarged liver, chronic back pain, depression and penile lesions.	Mr. H did not recall this appointment but did not accept that it could have been 20 minutes long. He did not recall discussing the issues in the note.
March [date], 2007	K005, 2 time units	Dr. Attallah's note provides information about Mr. H's chronic back pain, irritable bowel syndrome, stress and mild depression, and medications including a change in Effexor. As well, it states, "…counselled x 46 min 11:30-12:16pm" without elaboration.	With respect to possible counselling, Mr. H responded, "It might say it, but I don't remember it and I was never there long, that I know… I really remember usually being there for about 10 minutes." He testified later that he was "100% sure" that the visit could not have been 46 minutes long, although he did not recall the appointment or details of the discussion.
April [date], 2007	K005, 2 time units	[Dr. Attallah's note mentions issues of bowel function, effect of Effexor, use of pain medication, anxiety, depression, and chronic pain. Medication prescriptions are noted. It closes with:] "Counseled re: use addictive behavior x 46 mins 2-2:46pm."	Mr. H acknowledged that he did not recall this or other appointments specifically. He denied that this appointment or any other could have been 46 minutes long.
June [date], 2007	K005, 2 time units	[Dr. Attallah's note describes review of past use of pain medication, current status of chronic pain, depression,	Mr. H did not remember any details of this appointment, but was certain that it had not been 46 minutes as he had

		athlete's foot, reflux and H pylori test result, and prescriptions for Liprosol, Champix, and Percocet, and counselled re quitting smoking.]	never had a visit that long. He stated that he could remember the length of appointments much better than the discussions.
November [date], 2007	K005, 1 time unit	[Dr. Attallah's note is very brief, mentioning knee pain and counselling for 20 minutes, 2:05-2:25 pm, apparently for chronic pain.]	Mr. H did not remember the visit at all. He stated that he "can remember how long [he] was there". Although he testified that he couldn't remember whether this appointment was 20 minutes, he didn't think that it had been.
December [date], 2007	K005, 2 time units	[The complete encounter note is:] S: he is very anxious about dates on his insurance work forms. A: anxiety, counselled for 46mins. From 4:15-5:01pm, reassurance given.	Mr. H recalled a visit at which he needed a sickness and accident form completed, and if it were not completed properly then his pay would be delayed. He was uncertain whether this was the visit he recalled, but did remember being stressed and frustrated by Dr. Attallah's approach to filling out the form. He didn't think he had talked to Dr. Attallah about his mental health on that day and denied that they had talked about anxiety for 46 minutes.
January [date], 2008	K005, 1 time unit	The note describes some details of the surgery and of his pain medication prescriptions and the need to reduce them. The assessment is knee and back pain, then, "Interviewed and	Mr. H recalled seeing Dr. Attallah shortly after knee surgery and accepted that this might have been that visit. Asked whether Dr. Attallah might have counselled him for 46 minutes about smoking,

		counselled for 46mins. From 2:30pm-3:16pm. f/u regarding smoking cessation and wart Tx."	pain medication, and wart treatment, Mr. H responded: "We might have talked about it, but there was no counselling. And, I can't see -- there was never a 46-minute appointment ever. Ever. All this counselling, I don't know." Mr. H reiterated in later testimony that he was definitely never at a visit that was 46 minutes long. He could not remember whether this one took 20 minutes.
February [date], 2008	K005, 3 time units	The chart note sketches out his knee and chronic pain issues, upcoming eye surgery, and his wish to review the OR note for his knee surgery. It includes "interviewed and counselled" in respect of chronic pain, and "interviewed and counselled for 76mins. From 1:00pm-2:16pm."	Mr. H did not specifically recall this visit, but could not accept that it had been 76 minutes. He pointed out that he would have had to be at work at 2:30 pm. He also took issue with the idea that he had had questions about the OR note. He stated that he would not have understood much of the note, his knee was fine following surgery, and if he'd had questions he would have asked his surgeon.

Credibility and reliability. The Committee found Mr. H to be credible but he had difficulty recalling the details of specific visits. Mr. H readily acknowledged that he had few recollections of specific visits or dates. However, he was consistent in his general observations about the length and content of his visits, although at times was perhaps more categorical in his statements than warranted.

It was clear that Mr. H based his testimony on an aggregate recollection of his visits but he also provided explanations that support his testimony. In respect of his assertions that the visits were typically ten minutes and possibly only once longer than 20 minutes, it was readily apparent that Mr. H's goals for his encounters with Dr. Attallah or any physician were quite limited, and did not include any counselling or support for any mental health issues. His recollection of discussions or questions was that they were very brief and not in depth, and he pointed out that it takes only a few moments to go through a series of quick questions and answers about what may appear in a note to be a list of substantive topics. Mr. H also commented on the long periods of time spent in the waiting room and would have been able to relate this time to the time he spent with Dr. Attallah. It seems very likely that Mr. H would have been well aware if a visit went on much longer than 20 minutes, and certainly 46 minutes or more.

Mr. H appeared uncomfortable, understandably, with discussion of sensitive personal health information. He gave some inappropriate, flippant answers. He gave them when pressed during cross-examination to distinguish whether a ten-minute appointment could have been 15 minutes, a 15-minute appointment 20 minutes, and so on, and after he had repeatedly acknowledged that he recalled little of specific visits. These answers were not helpful, but the Committee found that for the most part Mr. H did his best to be of assistance.

The Committee accepts Mr. H's evidence that his visits with Dr. Attallah were rarely, if ever, longer than 20 minutes.

MS I

In respect of his claim for services to Ms I on October [date], 2008, the College alleges that Dr. Attallah did not provide primary mental health care for which he claimed a K005 code, four time units (at least 1 hour and 46 minutes).

Further, the College alleges that Dr. Attallah did not provide primary mental health care to another patient, Ms J. who has the same first name as Ms I, and whose chart note for the same day was nearly identical, and for which he claimed a K005 code, three time units (minimum 76 minutes).

Ms I used to live in St. Catharines. She began seeing Dr. Attallah as her family doctor in 2007, at which time she had a different surname. She saw him on about 12 occasions, for one full physical examination, smoking cessation, sinus problems and back pain. Ms I stopped seeing Dr. Attallah in spring 2008 because the wait times were "extreme" and she had found a new family doctor, whom she continues to see. Ms I had no concerns with Dr. Attallah's medical care.

Ms I testified that she did not see Dr. Attallah on October [date], 2008, that she was no longer his patient, and that she was seeing another physician as her family doctor at that time.

Dr. Attallah's note in Ms I's chart for that day opens with the statement, "suspect that this dictation could belong to [Ms J] Oct. [date]/08" and then notes a concern about a gynecologic problem for which she received treatment from an oncologist, and anxiety and depression for eight years. It concludes with, "Treated and counselled x 76 min from 2:30 to 3:46 pm." There are no subsequent visit notes.

Ms I denied that she had ever seen an oncologist or ever had any mental health treatment prior to 2015. She denied the possibility that Dr. Attallah could have provided her mental health care for 106 minutes on that day, and stated that the longest appointment she had ever had with him was about 45 minutes for a physical examination.

Dr. Attallah's note for Ms J on October [date], 2008 opens with, "suspect that this dicta belongs to [Ms I]." The balance of the note is highly similar to the note for Ms I, with minor differences in phrasing and typographical errors. The last line is the same, "Treated and counselled x 76 min from 2:30 to 3:46 pm."

Ms I acknowledged that she took a "sick day" from her work on October [date], 2008. This was documented in a report from her employer that she included with an email to a College investigator on May 15, 2015. The email says that it is "unfortunate" that she was off work that day, knows that she didn't see Dr. Attallah, and offers to help with anything further in the investigation. Ms I acknowledged that she had wanted to help the College in its investigation and that the sick day report "did not help". She also testified that it was highly possible that she took the day off for a reason other than illness as she had reported to her employer. She did not recall what she had done that day.

Credibility and reliability. Ms I was clear and consistent in stating that she did not attend Dr. Attallah's office on the day in question, while admitting that she was unable to recall why she took that day off work, and that it was unlikely because of illness. It seems highly improbable that she would forget a visit lasting at least one hour and 46 minutes, as billed, or 76 minutes, as recorded.

The Committee acknowledges Ms I's expressed wish to assist the College case, but finds that she is a credible witness and that her evidence is reliable on the matter of her non-attendance on the day in question. The Committee understood Ms I to be expressing a willingness to assist with the investigation, but did not take that to mean that she bore any ill-will towards Dr. Attallah or that her evidence was unreliable in the result.

MS K

Dr. Attallah billed OHIP for counselling (K013, one time unit) for Ms K's mother, Ms L, and Ms K for an assessment (A007), both on February [date], 2006.

The College alleges that that Ms L did not attend at Dr. Attallah's office on that day and that Dr. Attallah did not provide the counselling to Ms L for he which made a claim.

Dr. Attallah's billing for Ms K is not at issue.

Ms K lives in St. Catharines. She was a patient of Dr. Attallah from about 2005 until 2013 or 2014. She was not able to recall dates or details of visits. She stopped seeing him because of difficulty in making appointments. Ms K was diagnosed with diabetes in early 2006 at hospital. She recalled seeing Dr. Attallah subsequently and accepted that this may have been on January [date], 2006. Her mother, Ms L, and her aunt are both diabetic.

Ms K saw Dr. Attallah again on February [date], 2006. His chart note for her that day is as follows:

> 24 year old female for f/u of her diabetes.
> O/E
> Her HgA1c was 8.1 and urinalysis positive for blood and glucose
> A: uncontrolled Type II diabetes
> P: will change Metformin to Avandamet, DER referral

Dr. Attallah's note in her mother Ms L's chart, which is also the only note in her chart, for the same date is:

> Patient of another physician with Type I diabetes on insulin. [Ms K] has given permission to discuss her situation with her mother, [Ms L] and has a few questions.
> P: counselled x 20 min from 3:00 to 3:20 pm

Ms K testified that she was accompanied at one of her visits to Dr. Attallah by her aunt, to support her with her anxiety issues, but could not recall the date. Ms K insisted that no other family member ever accompanied her, and specifically that her mother, Ms L, never accompanied her. She consistently denied that her mother attended her appointment on February [date], 2006. Ms K denied that Dr. Attallah ever asked her about sharing her health information with her mother.

For some time around the visit in question, Ms K had minimal contact with her mother, perhaps a phone call at Christmas, for example. They had had a strained, "off and on" relationship for 20 years and at times her mother did not know where Ms K was living. Ms K acknowledged that she moved back to live with her parents for a month or two but could not recall when. She did not think that it was in 2006, although Dr. Attallah's chart note of October [date], 2006 indicates that she had moved back to her parents'.

Ms K acknowledged that she knew her mother's address and phone number but not her health card number.

Ms K was shown the Provider Complaint Report (exhibit 5) headed, "Complaint #4, anonymous caller", and dated February 17, 2006. Ms K denied having made this call to the Ministry. The report, not admitted for the truth of its contents, notes that Ms K was seen for diabetes by Dr. Attallah on January [date], 2006 and February [date], 2006, and that she was accompanied by her aunt on the first visit and her mother on the second. The report contains the health card numbers of her aunt and her mother and notes the concern that Dr. Attallah had billed for services to them that were not provided.

Credibility and reliability. The Committee had concerns about the reliability of Ms K's evidence, particularly with respect to whether her mother accompanied her on February [date], 2006. She acknowledged that she could recall very little detail of visits, dates of visits and other events, yet expressed complete certainty on the one point that her mother never accompanied her. The Committee concludes that she and her mother have had a difficult relationship, and that Ms K is mistaken in her evidence that her mother did not accompany her on the day in question. In particular, no explanation was provided for the fact that Dr. Attallah was in possession of Ms. L's address and health card number. There is no evidence that she attended Dr. Attallah's office on any other occasion upon which she could have provided this information. Although Ms K knew her mother's address; she testified that she did not know her health card number.

MS L

Ms L is the mother of Ms K. She lives in St. Catharines. She has visual impairment, diabetes, has had a heart attack and has been on hemodialysis since last year. There is a strong history of diabetes in her family including in her older sister. She worked in member services at CAA for many years but is now on permanent disability. She testified by video link.

Ms L had her own family doctor, beginning when Ms K was born over 30 years ago until he retired this year.

Ms L testified that she did not know and had never met Dr. Attallah, did not recognize his name, and was never a patient of his. However, she then stated that Ms K had mentioned him as her [Ms K's] doctor. She denied that she had ever spoken to Dr. Attallah or that he had provided medical services or treatment to her on February [date], 2006 or ever.

Ms L testified that she never attended at Dr. Attallah's office with Ms K or accompanied her at any physician's office. She never discussed Ms K's diabetes or other health issues with Dr. Attallah. She denied the possibility that she had in fact accompanied Ms K to an appointment with Dr. Attallah and discussed Ms K's health issues but had since forgotten because of the passage of time.

Ms L did recall driving Ms K to one appointment with a physician in what was likely the same building as Dr. Attallah's office, but said she did not go in with her. Ms L did see a diabetic specialist physician in that building, but only within the last three or four years, and she described the physician as a white female who was obviously not Dr. Attallah.

Ms L did not recall whether Ms K was living at home when she was diagnosed with diabetes, but knew that she could not have been living at home in January and February 2006 because her [Ms L's] father was very ill at the time and Ms K was not present. She did acknowledge being on speaking terms with Ms K around the time of her diagnosis of diabetes.

Ms L acknowledged that the date of birth, address, and phone number recorded in Dr. Attallah's chart note for her were accurate. She denied that she had provided this information or her health card number to him, and said she was very careful about who she gave her health card number to. She could offer no explanation for the information being in the chart note but acknowledged that Ms K, in 2006, would have known the details of her diabetes and much of the other information, and that her [Ms L's] sister knew of her diabetes and insulin use as well. She had not given her health card number to either, however. Ms L denied ever making a complaint about Dr. Attallah or calling the Ministry about him, and denied knowledge of any call to the Ministry.

Credibility and reliability. The Committee had reservations about Ms L's reliability. Ms L was consistent, indeed categorical, in her testimony that she had never attended Dr. Attallah's office with Ms K, and was never his patient. There is an inconsistency or mis-statement in her testimony, likely minor, in that Ms L said that she did not recognize Dr. Attallah's name, and then shortly after, said that Ms K had mentioned to her that he was her doctor. The fact that Dr. Attallah has a note pertaining to Ms L on the day in question, albeit with scant detail beyond the demographics and health card number, is at odds with Ms L's testimony, and the Committee is of the view that her testimony in respect of whether she accompanied Ms K on February [date], 2006 is not reliable, as the only reasonable explanation for Dr. Attallah having her health card number is that she provided it to him.

MS M

In respect of claims made on six occasions between June 2006 and August 2007 using Ms M's health card number, the College alleges that:

- Dr. Attallah collected Ms M's health card number with no proper purpose
- Dr. Attallah improperly claimed the fee code for "interview with a relative" (K002) on three occasions
- Dr. Attallah did not provide the services to Ms M for which he claimed various fee codes (individual counselling, K013, and individual psychotherapy) on three occasions
- Dr. Attallah did not spend at least the minimum time providing time-based services (K002, K013 and K007) required to support his claims
- Dr. Attallah's documentation in Ms M's medical chart is false or inaccurate.

Ms M is a woman in her 90s, now living in Vineland. She testified by video link.

Ms M's husband became a patient of Dr. Attallah in 2004. He died in 2008. Ms M accompanied her husband to all of his appointments because he didn't always understand what the doctor was saying, he wanted her to be there to listen, and because she was his caregiver. Ms M said that she remembered the events in question "pretty clearly" because that "was [her] only job at the time, was to take good care of my husband, … anything that happened to him was very important to me."

Ms M was very clear that she was never a patient of Dr. Attallah. She had her own family doctor, who had taken over her care from a retiring physician whom she first saw in 1951. She stated that whenever Dr. Attallah asked her any questions about herself, she would say, "I'm not your patient" in order to make the point to him that she wasn't his patient.

Ms M described being asked by a receptionist for her health card number when she and her husband first went to register him as a patient. She objected initially but then gave it after receiving an explanation. Ms M would on occasion remind the receptionist that she was not a patient if the question arose, but said she was not asked again for her health card number.

Ms M testified that she:

- never talked about her own health with Dr. Attallah, including any anxiety she may have had or personal feelings
- never received any medical services from him
- never saw Dr. Attallah on her own
- never agreed to receive medical services from him
- never consented to or saw him for counselling or therapy
- is confident she would recall having had any medical service, assessment, or treatment, and

- never had a separately-booked appointment to talk about her husband's health.

Ms M and her husband would typically spend half an hour to an hour in the waiting room initially, then about ten minutes in a treatment room waiting for Dr. Attallah. She testified that Dr. Attallah would usually spend about ten minutes with them. She went on to state:

> I always thought that, for the length of time we would wait in the waiting room, we were out of the appointment room pretty darn quick. But, it was – I'm sure it was never more than 10, maybe 15 minutes tops.

And, later she said: "Twenty minutes was stretching it. I'd say 10, 15 minutes…it might have been a little longer."

The longest time Dr. Attallah spent with them was in her husband's second last appointment, when he was quite unwell. Dr. Attallah was not present continuously though, and saw other patients and arranged x-rays and an ultrasound. Ms M estimated that he spent 40 to 45 minutes with them in total on that day. She stated: "… that day, that was the first time and the only time that he just seemed to really pay attention to my husband and was concerned about him." At no other visit did Dr. Attallah spend 40 minutes with them.

Ms M identified her signature and the response she made to the OHIP Service Verification letter sent October 2007, asking about a claim by Dr. Attallah for counselling at least 46 minutes on August [date], 2007. Her response includes a handwritten note which begins with the statement she was not a patient of Dr. Attallah but her husband was. She testified that she checked the "unsure" box with respect to verifying the service because she was unsure what the Ministry wanted to know and knew that she was not the patient. As instructed on the letter, she went on to explain her uncertainty.

Dr. Attallah's complete chart note and a summary of Ms M's testimony, if any, for each of the claims in question are set out below.

Date	Fee code	Dr. Attallah's full chart note for MS M	Testimony of Ms M
June [date], 2006	K013, 1 time unit	Counselled with regards to her husband's condition for 20 mins from 12:39-12:59	[none]
November [date], 2006	K002, 1 time unit	[blank]	[none]
May [date], 2007	K002, 2 time units	Counselled with reagrds [sic] to her husband x 46 mins from 10-10:46AM	Ms M testified that Dr. Attallah did not spend 46 minutes talking to her about her husband's health on that day. She did not have a separately-booked appointment that day or ever.
June [date], 2007	K002, 1 time unit	S: interviewed and counselled with regards to her husband x 20 minutes from 11:10 to 11:30 am	[none]
August [date], 2007	K013, 2 time units	S: had some questions with regards to her husbands [sic] SOB A: anxious P: counselled x 46 minutes from 11:54 to 12:40 pm fu prn	Ms M testified that Dr. Attallah may have spent 46 minutes in total, in and out of the treatment room and seeing other patients, but did not spend 46 minutes speaking to her about her husband's condition. She was scared when her husband couldn't get his breath but did not believe she had anxiety.
August [date], 2007	K007, 1 time unit	S: interviewed and counselled with regards to her husband she states that	Ms M testified that Dr. Attallah might have spent 20 minutes

		she believes there was a similar mass about a year ago, this would be reassuring however it is dubious concern is about malignancy and she is aware of this x 20 minutes from 10:30 to 10:50 am	explaining what had been found on the x-rays.

Credibility and reliability. The Committee found Ms M to be very credible and reliable and gives her evidence significant weight. Her explanation for why she remembered the visits to Dr. Attallah were reasonable and borne out by the details she provided. Her evidence was clear and there were no inconsistencies. Her testimony is consistent with the documentary evidence of her reply to the OHIP Service Verification letter.

Witnesses who were former employees in Dr. Attallah's office.

BARBARA COCHRANE (receptionist)

Ms Cochrane lives in Welland. She works as a purchasing assistant and has held other administrative positions. She obtained a certificate as a medical office assistant from Niagara College in 2005 for which she completed various courses including medical terminology and medical office administration.

For a period of four or five weeks in 2006, Ms Cochrane worked in Dr. Attallah's office at the reception desk, booking appointments for patients, checking patients in, and taking their information. She took one day off work during that period. Ms Cochrane chose to leave the position because she was paid only monthly and found it difficult to manage her finances, and because she found it stressful dealing with patients who were complaining or angry. She denied any animosity or ill will towards Dr. Attallah.

When checking patients in for their appointments, Ms Cochrane would take their health card, write down their health card number, and verify that it was the patient's card. She testified that Dr. Attallah told her, at the beginning of her employment, to take the health card information from anyone attending with a patient who was going to accompany them into a treatment room. She testified that she had other such conversations, although she could not recall with whom, and that "There were reminders to make sure we got the health cards." Ms Cochrane said that this memory sticks out for her because she thought it was very odd to get information for people who didn't actually have an appointment. She gave the example that she had never been asked for her own health card information when taking her children for medical appointments.

Ms Cochrane went on to state that Dr. Attallah told her that, because accompanying individuals were going into a treatment room, "he was consulting them as well." Several family members asked her why she was requesting their health card information. She responded to them that Dr. Attallah had asked that she obtain the information "from anyone who was going in to see him."

In addition, Ms Cochrane testified that:

- Dr. Attallah never explained to her that she should take health card information from certain people, certain categories of people, or only those accompanying patients who were also going to receive a service, but rather that "it was everyone".
- Dr. Attallah did not instruct her to ask accompanying individuals why they were attending, and determine whether to obtain their health card information.
- Dr. Attallah did not instruct her to explain to individuals accompanying patients that they were going to receive a service.

- Dr. Attallah never tried to educate her about when something might qualify as an insured service.
- Most appointments were scheduled as 15 minutes long, except physical examinations which were longer and new patients who were booked for 30 minutes.
- It was not office practice to book patients and relatives or others who would participate in the encounter in longer, counselling appointments, anticipating that counselling might be needed.
- It is not possible that she misunderstood Dr. Attallah's instructions or misapplied or had trouble implementing the policy.

Credibility and reliability. The Committee found Ms Cochrane to be credible and her evidence reliable in respect of Dr. Attallah's office practices during a brief period in 2006. She acknowledged when she was uncertain about details and did not over-state her observations. While it appears that the work experience was unsatisfactory for her, this did not appear to influence her testimony on significant points. Ms Cochrane was clear and consistent in her evidence on the routine collection of health card numbers from accompanying individuals and on the direction that she received from Dr. Attallah. The Committee sees no reason to discount her evidence about what Dr. Attallah told her about "consulting" accompanying family members. She provided reasonable explanations for why she recalled particular facts. Her comments in respect of patients' concerns about wait times and family members asking why their health card numbers were needed is consistent with the testimony of other witnesses.

SHARON STITT (billing assistant)

Ms Stitt lives in St. Catharines and works as a medical secretary, including booking patients and taking their information, billing OHIP, and transcribing dictation.

Ms Stitt did OHIP billing for Dr. Attallah for about two years or so beginning at the end of 2006. She worked one or two hours per week. She was in the office every week but sometimes only once. Ms Stitt was also employed full-time in a surgeon's office at that time. This was her primary employment and she had always felt unable to give as many hours to the position with Dr. Attallah as he had wanted. As well, Ms Stitt had a part-time job as a bank teller, five hours on Saturday mornings.

Ms Stitt submitted Dr. Attallah's claims electronically to OHIP, using fee codes, diagnostic codes and time units that Dr. Attallah wrote on his day sheets. Ms. Stitt was the primary employee entering claims from day sheets, at least initially, but not the only one. The day sheets were printed from the computer the night before or morning of the day, and would list all patients with appointments scheduled for that day. The information for patients added on to the schedule was hand-written in by Dr. Attallah.

Some claims were automatically rejected by OHIP, perhaps because the patient's birth date or health card number version code was incorrect, for example. As well, certain codes cannot be billed together and were rejected. Ms Stitt saw some of the rejected claims, but not all, and said that other staff were responsible for processing them.

Ms Stitt recalled, in particular, rejection of claims for the fee code K002 which could not be billed with other codes for the same patient. She recalled talking to Dr. Attallah to explain that K002 claims would be rejected when submitted with other codes. In particular, she testified that she talked with Dr. Attallah about the rejections of claims that included both A-codes (assessments) and K-codes, and that they could not be billed together. She stated that he told her "just to keep billing", but could not recall other details of the conversation.

Ms Stitt left the position with Dr. Attallah because she found that there were too many people involved in billing. She denied that she bore any ill will toward him.

Credibility and reliability. The Committee found Ms Stitt to be credible and reliable in her evidence. She was consistent in her testimony and readily acknowledged the limited nature of her employment and matters to which she could or could not speak from personal observation. The Committee finds her testimony about her discussion with Dr. Attallah regarding the rejection of K002 claims to be of assistance.

DECISION

For the reasons set out below, the Committee finds to be proven, on a balance of probabilities and on the basis of evidence that is clear, cogent and convincing, the allegation that Dr. Attallah engaged in disgraceful, dishonourable or unprofessional conduct in that:

1. He collected, with no proper purpose, the health card numbers of family members when they attended his office solely to accompany a patient.

2. He billed OHIP improperly by:

    a. Billing OHIP for interviews of family members of his patients using the health card number of the family members when he knew that

        - The claims should have been made using the health card numbers of his patients
        - The claims would not be eligible for payment if he used the health card numbers of his patients
        - To the extent he interviewed family members, the substance was part of the service he rendered to his patients and for which he billed OHIP

b. Billing OHIP for services that he did not render or for time-based services when he did not spend sufficient time rendering the services to justify the claims

3. He created false or inaccurate records to support his OHIP billings

SPECIFIC FINDINGS AND REASONS

ONUS

The Committee recognizes that the burden is on the College to prove the allegation of professional misconduct. The standard of proof is the civil standard, that is, a balance of probabilities which must be based on evidence which is clear, cogent, and convincing (*F.H. v. MacDougall*, 2008 SCC 53 (CanLII). There is no onus on Dr. Attallah to disprove the allegation

ISSUES

Issue 1. Did Dr. Attallah collect, with no proper purpose, the health card numbers of family members of his patients when they attended his office only to accompany their relatives who were his patients?

The College alleges that Dr. Attallah improperly collected the health card numbers of Ms B, Mr. C, Ms D, the children of Ms G, and Ms M.

Did Dr. Attallah collect their health card numbers?

The Committee finds that Dr. Attallah collected the health card numbers of Ms B, Mr. C, Ms D, the children of Ms G, and Ms M, who were family members accompanying

patients. The evidence for this is the testimony of these individuals (Ms G in the case of her children), the records of Dr. Attallah's OHIP billings and the records of the health card numbers in Dr. Attallah's office charts.

In respect of Ms E, the Committee finds, on the basis of her testimony, that Dr. Attallah did not collect her health card number, because she refused to provide it, although she was asked to do so on more than one occasion based on her evidence.

Did Dr. Attallah have a proper purpose for collecting or asking for the health card numbers?

The Committee finds that the collection of health card numbers was intentional and without a proper purpose, except in respect of Ms G's children. Further, the Committee infers that Dr. Attallah's intention was to make improper claims to OHIP.

The Committee is not prepared to find that Ms G's children's health card numbers were collected without a proper purpose. Ms G's testimony and Dr. Attallah's chart notes for March [date], 2010 are inconsistent in respect of whether it was planned or anticipated when they arrived that her children would receive an insured service that day. The fee codes that may have been billed using the children's health card numbers are not in evidence.

More generally, Ms Cochrane's evidence was that Dr. Attallah instructed her to collect the health card number of anyone accompanying a patient to a treatment room, and that there were reminders of this in the office. Moreover, she testified that Dr. Attallah explained to her that, because the family members were accompanying a patient to the treatment room, "he was consulting them as well."

Ms E testified that Dr. Attallah told her that if her sister was his patient, then the whole family needed to be, and that if Ms E did not provide her health card number then her sister could no longer be his patient. The Committee believes Ms E that this statement was made to her. This was an improper.

Mr. C's evidence was that Dr. Attallah told him that he had "the right to charge" any time he spoke with Mr. C. This was not true and should not have been communicated to Mr. C.

The statements of each of these witnesses was uncontradicted and together they point to a practice of routine collection of health card numbers from family members, and to an intention on the part of Dr. Attallah to bill OHIP for services that were not provided and/or eligible for payment.

Further, the Committee finds that Dr. Attallah's statements to Ms E reflect his wish to obtain her health card number for billing purposes rather than his seeking in any way to establish a family-oriented clinical practice.

This practice of routine collection was questioned by Ms Cochrane, who thought it odd and out of keeping with her own personal experience at doctor's offices. Ms B, Mr. C, Ms D, and Ms M asked the receptionist or Dr. Attallah why their health card number was needed, and objected when asked to provide it. Ms B thought it inappropriate and subsequently made a complaint. Mr. C asked Dr. Attallah why his health card number was needed, thought it inappropriate to be asked, was asked for it repeatedly, and declined to provide it when he felt he could.

Lastly, the Committee expects that, were Dr. Attallah legitimately providing counselling or interviews to family members, there would be evidence of pre-booked, separate appointments for at least some such discussions, being a requirement for such services.

The Committee heard no such evidence. Further, the testimony of Ms Cochrane was that routine appointments were scheduled at 15-minute intervals, and that patients with accompanying family members were not booked for longer appointments in anticipation of possible counselling.

Ms Cochrane's evidence pertains to a period of just a few weeks in 2006. However, the testimony of the family members indicates that the policy of collecting health card numbers extended over a much longer period. Ms M testified that she was asked for her health card number when her husband first registered as Dr. Attallah's patient, which was in 2004. Mr. C was asked routinely for his health card number when he accompanied his father. The notes in his chart begin in April 2006 and end in February 2008. Ms D accompanied her sister at Dr. Attallah's office in July 2007. Ms E accompanied her sister in or around September 2007.

Whether the policy to collect the health card number of any family member accompanying a patient to a treatment room was fully implemented or effective is not relevant.

In summary, the Committee finds that Dr. Attallah routinely collected the health card numbers of family members accompanying patients. He had no proper purpose in doing so and his intention was to use the information for improper billing.

Did Dr. Attallah make improper use of some family members' health card numbers?

As set out below, the Committee finds that Dr. Attallah made improper use of the health card numbers of Ms B, Mr. C, Ms D and Ms M in his billing of K002 and other fee codes.

Issue 2. Did Dr. Attallah improperly bill OHIP for services to patients and family members?

In respect of the eligibility requirements and payment rules for fee codes including K005, K007, K013, and K002, the Committee accepts the following:

- Dr. Anweiler's evidence and the evidence of Dr. Attallah's application for OHIP registration that Dr. Attallah is expected to know the eligibility requirements and payment rules of the fee codes he uses, and is accountable for claims made to OHIP under his billing number. The Committee recognizes that the Schedule of Benefits and related bulletins are lengthy and complex as a whole, but the content relevant to any physician's practice and the limited number of fee codes he or she uses are encompassed in a modest part of the documentation.

- Dr. Anweiler's evidence and the Schedule of Benefits (page GP37, A18) that the number of time units payable for time-based services such as individual psychotherapy (K007), primary mental health care (K005), individual counselling (K013), and interview with a relative (K002), must be calculated based upon consecutive time spent in direct patient contact rendering the service. The minimum time spent in consecutive direct patient contact is 20 minutes.

  Further, individual counselling (K013) is defined as counselling rendered to a single patient; group counselling (K040, K041) is rendered to two or more patients (GP39, A13). Primary mental health care (K005) is defined as individual care (A13). Psychotherapy rendered to two or more family members in attendance at the same time is family psychotherapy (K004) (A14).

  The Committee concludes that when individual time-based services are rendered to two patients concurrently, it is not proper to apply the fee codes for services to an individual to each patient: a physician cannot logically spend consecutive time rendering a service to one patient at the same time they are spending consecutive time spent rendering another service to another patient. Were that

allowed, then a physician would be paid twice for the same period of time. A physician could, however, spend consecutive time rendering a service to one patient, followed by consecutive time rendering a service to another patient, even if both patients were present throughout.

- Dr. Anweiler's evidence and that of the Schedule of Benefits (page GP8) that physicians must have a record to document every claim made to OHIP, and that the record must demonstrate that the service claimed was the service rendered and that the service was medically necessary. Start and stop times are required for time-based services.

- That a patient assessment includes, as one of its constituents, discussion with and providing advice and information to the patient or family member on matters related to the assessment, service provided, and, where appropriate, test results (page GP15).

  Any advice given to a patient that would ordinarily constitute part of an assessment does not constitute counselling, i.e. K013 (GP39).

  Similarly, the code "interview with a relative" (K002) is not to be claimed when the information being obtained is part of the history normally included in an assessment of the patient.

  The Committee recognizes that the definitions of the time-based services at issue here are broad, but is of the view that chart notes should contain at least some information to distinguish an exchange that would be an expected part of an assessment (e.g. brief, routine advice, a few questions or a simple expression of concern by a family member) from an interaction that is more substantial or differs in a way that would support claims for interviews, counselling, psychotherapy, or mental health care. Where a chart note is minimal (e.g.

"interviewed and counselled in regards to father"), the Committee finds this to be weak evidence that the counselling, interview, psychotherapy or mental health care took place.

- Claims for fee code K002 (interview with a relative), require that

    - K002 must be billed to the health card number of the patient whose health is the subject of the interview, not the health card number of the relative being interviewed
    - K002 claimed on the same day as an assessment by the same physician is not eligible for payment regardless of diagnostic codes
    - There must be a separate, pre-booked appointment for the interview or the amount payable is adjusted to the lesser "assessment" fee
    - K002 applies to situations where medically necessary information cannot be obtained from or given to the patient or guardian, e.g. because of illness, incompetence, etc.

- Claims for individual counselling (K013) require that there be a separate, pre-booked appointment and are not eligible for payment when claimed on the same day as an assessment.

Issue 2a. Did Dr. Attallah improperly bill OHIP by billing fee code K002, "interview with a relative" using the health card number of the family members when he knew that

(i) ***The claims should have been made using the health card numbers of his patients***

(ii) ***The claims would not be eligible for payment if he used the health card numbers of his patients and***

(iii) ***To the extent he interviewed family members, it was part of the billable service he rendered to his patients?***

The Committee finds that Dr. Attallah improperly billed the fee code K002 (interview with a relative) on multiple occasions in respect of Ms A, Mr. C, Ms D, Ms F, and Ms M. The Committee concludes that, in many instances, he did not provide the service he claimed.

Ms A

Dr. Attallah claimed K002 using Ms A's health card number on 18 occasions between September 2006 and January 2010. In two instances, there was no record in Ms A's chart to support any claim. In another 13 instances, Dr. Attallah's note was minimal. In three instances, Dr. Attallah's note contains a few words about a topic or topics discussed (July [date], 2007, December [date], 2007, and September [date], 2008). There was no record of start and stop times or the duration of any discussion that may have occurred in 14 instances.

On ten of those occasions, Dr. Attallah also billed time-based fee codes, K005 and K013, using Ms A's mother's health card number, and the balance were billed as assessments.

The Committee accepts Ms A's evidence that she never saw Dr. Attallah without her mother, never had a separate appointment to discuss her mother's health, and did not remember ever spending 46 minutes with him at a visit.

The Committee finds that Dr. Attallah's billings for K002 using Ms A's health card number are improper in that he should have used her mother's health card number, they did not take place at a separately-booked visit, few chart notes

provide any evidence that the service was provided, few charts record start and stop times, and it is more likely than not that Dr. Attallah was claiming for rendering time-based services to both Ms A and her mother at the same time on a number of occasions.

Mr. C

The Committee accepts Mr. C's uncontradicted evidence that he never had a separately-booked appointment to discuss his father's health and that he never saw Dr. Attallah on his own. Mr. C's testimony about the length of the K002 visits does not clearly contradict the evidence of Dr. Attallah's notes, which include start and stop times in each instance. Dr. Attallah's notes for three of four K002 visits (August [date], 2006, March [date], 2007, and June [date], 2007) say no more than "counselling", "interview" or both.

Dr. Attallah's OHIP records show that on each of the four dates on which he billed K002 using Mr. C's health card number, Dr. Attallah also used Mr. C's father's health card number to bill separately.

The Committee finds that Dr. Attallah improperly claimed the K002 fee code on four occasions in that he used Mr. C's health card number when he should have used his father's, and Mr. C did not have a separately-booked appointments. Given no evidence in three instances that any interaction took place beyond what would be expected during an assessment of Mr. C's father, the Committee finds that Dr. Attallah did not provide the service he claimed.

Ms D

The Committee accepts Ms D's evidence that she never had separately-booked appointments with Dr. Attallah and that Dr. Attallah never spent 46 minutes with her discussing her sister's health.

Ms D acknowledged having a brief, separate discussion about her sister's health with Dr. Attallah on one occasion. The Committee finds it more likely than not that this took place on July [date], 2007, the first of the two visits at which she accompanied her sister to Dr. Attallah's office. The only evidence that Dr. Attallah spent any other time with Ms D or might have rendered a service is Dr. Attallah's note for July [later date], 2007. His notes for both visits are extremely scanty and do not contain a reassuring level of information or detail. The Committee prefers the evidence of Ms D and finds, first, that Dr. Attallah did not provide the service for which he claimed K002 on July [date], 2007 and, second, that Dr. Attallah did not spend the minimum time (at least 46 minutes) rendering a service on July [date], 2007.

Further, Dr. Attallah's billing K002 was improper in that any such service should have been billed using Ms D's sister's health card number and there was not a separately booked appointment for an interview on either occasion.

Ms F

Dr. Attallah claimed K002 using Ms F's health card number on three dates in 2007. On each date, he also billed an assessment using Ms F's mother's health card number. Dr. Attallah's notes for two of the visits describe a brief assessment of Ms F. None of the three notes contains any information about counselling beyond that it was related to Ms F's mother. Start and stop times are recorded.

The Committee accepts Ms F's testimony that she never had a separate appointment to discuss her mother's health and never spent 46 minutes with Dr. Attallah discussing her mother's health.

The Committee finds that Dr. Attallah's billings for K002 using Ms F's health card number are improper in that he should have used her mother's health card number, they did not take place at a separately-booked visit, the chart notes provide almost no evidence that the service was rendered, and he did not spend the minimum time (46 minutes) rendering a service necessary to support two of the claims. Dr. Attallah did not render the services he claimed.

Ms M

Dr. Attallah billed K002 using Ms M's health card number on three occasions. He made no note in her chart in support of his billing for November [date], 2006 and his notes for May [date], 2007 and June [date], 2007 are extremely scanty. Dr. Attallah also billed A007 using her husband's health card number on each occasion. The only evidence that Dr. Attallah spent at least 46 minutes with Ms M on May [date], 2007 is the start and stop times he recorded. Given the inadequacies of the note, the Committee prefers Ms M's evidence that Dr. Attallah did not spend 46 minutes with her talking about her husband's health.

The Committee accepts Ms M's uncontradicted evidence that she never had a separately-booked appointment with Dr. Attallah to discuss her husband's health and that she always saw him in the presence of her husband.

The Committee finds that Dr. Attallah's claims for K002 using Ms M's health card number are improper in that

- any K002 claims should have been made using her husband's health card number;
- there were not separate, pre-booked appointments;
- Dr. Attallah did not spend the minimum time (at least 46 minutes) rendering a service on May [date], 2007; and
- there was no record to support the claim that he provided the service on November [date], 2006.

The Committee finds that there was no evidence of discussion or interaction that would qualify as an interview and that Dr. Attallah did not provide the services he claimed.

(i) Dr. Attallah knew that the claims should have been made using the health card numbers of his patients, not their family members.

As set out above in respect of the expectation that physicians know the eligibility requirements and payment rules of the fee codes they bill, Dr. Attallah knew or should have known this to be the case. With regard to K002 in particular, Dr. Attallah was sent an educational letter in May 2008 reminding him of the requirements and rules.

(ii) Dr. Attallah knew that the claims would not be eligible for payment if he used the health card numbers of his patients

Dr. Attallah knew or should have known of this payment rule as a general expectation as set out above, as well as from his discussion with his employee, Ms Stitt. The Committee accepts her evidence that, at some point during her two-year employment beginning late 2006, she discussed the rejection of a number of Dr. Attallah's claims for K002, and the automatic rule applied by OHIP that K002 and an assessment cannot be billed to a patient on the same day.

(iii) Dr. Attallah knew that, to the extent he interviewed family members, it was part of the billable service he rendered to his patients

As set out above, physicians are expected to be familiar with the requirements and payment rules of the fee codes they use. Dr. Attallah used the K002 fee code and the fee codes for assessments frequently. He knew or should have known that discussion, advice and information provided to a patient or family member are, to an extent, a constituent part of an assessment of a patient. This point was also made in the Ministry's educational letter in May 2008.

Issue 2b. Did Dr. Attallah improperly bill OHIP for services to patients and family members by billing for services that he did not render or for which he did not spend the minimum time required to justify his time-based claims?

The Committee finds that Dr. Attallah billed OHIP for individual counselling, individual psychotherapy, primary mental health care and intermediate assessments that he did not render or for which he did not spend the minimum time required to justify his time-based claims. He did so in respect of Ms A, Ms B, Mr. C, Ms F, Mr. H, Ms I, Ms J, Ms. Ms L, and Ms M. In many instances, Dr. Attallah did not provide the services he claimed.

Ms A

> November [date], 2006 (A007, intermediate assessment).
> The chart note is extremely sparse, mentions only asthma and that Ms A declined a flu shot. There is no documentation of a physical examination. Ms A had no recollection of discussing asthma with Dr. Attallah and denied he had ever done a physical examination of her. The Committee finds it more likely than not that no assessment was done and that the claim for A007 was improper.

August [date], 2007 (K005, primary mental health care, 2 time units).
There is only a blank template in Ms A's chart in respect of this date. Ms A testified that Dr. Attallah had never provided her with mental health care or counselled her for 46 minutes. The Committee finds that Dr. Attallah did not provide this service.

November [date], 2007 (A007).
The chart note makes reference only to interview and counselling in respect of vaccination for flu and meningitis, lacks a physical examination, and provides no support for the claim for an intermediate assessment. Ms A testified that she had not been assessed or had a physical examination. The Committee concludes that Dr. Attallah did not provide the service for which he claimed.

November [date], 2008 (A007), February [date], 2009 (A001), September [date], 2009 (A007), September [date], 2009 (A007), September [date], 2009 (A007), and December [date], 2009 (A007).
The chart notes relating to these claims are extremely sparse and offer no basis on which to conclude that the intermediate or general assessments for which claims were made were in fact carried out. The Committee finds that these services were not provided.

July [date], 2009 (K005, 1 time unit) and September [date], 2009 (K005, 1 time unit).
The chart notes in respect of these claims are extremely sparse, only seven and six words in length, respectively. They provide no reassurance that primary mental health care was provided as claimed. There is no record of start and stop times or duration of any interaction that may have taken place. The Committee finds that these services were not provided.

Ms B

February [date], 2006 (K007, individual psychotherapy, 2 time units).
The chart note for this date is brief. It references anxiety and questions Ms B had about her son. Ms B testified that she did not have an appointment that day for herself, was not expecting to receive any services, she was receiving counselling and Effexor from her own family physician at the time, the entire appointment with her son and Dr. Attallah was very brief and did not last 46 minutes, and that she was surprised and upset to be asked for her health card number as she left. The documentation does not suggest that the substance of any discussion with Ms B rose above that which be expected with a mother in an encounter with an unwell child. Further, the documentation provides minimal description of any psychotherapy that may have been provided.

The Committee accepts Ms B's testimony and finds that Dr. Attallah did not provide the service for which he claimed K007. Alternatively, he did not spend at least 46 minutes doing so as required when submitting a claim of two time units of code K007.

Mr. C

April [date], 2006 (K013, individual counselling, 1 time unit)
Dr. Attallah billed K013, 1 time unit (individual counselling) using Mr. C's health card number and K013, 1 time unit using his father's health card number. Dr. Attallah's notes for Mr. C and for his father contain the same brief paragraph referencing counselling "with regards to his dad", and recording the same start and stop times (4:00-4:46 pm) and 46-minute duration of the service. The Committee accepts Mr. C's uncontradicted testimony that the discussion was in regards to his father, that Dr. Attallah did not spend 20 minutes with him in

addition to that, that he never saw Dr. Attallah without his father, and that in general he spent virtually no time discussing his own health with Dr. Attallah.

The Committee finds that Dr. Attallah did not provide the service and thus improperly billed K013 using Mr. C's health card number on April [date], 2006. Further, counselling of an individual (K013) cannot be rendered or claimed for two people at the same time.

October [date], 2006 (K013, 2 time units)
Dr. Attallah billed K013, two time units (at least 46 minutes) using Mr. C's health card number and K002, two time units using his father's health card number. The content of Dr. Attallah's note for Mr. C is minimal. The start and stop times recorded in his chart and that of his father are identical (4:22-5:08 pm) and each of the two services is said to have been 46 minutes. The Committee accepts Mr. C's testimony about this visit, in addition to his evidence about his interactions with Dr. Attallah in general, that Dr. Attallah did not counsel him about his own health, nor did he spend 46 minutes counselling him.

The Committee finds that Dr. Attallah improperly billed K013 in respect of Mr. C in that he did not provide the service. Further, individual time-based services such as code K013 cannot be rendered simultaneously to two people.

February [date], 2008 (A007)
Dr. Attallah billed A007 (intermediate assessment) using Mr. C's health card number and K005, three time units (primary mental health care) using his father's health card number. Dr. Attallah's note contains no evidence of an assessment of Mr. C, only a copy of his note for Mr. C's father on the same day. The note for Mr. C's father states that he was interviewed and counselled for 76 minutes. It mentions that the visit is for follow-up of alcoholism and dementia,

and refers to his living arrangements, medication review, flu shot and TB skin test. The Committee accepts Mr. C's testimony that Dr. Attallah did not examine or otherwise assess him on that day and that he was present with his father throughout.

The Committee finds that Dr. Attallah improperly billed A007 using Mr. C's health card number in that he did not provide the service.

March [date], 2008 (A007)
Dr. Attallah billed A007 using Mr. C's health card number and A003 (general assessment) using his father's health card number. Dr. Attallah's note for Mr. C provides no evidence of an assessment and is very scant, simply stating that interviewing and counselling took place in regards to questions about Mr. C's father for a duration of seven minutes. The note for Mr. C's father is a reasonably detailed note reflecting a general assessment. Mr. C gave no specific testimony with respect to this visit.

The Committee finds that Dr. Attallah's claim for A007 using Mr. C's health card number is improper in that there is no evidence to suggest that an assessment was done. If the A007 fee code was mistakenly submitted rather than K013, for example, the Committee notes that seven minutes of service is recorded, insufficient for a claim for any time-based service.

March [date], 2008 (A007)
Dr. Attallah claimed A007 using Mr. C's health card number and A007 using his father's health card number. Dr. Attallah's note for Mr. C is again extremely brief and states only that interview and counselling took place and no evidence that Dr. Attallah did an assessment. The note for his father is a reasonably detailed

note reflecting an intermediate assessment. Mr. C gave no testimony specific to this visit.

The Committee finds that Dr. Attallah's claim for A007 using Mr. C's health card number is improper and that the service was not provided.

Ms F

January [date], 2007 (K007, 1 time unit).
This was Ms F's first appointment with Dr. Attallah and his chart note describes a general assessment with a plan for a full physical to follow. The start and stop times are 3:17 and 3:27pm, indicating ten minutes of service. The note records "counselling… re: orientation to practice."

Ms F's mother also saw Dr. Attallah as a new patient on that day and there is a comparable assessment and plan. Again, the start and stop times are 3:17 and 3:27pm, indicating ten minutes of service. The note records "counselling… re: orientation to practice."

Although the definition of individual psychotherapy (K007) in the Schedule is broad, Dr. Attallah's note provides little support for his claim to have provided psychotherapy to Ms F, particularly as he describes his counselling as relating to orienting her as a new patient to his practice. Further, ten minutes of service is recorded, not at least 20 minutes as claimed, which is also the minimum requirement for psychotherapy. Lastly, had Dr. Attallah met the requirements for individual psychotherapy, he nonetheless improperly claimed to have provided it concurrently to both Ms F and her mother.

The Committee finds that this claim is improper for the reasons above and that the service claimed was not provided.

November [date], 2007 (K013, 2 time units).
The chart note describes this appointment as follow-up on several issues and includes a limited physical examination. The definition of counselling is broad. The Committee accepts that some or possibly much of the substance of the interaction could be argued to fall within that definition, although the note does not distinguish it well from what would be expected in an assessment.

In respect of the time spent, the Committee finds Ms F's testimony that she did not have a pre-booked appointment to discuss her health and did not spend 46 minutes discussing her health with Dr. Attallah on that day or any other to be persuasive, and prefers it over the evidence in the note.

The Committee finds this claim improper in that Dr. Attallah did not spend the minimum time necessary to support his claim for this service.

Ms G

March [date], 2010 (K005, 1 time unit).
The chart note provides some detail of an assessment and discussion of mental health-related issues, as well as an assessment of Ms G's thyroid status. Ms G denied that Dr. Attallah spent 20 minutes counselling her.

The Committee finds the evidence of the chart note persuasive in respect of the substance of the service Dr. Attallah provided, and concludes that it might well have lasted 20 minutes. However, there is no record of start and stop times or duration (other than the claim for one time unit). Although the claim is not

eligible for payment for this reason and the visit may or may not be more properly characterized as an assessment rather than psychotherapy, the Committee is not prepared to find that Dr. Attallah failed to provide the service or spent less than 20 minutes doing so.

Mr. H

Dr. Attallah claimed the fee codes for primary mental health care (K005) on ten occasions, counselling twice (K013), and psychotherapy once (K005). With respect to the corresponding chart notes, several reflect somewhat or reasonably detailed assessments. In one instance, March [date], 2007, the note is very brief but lists several physical symptoms and findings. It mentions depression only as that single word, yet Dr. Attallah has chosen to characterize that encounter as counselling (K013). It is apparent that Mr. H has mental health, chronic pain and other conditions that could be the basis for the services represented by Dr. Attallah's claims, although there is little or no detail about such services. Start and stop times are consistently recorded.

With respect to the length of the encounters, all claimed as time-based services, the Committee puts some weight on Mr. H's testimony that, in general, his visits were brief, and concludes that it is likelier than not that they were less than 46 minutes. Given the limited or scant detail in Dr. Attallah's notes as well, the Committee finds that Dr. Attallah did not spend the minimum time required to support his claims for psychotherapy (K005) lasting at least 46 or 76 minutes: May [date], 2007, April [date], 2007, June [date], 2007, December [date], 2007, and February [date], 2008.

Ms I

October [date], 2008 (K005, 4 time units).
The Committee accepts Ms I's testimony that she was no longer a patient of Dr. Attallah on this date and did not attend at his office or receive any services from him. Dr. Attallah's chart entry does not support any claim to have rendered any medical services to Ms I that day, and certainly not mental health care for at least 1 hour and 46 minutes.

The Committee finds that Dr. Attallah did not provide the service for which he claimed K005 as above.

Ms J

October [date], 2008 (K005, 3 time units).
Ms J did not testify. Dr. Attallah's note is highly similar to that for Ms I, and records his suspicion that the note pertains to Ms I. There is thus no evidence that Dr. Attallah provided the service to Ms J for which claimed K005 or that he spent at least 76 minutes doing so.

The Committee finds that Dr. Attallah did not provide the service for which he made this claim.

Ms L

February [date], 2006 (K013, 1 time unit).
The Committee has concerns about the reliability of the evidence of Ms K and Ms L, and concludes that it is more likely than not that Ms L did accompany Ms K at her appointment that day. The basis for this is, first, the inherent unlikelihood that, whether he provided a service or not, Dr. Attallah would have in this single instance created a chart and visit note and submitted a claim to OHIP for

someone who was not and had never been present in his office, and second, the absence of any plausible explanation about how otherwise Dr. Attallah might have obtained her health card number. As well, Ms L's presence would be consistent with the notation in her chart that Ms K had given permission to discuss her [Ms K's] situation with her mother, notwithstanding Ms K's testimony that she did not do so.

The content of the note in Ms L's chart is minimal. There is no evidence that any discussion that took place rose beyond what would be expected in conjunction with Ms K's assessment that day. The note records simply "has a few questions". The available evidence fails to provide meaningful support for Dr. Attallah's claim that he provided counselling to Ms L that day.

The Committee finds that Dr. Attallah did not provide this service.

Ms M

June [date], 2006 (K013, 1 time unit)

Dr. Attallah claimed K013, one time unit using Ms M's health card number and A007 using her husband's health card number. The note for Ms M is minimal and states only that she was counselled for 20 minutes about her husband. The note for her husband contains some detail of his multiple problems and includes physical examination. Ms M did not provide testimony about what happened on any specific date but the Committee accepts her uncontradicted testimony that she never talked to Dr. Attallah about her own health, never saw him except with her husband, and never had a separately booked appointment with him.

The Committee prefers the evidence of Ms M over the minimal chart note and finds that Dr. Attallah did not provide the service claimed. His claim for K013 is improper.

August [date], 2007 (K013, two time units)
Dr. Attallah claimed K013, two time units using Ms M's health card number and A003 using her husband's health card number. The note for Ms M is again minimal. It states only that she was counselled for 46 minutes about her husband. The note for her husband is detailed and consistent with a general assessment. Ms M testified that Dr. Attallah may have spent 46 minutes in total with them but was in and out, seeing other patients and ordering tests.

The Committee again prefers the evidence of Ms M over the minimal chart note, and finds that Dr. Attallah did not provide the service claimed.

Issue 3. Did Dr. Attallah create false or inaccurate records to support his OHIP billings? Did he create charts for individuals who were not his patients?

The Committee has found (above) that Dr. Attallah failed to render services for which he submitted claims and/or failed to spend sufficient time with patients to justify time-based claims, in respect of Ms A, Ms B, Mr. C, Ms D, Ms F, Mr. H, Ms I, Ms J, Ms L, and Ms M.

To the extent that Dr. Attallah's chart notes describe these services or state that he rendered them and/or spent at least the time required to justify them, the Committee finds that Dr. Attallah has created notes that are false or inaccurate.

The Committee was not persuaded in any way of the accuracy of Dr. Attallah's notes by the minimal evidence that he dictated notes in front of a few patients during their visits.

One witness has hearing problems and could not hear Dr. Attallah well. The Committee heard no other evidence with respect to how and when Dr. Attallah completed or edited his notes.

Dr. Attallah created charts for individuals who were not his patients

The Committee is struck by the testimony of three witnesses (Ms A, Mr. C, and Ms M) that they had no expectation of receiving or any intention of seeking medical services from Dr. Attallah, but had attended his office for the specific and sole purpose of accompanying a relative who was a patient. The witnesses provided Dr. Attallah with little or no health information, never saw Dr. Attallah alone, spent little or no time discussing their health with him, did not believe they had received any medical services and were surprised, among other reactions, to learn that he had submitted claims for insured services for them. Each of them had questioned the need for and/or objected to providing their health card number. Moreover, Ms M testified that she told Dr. Attallah more than once that she was not his patient, whenever he began to ask her personal questions.

Counsel brought the Committee's attention to *CPSO v Kayilasanathan*, 2019 ONSC 4350 (CanLII) and *CPSO v Redhead*, 2013 ONCPSD 18 (CanLII) in respect of determining whether a physician-patient relationship exists.

In *Kayilasanathan*, the Divisional Court held on appeal that the Committee had properly found that Ms A's view on whether she and the defendant physician were in a physician-patient relationship was irrelevant. In their analysis of the question, the Committee had considered the factors in *Redhead*, including whether the physician had a patient file that included history, physical examination, diagnosis, plan of management, prognosis, diagnostic imaging reports, and a written record of treatments.

The Committee found in *Kayilasanathan* that the physician had recorded a "detailed description of a history, physical examination, diagnosis, and plan of management, and direction for a follow-up." By contrast, the Committee finds no or minimal detail in Dr. Attallah's notes for any of the three family members whose status as a patient is in question. Beyond the fact that charts and visit notes exist, they do not provide the detail that is indicative of the establishment of a physician-patient relationship and as was found in *Kayilasanathan* and is described in *Redhead*.

With respect to other factors in *Redhead*:

- *Whether there were OHIP billing records for services provided*. The Committee finds, as set out above and for reasons unrelated to the question of whether these family members were patients of Dr. Attallah, each of the OHIP claims related to them was improper and none of the claimed services were provided. Accordingly, the Committee puts no weight on this factor.
- *The number and nature of treatments received and the location.* The documentation in Dr. Attallah's notes provide little or no support for the nature of the services claimed, and the Committee has found that the claimed services were not provided. With respect to location, the family members attended Dr. Attallah's office to accompany a relative, with no intention or expectation of receiving a medical service. The Committee puts no weight on this factor.
- *Whether the physician prescribed medication.* Ms A testified specifically that Dr. Attallah had never prescribed medication for her and the Committee found no evidence that he had done so for Ms A, Mr. C and Ms M.
- *Whether the person had their own family physician.* Ms A, Mr. C and Ms M each testified that they had their own family physician of long standing, and there is no evidence otherwise.
- *Whether there were completed consent to treatment forms, letters of referral to another physician, letters received from another physician, or documents in*

which the physician refers to the person as his or her patient. The Committee heard no evidence that this was the case in respect of Ms A, Mr. C or Ms M and identified no such documents in their charts.

With respect to a fourth witness, Ms D, Dr. Attallah's chart notes, minimal as they are, reference only her sister. His only two OHIP claims using Ms D's health card number are for K002, that is, interview with Ms D about the health of her sister, with no claims for services in respect of Ms D herself. Consequently, the Committee finds no basis in Dr. Attallah's chart or billings, or consideration of other *Redhead* factors, to conclude that Ms D was a patient of Dr. Attallah's.

In summary, considering the totality of the evidence and circumstances, the Committee finds that Ms A, Ms D, Mr. C and Ms M were not patients of Dr. Attallah during the relevant period. Accordingly, the Committee finds that Dr. Attallah created charts for individuals who were not his patients.

Issue 4. To the extent such actions occurred, were they intentional and part of a larger pattern, or were they administrative errors that do not rise to being professional misconduct?

Collection of health card numbers.

As set out above, the Committee finds that the routine collection of health card numbers from family members accompanying patients to visits with Dr. Attallah was intentional, reflects a larger pattern and policy over several years, lacked a proper purpose and was intended to submit improper and unjustified OHIP billing. Ms Cochrane's evidence that Dr. Attallah instructed her to collect the health card number of anyone accompanying a patient to a treatment room was clear, uncontradicted, persuasive, and consistent with the testimony of the family members. She knew that

this was out of the ordinary. Family members also questioned why their health card numbers were being asked for.

OHIP billings

The intentionality evident in Dr. Attallah's routine, improper collection of health card numbers logically carries over to his approach to billing and to maintaining charts.

Dr. Attallah knew or should have known the requirements for claims for K002, "interview with a relative". He was reminded by Ms Stitt that K002 and an assessment cannot both be billed on the same day to the same patient or else one of the claims will be rejected. However, if the interview was claimed (improperly) using a family member's health card number, it would, by contrast, not be automatically rejected. The Committee notes that, in every instance but one, whenever K002 was billed to a family member's health card number (Ms A, Ms D, Mr. C, Ms F and Ms M), Dr. Attallah also claimed for an assessment of the patient and thus, in essence, was paid twice for the same visit.

Dr. Attallah was made aware in May 2008 that the volume of his claims for K002 services in 2007 placed him in the top five percent of Ontario physicians billing this code, and the Ministry reminded him of the requirements to bill K002. Despite this, the evidence before the Committee is that Dr. Attallah continued to bill K002 improperly to family members through January 2010, and to bill his patients for the same visits.

The Committee finds it highly improbable that Dr. Attallah would render time-based services for precisely 20, 46, or 76 minutes in virtually every instance - the minimum lengths of service required to claim one, two, or three time units, respectively – as is documented in his notes.

The Committee recognizes that, in a given instance, a claim may be mistakenly submitted that is not appropriate to the service provided or justified in the chart. As well, despite the responsibility, a physician or their agent may not be aware of a given billing requirement. Occasional administrative lapses are to be expected.

However, it is also to be expected that physicians will take reasonable steps to stay current with billing requirements and respond when issues such as the rejected K002 claims or the education letter from the Ministry or the questions of multiple patients about the propriety of requesting their health card numbers are raised. It is to be expected that errors would be corrected and not be allowed to persist, but the Committee found no evidence of correction.

The number of patients, visits, and OHIP claims at issue must be a very small percentage of Dr. Attallah's practice during the five years in question. However, in the evidence before the Committee, there is a clear pattern of involvement of family members that resulted in billings payable to Dr. Attallah for both the patient and family member for the same visit. The pattern reflects a policy that Dr. Attallah directed his office staff to implement. It is also apparent that most of the improper billing involved "K-codes", for which the definitions of service are broad and the fees higher than for assessments (significantly so when multiple time units are claimed). Lastly, the Committee heard no evidence that would indicate any response or change in Dr. Attallah's billing practices over the period in question.

The statements attributed to Dr. Attallah, which were not contradicted by him, attest to his intention to take this opportunity to bill more and higher-paid fee codes than was justified, regardless of questions and information brought to his attention. The Committee finds that Dr. Attallah's improper billings reflect a larger and purposeful pattern of actions over an extended period of time, February 2006 to January 2010.

Patient records

The Committee recognizes that, in isolation, an inadequate or absent chart note does not necessarily mean that a service was not provided. It is nonetheless struck by the minimal content in a great many of the notes supporting Dr. Attallah's improper claims, especially those for family members. These notes contrast sharply with the detail and substance Dr. Attallah typically records in his notes for other patients and visits, e.g. his notes for the patients who family members were accompanying. Dr. Attallah is clearly fully capable of creating reasonable notes that document and support his care.

The Committee was also struck by Ms I's and Ms J's charts, which share essentially the same note for a particular date. An administrative error could inadvertently result in a misplaced note with no suggestion of impropriety, and Dr. Attallah acknowledged the problem in both charts, yet his explanation that the (same) note did not belong in either chart but did belong in the other patient's chart makes no sense. The Committee found no evidence that any service was provided to either patient or that any attempt was made to correct the records, but Dr. Attallah nonetheless submitted claims for more than three hours of time-based mental health care for these two patients.

In summary, the Committee finds that Dr. Attallah's collection of health card numbers, improper billing, and false or inaccurate charts were not the result of inadvertent administrative errors but represent a pattern and were purposeful. Further, it is likelier than not that the pattern applies to his practice during the period in question beyond the individuals whose evidence has been considered.

Issue 5. Did Dr. Attallah engage in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional?

The professional misconduct regulation under the *Medicine Act, 1991*, includes a "catch-all" provision intended to capture misconduct that is not otherwise specifically defined:

> "an act or omission relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional."

There is no statutory definition of disgraceful, dishonourable or unprofessional conduct, but Steinecke writes in *A Complete Guide to the Regulated Health Professions Act*, Release 37, September 2019, (in 6:60.20, page 6-101):

> "The catch-all provision is not intended to capture the legitimate exercise of professional discretion or mere errors of judgment. However, conduct need not be dishonest or immoral to fall within the definition. A serious or persistent disregard for one's professional obligations is sufficient."

Both disgraceful and dishonourable conduct carry an element of moral failure, whereas conduct need not involve dishonest or immoral elements to be considered unprofessional. Conduct need not harm the practitioner's client or staff to be unprofessional.

The Committee finds that Dr. Attallah has engaged in conduct that would reasonably be regarded as disgraceful, dishonourable or unprofessional, in that he has:

- routinely collected and directed his staff to collect the health card numbers of family members of his patients, and used them improperly;
- knowingly billed OHIP improperly for interviews with relatives and for other services he did not provide or in which he spent insufficient time; and
- created charts and notes that are false or inaccurate to support his improper billings.

Ontario's publicly-funded system for payment to physicians in good faith for the medical services they provide is based on honesty and trust. Family members questioned why their health card numbers were being collected, knew that it was inappropriate, and objected. Further, the unusual pattern of Dr. Attallah's K002 billings was brought to his attention by OHIP. Dr. Attallah continued regardless. His actions were dishonest. He abused the trust that his patients, their family members, and the public have that he and the profession will act in their best interests. In addition, he involved his office staff in his misconduct and abused their trust as well.

The Committee found the decision of *CPSO v Kumra*, 2019 ONCPSD 32, where a finding of disgraceful, dishonourable or unprofessional conduct was made, useful. The physician directed his staff to collect the health card numbers of family members who were not present and billed OHIP for services he did not provide.

The Committee also made a finding of disgraceful, dishonourable or unprofessional conduct in *CPSO v Chandra*, 2018 ONCPSD 28. The physician collected health card numbers of family members who were not present, and billed OHIP very large sums in total for services he did not provide. The evidence from patients and the pattern of billings was found sufficient to infer the fraudulent nature of the billings.

Although the number of family members in *Kumra* and *Chandra* was greater, and the improper financial gain clearly much greater in *Chandra*, Dr. Attallah's conduct demonstrates, at a minimum, a serious and persistent disregard for his professional obligations. The Committee finds that the amount by which Dr. Attallah may have benefitted financially from improper billings is not relevant to the finding of disgraceful, dishonourable or unprofessional conduct. The Committee considered and rejected a related proposition in *CPSO v Taylor,* 2016 ONCPSD 22, where it was submitted that the amount of the physician's improper gain was (relatively) modest, to the point that he

would have lacked a financial motive to engage in the alleged misconduct. We agree with this conclusion.

Issue 6. Should the Committee draw an adverse inference from Dr. Attallah's decision not to testify?

Dr. Attallah did not testify. The College submits that an adverse inference should be drawn from this, on the basis that the Committee can assume that Dr. Attallah would have testified if he had evidence that would contradict the evidence called by the College.

Justice Sopinka wrote in *The Law of Evidence in Canada*, Fifth Edition, paragraph 6.471:

> In civil cases, an unfavourable inference can be draw when, in the absence of an explanation, a party litigant does not testify… The failure to call a material witness amounts to an implied admission that the evidence of the absent witness would be contrary to the party's case, or at least would not support it.

Counsel for the College and Dr. Attallah brought the Committee's attention to *CPSO v Peirovy*, 2018 ONCPSD 6, *CPSO v Kayilasanathan*, 2018 ONCPSD 50 (upheld in 2019 ONSC 4350), *CPSO v McIntyre*, 2015 ONCPSD 25 and other prior cases on the issue of the Committee's ability to draw an adverse inference.

The parties agree on the legal principles that apply with respect to adverse inference but hold opposing views on whether the College has made out a *prima facie* case. A *prima facie* case is simply a case to be met, consisting of the presentation of evidence that, if accepted, could result in a finding of professional misconduct (*CPSO v Peirovy*, 2018 ONCPSD 6). That a *prima facie* case has been established is a prerequisite to drawing an adverse inference.

The Committee finds that the College has made a *prima facie* case that Dr. Attallah engaged in disgraceful, dishonourable or unprofessional conduct, as set out above. Thus, it is open to the Committee to draw an adverse inference from his failure to testify.

The Committee draws the inference that Dr. Attallah's evidence would not support his case with respect to the following issues:

- The practice of collecting health card numbers from family members of patients
- The evidence provided by family members and staff with respect to what they were told by Dr. Attallah
- The improper billing of K002
- The improper billing of other fee codes for services not provided or for insufficient time spent, including billing for one family member who told him repeatedly she was not his patient
- Discrepancies between the testimony of patients and family members and the evidence of his medical charts, and
- The findings of false and inaccurate charts.

In any event, it is the Committee's view that the allegations are proven on a balance of probabilities without relying on the drawing an adverse inference, but that the findings are made overwhelming by doing so.

CONCLUSION

The Committee finds that:

- Dr. Attallah improperly collected the health card numbers of family members who were at his office solely to accompany their relatives who were his patients.

- Dr. Attallah used those health card numbers to improperly bill OHIP for interviews that he knew would not be paid for if he billed them, as he should, to the patients' health card numbers.

- Dr. Attallah billed OHIP using patients' and family members' health card numbers for services that he did not provide or he spent insufficient time providing time-based services to justify the claims he made.

- Dr. Attallah created false or inaccurate charts to justify his claims to OHIP, including charts for family members who were not his patients.

Having regard to these facts, the Committee finds that Dr. Attallah committed an act of professional misconduct, in that he 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.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the findings made at the earliest opportunity.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Attallah, 2020 ONCPSD 38

DISCIPLINE COMMITTEE
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**
which is Schedule 2 of the ***Regulated Health Professions Act***, ***1991***,
S.O. 1991, c. 18, as amended.

B E T W E E N:

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. GABRIEL NICOLA ATTALLAH

PANEL MEMBERS:

DR. MELINDA DAVIE (Chair)
DR. J. WATTERS
MR. M. KANJI
DR. DEBORAH HELLYER

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. C. SILVER
MR. K. MAIJALA

COUNSEL FOR DR. ATTALLAH:

MR. R. BREEDON

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MS K. POTTER

Hearing Dates: June 22 and 23, 2020
Decision Date and Release of Reasons Date: September 10, 2020

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

On March 12, 2020, the Discipline Committee ("the Committee") of the College of Physicians and Surgeons of Ontario ("the College") found that Dr. Attallah committed an act of professional misconduct, in that he 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.

On June 22 and 23, 2020, the Discipline Committee heard, via videoconference, evidence and submissions on penalty and costs, and reserved its decision.

SUBMISSIONS ON PENALTY

College counsel submitted that the only adequate penalty was revocation of Dr. Attallah's certificate of practice and a reprimand.

Counsel for Dr. Attallah submitted that revocation was not warranted and that a suspension in the range of 3 – 6 months and a reprimand would be an appropriate penalty.

DECISION ON PENALTY

For the reasons that follow, and as detailed in the Order below, the Committee directs that Dr. Attallah's certificate of practice be revoked immediately and that Dr. Attallah appear before the Committee to be reprimanded.

SUMMARY OF EVIDENCE ON PENALTY

The College presented no evidence on penalty.
Dr. Attallah testified on his own behalf.

Dr. Attallah's curriculum vitae, a brief of character references, and a copy of the Schedule of Benefits of the Ministry of Health, dated March 19, 2020 ("2020 SOB"), were admitted as exhibits.

Dr. Attallah's testimony

Dr. Attallah has been on paternity leave since 2015, with children aged one, three and five years at home. He has been working some shifts at a COVID clinic and does some surgical assisting.

Dr. Attallah stated that he had read the Committee's decision and reasons on liability and that he understood the findings made against him.

Dr. Attallah has no criminal conviction.

Payment made by Dr. Attallah

Dr. Attallah stated that he had made what he termed an "*ex gratia"* payment of $9,214.85, which he described as "a gratitude payment for having the [criminal] charges withdrawn". He denied that this was a "repayment". He later stated that the amount represented billings for work that he had done in respect of which there might have been a "discrepancy". Dr. Attallah testified that he did not challenge the amount at the time, but said that his billings were not audited and that any discrepancy may in fact have been less than $500.00. He stated that he had lost significant billing income because an employee had not corrected and resubmitted claims that had been rejected by OHIP.

Practice changes Dr. Attallah intends to make.

Dr. Attallah testified that he certainly "will be making a change" should he be permitted to return to his previous practice. The "biggest change" would be that he would no longer collect health card numbers from relatives or other individuals accompanying patients to his office, because the 2020 SOB now makes clear that relatives are included as part of the service to patients. He described this as an "incredibly huge change" in the SOB, which makes the SOB much easier to follow, and means that he no longer needs to resort to group billing codes.

As an example, Dr. Attallah drew attention to the 2020 SOB (exhibit 19), page GP54, specifically the payment rule pertaining to the calculation of time units for OHIP claims for psychotherapy, psychiatric and counselling services: "…the minimum time required in direct contact with the patient (or patient's relative or patient's representative as the case may be) and the physician in person is as follows…".

College counsel drew attention to the corresponding payment rule in the 2005 SOB (exhibit 7), page GP37. It is identical to that in the 2020 SOB.

The Committee heard no evidence of other changes Dr. Attallah would make in his practice.

Dr. Attallah's apology and acknowledgements.

Dr. Attallah testified that he is "very sorry for the circumstances that have led me here", and promised to do better.

Asked whether he apologized for deliberately collecting health card information from family members in order to submit improper billings, Dr. Attallah stated: "I understand [the Committee's] findings and apologize for the circumstances that

I'm in right now." Asked again, he stated that he respects the Committee's decision and pledges to do better, adding: "I was not really given an opportunity to describe the full circumstances, and I think that you're taking it out of context". He stated further: "I think it's better to say that I apologize for the things I could have done better. It's hard to apologize for human error".

In respect of his having submitted claims for services he had not provided, Dr. Attallah apologized "for all the conduct that was considered unprofessional".

In respect of the finding that he had created false or inaccurate medical records to support improper billings for individuals who were not his patients, Dr. Attallah stated that he was "very sorry about that". Asked if he recognized that false or inaccurate information in a medical record could seriously affect that patient in the future, Dr. Attallah responded that he agreed and "would never intentionally do that".

Dr. Attallah agreed that creating false medical records would be very serious misconduct. He stated further that "There is nothing false in my records … that is not just human error".

With respect to whether he recognized the potential effect on patients' applications for health insurance in the future, he stated: "Absolutely, that's why I raised that issue with all the patients that provided their health cards, and clarified it and got their consent".

Health care resources.

Dr. Attallah did not accept the proposition that the Ontario health care system has limited funds available to it, and continued:

> "I don't believe that we're economists and that the economy is a finite fund, no. It has to do with fair exchange of value for work that we do to keep things sustainable. It would be irresponsible not to bill the work that I do because then my office would not run, of course, in accordance with the Schedule of Benefits at the time".

Dr. Attallah acknowledged that OHIP fraud can seriously impact the health care system, and stated that he "would never engage in that". He endorsed the view that a physician who knowingly takes money from OHIP to which they are not entitled breaches the trust of patients, and that "true fraud" should be condemned. He stated that he "never did that or if I did then it was never intentional".

Dr. Attallah declined to give direct answers to some questions, e.g. in respect of his apology. The Committee found some of his responses difficult to understand, e.g. in respect of a health care economy.

Character references

Twelve individuals (including one couple) provided written character references: five were patients (including the couple), four were colleagues in the regional hospital department of mental health, one was the administrator of a residence where Dr. Attallah had provided care, and two were individuals who know Dr. Attallah in other contexts.

The writers were uniformly positive in their comments on Dr. Attallah's qualities as a person and a physician. The patients described Dr. Attallah as caring, compassionate, dedicated and knowledgeable. They considered his care excellent and would want to be his patients again. His colleagues described him as respected and appreciated by his colleagues generally, committed to the care of complex and vulnerable patients, and knowledgeable. He had provided timely, comprehensive, and useful assessments and follow up, and contributed to organizational processes of care. The residence administrator and other individuals echoed a number of these comments.

PRIOR DECISIONS

The parties put before the Committee a number of prior cases involving dishonest and improper billing, most often billing of OHIP, but also of insurers and patients. In several instances, the physician had been criminally convicted of fraud. As well, a number of the physicians had engaged in other significant misconduct. Whether the physicians showed insight into their misconduct, accepted responsibility, were remorseful, made restitution, cooperated with the College investigation, and/or had a prior discipline history, varied.

- *CPSO v. Bogart*, 2001 ONCPSD 11 ("*Bogart*") and *R. v. Bogart*, 2002 CanLII 41073 (ONCA).

In *Bogart*, the physician had been criminally convicted of defrauding OHIP of more than $900,000.00 over a period of seven years. The Committee rejected the physician's view that this offence was not related to his suitability to practice:

> Fraud is a crime that does affect a physician's suitability to practise medicine as trust and integrity are fundamental to the agreement between the physician and OHIP in the fee-for-service arrangement

> and are fundamental to the relationship between physicians and their patients.

The Committee held that significant OHIP fraud generally deserves the penalty of revocation, and seriously considered revocation in this instance. However, the physician had accepted full responsibility for his actions, had made restitution to OHIP, had a difficult family background and disability, and had been exploited and assaulted by an intimate partner. The Committee also found that the physician's professional skills were an asset to a number of dependent patients, and concluded that the public would not be served by permanent removal of his skills from the community. In light of these mitigating factors, the panel directed a reprimand, an 18-month suspension conditionally reduced to 12 months, and various terms and conditions including monitoring of his billings.

In respect of his criminal conviction for fraud, the Crown appealed the original conditional sentence. The Court of Appeal, allowing the appeal, imposed in its place an 18-month jail sentence, affirming that the most important sentencing principle in such instances is general deterrence. The Court, citing *R. v. Gray* (L.V.) (1995), 1995 CanLII 18 (ONCA), 76 O.A.C. 387, wrote:

> [31] [T]here are few crimes where the aspect of deterrence Is more significant. It is not a crime of impulse and is of a type that is normally committed by a person who is knowledgeable and should be aware of the consequences. That awareness comes from sentences given to others.

- *CPSO v. MacDiarmid*, 2001 CarswellOnt 9807 (“*MacDiarmid”).*

In *MacDiarmid*, the physician admitted that he had committed an act of professional misconduct, in that he had been convicted of defrauding OHIP of approximately $150,000.00 in 1998 and the clinic in which he worked of approximately $155,000.00 in the four years prior. The physician had developed some insight into his actions, had undergone treatment for depression and had made full restitution. The Committee directed a five-month suspension of the physician’s certificate and various terms and conditions including a requirement to continue in therapy and monitoring of his OHIP billing.

- *CPSO v. Moore*, 2002 ONCPSD 16 (“*Moore*”) and *Moore v. CPSO*, 2003 CanLII 7722 ONSCDC.

In *Moore*, the physician admitted that he committed an act of professional misconduct, in that he had been convicted of defrauding OHIP of $75,000.00 over a period of three years. He had complied with the court’s restitution order to date. In considering penalty, the Committee observed that general deterrence and maintenance of public confidence in the profession and its ability to govern itself are of paramount importance in cases of such misconduct. The Committee had regard to the (then) recent decision in *CPSO v. Pakes*, 2000 ONCPSD 15, where the Committee wrote:

> “In future, physicians who are found to have participated in health care fraud should be prepared to face penalties of increasing severity as their cases come before panels of the Discipline Committee”.

The Committee also noted the College’s February 2001 guidelines on normative penalties for health care fraud (published after the misconduct in question) to support its position that increased penalties were required to

achieve deterrence: "…in most cases of substantial, premeditated fraud, the penalty of revocation should be the norm". The College sought a lengthy suspension and a substantial fine. The mitigating factors considered by the Committee were that the physician had no previous disciplinary record, that he had complied with the restitution order and that he pleaded guilty to professional misconduct. The Committee ordered a 12-month suspension of the physician's certificate conditionally reduced to a six-month suspension, a reprimand and a fine of $5,000.

- *CPSO v. Scott*, 2002 ONCPSD 15 ("*Scott*").

In *Scott*, the physician admitted that he had committed an act of professional misconduct, in that he had been convicted of defrauding OHIP of $592,600.00 between 1992 and 1999. The Committee found it to be an aggravating factor that he did not express an understanding of, or sympathy for, the patients who had attempted to have the false entries in their medical records corrected. In addition, he had victimized elderly patients and close friends. The Committee found that only revocation would adequately address the principles of public protection and specific and general deterrence in respect of this extremely serious breach of professional trust.

- *CPSO v. Tolentino*, 2002 CarswellOnt 8834 ("*Tolentino*").

In *Tolentino*, the physician admitted that he had committed an act of professional misconduct, in that he had been convicted of defrauding OHIP of just over $58,000.00 between 1995 and 1998. The Committee seriously considered revocation as an appropriate penalty in light of the "ever escalating problem" of health care fraud and (then) recent decisions that had articulated the need for increasing the severity of penalties to deter such conduct. The "scale of the fraud" was considered in "the lower range" when compared to other cases that had been before recent discipline panels. The

Committee found that the physician had demonstrated significant remorse, had been cooperative with the police and College investigations, had been diligent in making restitution in compliance with a court order, and had had an otherwise unblemished 35-year career. Further, the risk of re-offending was considered low. The Committee directed a four-month suspension (which it termed "significant") and a reprimand.

- *CPSO v. Kitakufe*, 2010 ONCPSD 15 ("*Kitakufe*").

In *Kitakufe*, the physician admitted that he had committed an act of professional misconduct, in that he had been convicted of participating in a scheme to defraud the Ministry of Health of approximately $97,000.00 by claiming for services to individuals who were not his patients and improperly writing them opioid prescriptions. Further, he was convicted of conspiring to traffic in a controlled substance. The physician committed to receiving psychotherapy, accepted responsibility for his actions, and expressed remorse. He had a discipline history at the College and in the United States. The Committee directed revocation of the physician's certificate of registration and a reprimand.

- *CPSO v. Sinclair*, 2015 ONCPSD 8 ("*Sinclair*").

In *Sinclair*, in an agreed statement, the physician admitted that he had committed an act of professional misconduct, in that he had been convicted of offences including possession of controlled substances for the purposes of trafficking and fraud of more than $200,000.00. The latter related to his issuing narcotic prescriptions for patients who did not receive them and billing OHIP and various insurers for those services. The Committee accepted a jointly proposed penalty of immediate revocation and reprimand.

- *CPSO v. Shin*, 2015 ONCPSD 19 ("*Shin*").

In *Shin*, the physician admitted in an agreed statement that he had committed an act of professional misconduct, in that he had been convicted of defrauding OHIP of $43,176.00 in 2006 and 2007. He had improperly billed OHIP for uninsured eye examinations and for uninsured contact lens fittings which were done by his staff and not by the physician. The Committee found the misconduct to be deliberate and very serious, a violation of the trust placed by the public in the profession and an undermining of the credibility of the profession as a whole. Further, it noted that it is a fundamental responsibility of physicians who bill OHIP that they ensure that they understand the requirements for billing a service. The Committee accepted a jointly proposed penalty of a five-month suspension, a reprimand, and various terms and conditions including monitoring of the physician's billings and medical records.

- *CPSO v. Patel*, 2015 ONCPSD 22 ("*Patel*").

In *Patel*, the physician was found to have engaged in a number of improper billing practices including billing for more than $34,000.00 during a period in 2011 when he was on vacation. In addition, he failed to meet the standard of practice in his care of patients, was incompetent, failed to properly supervise his staff, and breached an undertaking to the College in respect of the delegation of controlled acts to his staff and following the recommendations of his clinical supervisor. The physician had appeared twice previously before the Committee on matters relating to failure to meet the standard of practice. He made full restitution to OHIP. The Committee directed revocation and reprimand.

- CPSO *v. Marcin*, 2016 ONCPSD 7 ("*Marcin*").

In *Marcin*, the physician had been convicted of defrauding OHIP of just over $100,000.00 by billing between 2007 and 2011 for services she had not provided. In addition, she had had an inappropriate relationship with a patient, falsified the medical record to cover this up, provided misleading information and attempted to delay the College's investigation, failed to meet the standard of practice in her prescribing of narcotics and related substances, breached an undertaking she had made to the College, and was incompetent. The Committee accepted a jointly proposed penalty of revocation and a reprimand in the face of what it termed "overwhelming misconduct".

- *CPSO v. Taylor*, 2016 ONCPSD 22 (liability) and 2017 ONCPSD 17 (penalty); *Taylor v. CPSO*, 2018 ONSC 4562 (Div. Ct.) ("*Taylor*").

In *Taylor*, the physician improperly and deliberately billed patients who had chosen the more expensive of two ophthalmologic procedures when he actually performed the less expensive one. He directed his staff to alter patient records to show that the more expensive procedure had been done. As well, he attempted to obstruct the College investigation by having his staff falsely report the theft of a safe containing medical records. The physician made restitution and had no discipline history. He was not criminally convicted of fraud. The Committee characterized the physician's misconduct as premeditated, exploitative, dishonest and lacking integrity, and directed revocation and a reprimand. The decision was upheld by the Divisional Court, where the court noted (at paragraph 95) that the penalty of revocation fell within the appropriate range for such misconduct.

- *CPSO v. Chandra*, 2018 ONCPSD 28 ("*Chandra*").

In *Chandra*, the physician systematically defrauded OHIP of more than $2,000,000.00 between 2012 and 2015 by recruiting patients in his office and making payments to them for the fraudulent use of their health card information and that of their family members. In addition to other forms of

misconduct, the physician failed to cooperate with the College in its investigation. The Committee directed revocation, a reprimand, and the maximum fine available.

- *CPSO v. Kumra*, 2019 ONCPSD 32 ("*Kumra*").

In *Kumra*, the physician directed his staff to register family members of individual patients attending his office as patients and to bill OHIP using their health card information. In addition, he improperly accepted cash payments from patients for completing special diet program forms without adequate assessment in respect of the program's requirements. The physician attempted to obstruct the College's investigation and was found to have failed to meet the standard of practice of the profession in several regards. He had appeared before the Committee previously on a matter involving dishonesty. The Committee acknowledged the physician's resignation of his certificate of registration and his undertaking never to reapply in any jurisdiction. The decision records that otherwise the Committee would have undoubtedly revoked his certificate of registration. The Committee directed that the physician appear before the panel to be reprimanded.

The decisions put before the Committee are uniform in speaking to the seriousness of misconduct involving deceitful billing and breach of the profession's core value of trust. The Committee finds them useful in establishing a range of penalties for the misconduct in the present matter, and notes that revocation was ordered in several recent decisions.

Five of the decisions were released in 2001 or 2002: in four instances, a suspension was imposed (*Bogart, MacDiarmid, Moore,* and *Tolentino*). Revocation was seriously considered in two of those cases (*Bogart, Tolentino*), but was not ordered due to the mitigating factors found in those cases. In *Scott*, the physician's certificate was revoked. In three of the decisions, the Committee

commented on the frequency of cases of deceitful billing and fraud, increasingly severe penalties in recent cases for such misconduct, and/or the need for the profession to expect severe penalties in the future (*Bogart*, *Moore*, and *Tolentino*).

The other eight decisions put before the Committee were released more recently, between 2010 and 2019. In each case but one (*Shin*), the physician's certificate was revoked (*Kitakufe, Sinclair, Patel, Marcin, Taylor, Chandra* and *Kumra).*

There is no case in which the facts and circumstances are identical to those in the present matter. A number involve criminal conviction and/or multiple forms of misconduct not found in this case. As well, some of the prior cases have aggravating factors and many have mitigating factors that further distinguish them.

Among the decisions released since 2010, the facts in *Taylor* are most like the facts in the present case.

The facts in *Taylor* include deliberate billing for services not provided, falsification of patient charts, and the absence of prior discipline history or conviction of fraud. These facts are broadly similar to those in the present matter, although the physician in *Taylor* involved his employees more extensively. The penalty of revocation was upheld on appeal. The Committee found *Taylor* useful in determining the appropriate penalty in this case.

ANALYSIS

Approach to penalty

The principles guiding the imposition of penalty are well-established. The protection of the public is paramount. Other key principles include: maintaining

public confidence in the integrity of the profession and in its ability to regulate itself in the public interest; denouncing wrongful conduct; specific deterrence as it applies to the member; general deterrence in relation to the membership as a whole; and, where appropriate, the member's potential for remediation.

In matters of deliberate and dishonest conduct, the primary penalty considerations are protection of the public and maintaining the public's confidence in the profession. Such misconduct undermines the trust that is fundamental to the relationships between physicians and their patients and to the reliance that society places on the integrity of physicians in their dealings with OHIP. As the Committee noted in *Moore*, the public expects that every physician will act with honesty and integrity, and the profession must condemn any physician who compromises the public trust. Further, the Committee agrees with the reasons in *Taylor* where general deterrence is identified as a critical penalty consideration in cases of deceptive billing. This view was upheld by the Divisional Court. This view is also consistent with the Ontario Court of Appeal's decision in *Bogart* (see above, paragraphs 30 and 31).

The task for the Committee is to consider carefully the facts and circumstances and to arrive at a penalty which is fair, reasonable and serves the acknowledged penalty principles. The nature of the misconduct and aggravating and mitigating factors need to be considered. In general, the penalty should be proportionate to the misconduct, like cases should be treated alike, and the Committee should have regard to penalties imposed in prior similar cases although it is not bound by them.

Nature of misconduct

Dr. Attallah engaged in disgraceful, dishonorable, or unprofessional conduct in that he:

- Routinely collected health card information from family members accompanying patients to his office, with the intention of improperly billing OHIP

- Improperly and deliberately billed OHIP for interviews with relatives

- Improperly and deliberately billed OHIP for services which he did not provide or for which he did not spend sufficient time to justify his time-based claims

- Created false or inaccurate records to support his improper billings, including creating medical charts for individuals who were not his patients.

Dr. Attallah's misconduct was very serious, intentional, and ongoing. Dr. Attallah continued his misconduct despite being questioned by family members and patients about the collection of health card numbers and/or billings for certain services. Further, the Ministry of Health brought Dr. Attallah's unusual pattern of K002 billings to his attention in an educational letter. Dr. Attallah breached the trust of his patients, his professional colleagues and society at large. Further, his creation of false or inaccurate records puts the future medical care of his patients at risk, may create problems for them should they seek health insurance, and may well cause them stress and difficulty in seeking to have corrections made. In many instances, Dr. Attallah submitted multiple improper claims for the same person: in respect of Ms A, for example, he submitted 29 improper claims over a period of more than three years.

Counsel for Dr. Attallah submitted that the quantum of improper billings was small relative to other cases that have come before the Committee, and is perhaps represented by the approximately $9,000.00 payment that Dr. Attallah made to OHIP, or the approximately $4,000.00 that counsel calculated from the

details of the liability decision. Counsel submitted that, accordingly, Dr. Attallah's misconduct was less serious than in many of the prior cases put forward.

The true quantum is not known. The Committee notes that the quantum may in fact be higher than $9,000.00: Dr. Attallah was among the top 5% of physicians using the K002 fee code in 2007 in terms of the number of times he billed this code. As well, the Committee found that the evidence admitted in respect of specific patients was representative of an ongoing and larger pattern of improper billing by Dr. Attallah.

Regardless, whether the true quantum is small or large - whether Dr. Attallah's dishonest actions yielded a small or a large financial gain - is of limited significance. In the Committee's view, Dr. Attallah's misconduct is characterized primarily by his deliberate dishonesty and breach of trust in billing for services he did not provide, his creation of false or inaccurate records to cover up his dishonesty, the potential harm to people for whom he billed services that he did not provide, and his sustained misconduct in the face of questioning by patients and relatives, and having his exceptional billing practices brought to his attention by OHIP. No physician has the right to take improper advantage of the trust-based, fee-for-service system of compensation of physician services by submitting claims to OHIP for payment to which they know they are not entitled.

Aggravating factors

Nature of the misconduct.

The deliberate and ongoing pattern of Dr. Attallah's misconduct, his fundamental breach of trust, his creation of false or inaccurate medical records, and the potential distress and harm to patients and others from such records are serious aggravating factors.

Involvement of office staff.

Dr. Attallah's involvement of his office staff in his misconduct is an aggravating factor.

Mitigating factors

Character references.

The Committee is aware of the limitations of character evidence in cases of dishonesty or fraud, and accords Dr. Attallah's references little weight as a mitigating factor. The letter writers have no reason to have knowledge of Dr. Attallah's billing and charting practices, nor do they suggest that they do so. There is no indication that any of the writers were aware of the specific misconduct findings against Dr. Attallah or had read the decision and reasons. The issues addressed in the character references have little or no relevance to Dr. Attallah's misconduct.

Dr. Attallah's payment.

Dr. Attallah's payment might be seen as a form of restitution or demonstration of a willingness to make restitution. Dr. Anweiler's evidence at the liability hearing was that Dr. Attallah had repaid OHIP an amount ($9,214.85) equal to what were considered improper billings. However, the Committee puts little weight on the payment as a mitigating factor since Dr. Attallah testified that this was not a repayment to OHIP, but rather an "*ex gratia*" payment made to the Crown as a "gratitude payment for having the charges withdrawn".

Quantum of improper billings.

The quantum is but one factor to assess in characterizing the severity of Dr. Attallah's misconduct and the Committee finds it to be of limited significance, as set out above. Accordingly, even were it to accept that the quantum is modest, the Committee would put limited weight on that fact in judging his misconduct or as a mitigating factor.

This is consistent with *Taylor* (2017 ONCPSD 17, page 13), where the Committee concluded that neither the magnitude nor the duration of improper billing, alone or together, are the principal factors in determining the appropriate penalty. Further, the Committee in *Taylor* characterized the misconduct in terms of "premeditation, exploitation, dishonesty and lack of integrity" (page 14).

In *Tolentino*, heard in 2001, the Committee seriously considered revocation. In directing a "serious suspension" and reprimand, it accepted that the "scale" of the dishonest billings was "in the lower range" compared with (then) recent cases. However, the Committee identified significant mitigating factors that included remorse on the part of the physician, diligent repayment, a history of depression – factors absent in the present matter. The Committee went on to point out that "future cases of OHIP fraud may well require revocation to address this continuing problem" (paragraph 10).

Insight and remorse.

Despite testifying that he had read the liability decision and understood its findings, Dr. Attallah demonstrated little or no insight into his misconduct and was unwilling to accept responsibility for it. His testimony indicates that he does not believe he engaged in any misconduct, and that any billing or charting irregularities were the result of inadvertent errors and/or lack of clarity in the 2005 SOB. The Committee was struck by Dr. Attallah's innocent view of his own actions, while at the same time he readily accepted that "true fraud" should be

condemned and that false or inaccurate medical records could “absolutely” affect patients.

A number of Dr. Attallah’s explanations made no sense. For example, he described a payment rule for time-based services as being much more clear in the 2020 SOB when it is in fact identical to the rule in the 2005 SOB. Further, asked twice whether false or inaccurate medical records could impact a patient’s future insurance applications, Dr. Attallah agreed and testified that that is why he raised this issue with patients who provided their health cards, “clarified it”, and got their consent.

Dr. Attallah demonstrated no remorse. He apologized for the circumstances in which he finds himself and avoided apologizing for any specific misconduct. At one point, Dr. Attallah did apologize for “all the conduct that was considered unprofessional”, but the Committee is not persuaded that this is a sincere acknowledgement or acceptance of his misconduct.

The Committee rejects Dr. Attallah’s testimony that he was not given an opportunity to explain his circumstances and the actions which the Committee found to be misconduct. He had ample opportunity during the liability hearing to do just that and to rebut or provide context for any of the College’s evidence, but he made the choice not to do so.

Dr. Attallah offered no meaningful plan for change should he be permitted to return to practice. The only intended change he articulated was that he would no longer collect health card information from patients’ relatives or others as he no longer needs to do so given the (non-existent) change in the SOB. It is unsurprising that Dr. Attallah has no substantive plan as it is apparent that he does not believe he acted improperly in any way.

Lack of prior discipline history.

Dr. Attallah has no prior discipline history. The Committee puts limited weight on this as a mitigating factor as it is expected of physicians that they not be involved in discipline matters, and because his misconduct was calculated and went on for several years.

Impact on Dr. Attallah.

Dr. Attallah testified that he had spent his life savings on legal fees. Dr. Attallah's compensable clinical activity appears to have been modest during his extended paternity leave. Doubtless the Committee's penalty and costs order will have financial consequences for him.

The Committee had regard to *Bolton v. Law Society*, [1994] 2 ALL ER 486 (at page 492), as it had previously in *Moore*, *Kitakufe*, and *Taylor* (2017). The Committee also found useful *R v. Drabinsky*, 2011 ONCA 582, where the Court of Appeal wrote (paragraph 167):

> "Considerable personal hardship, if not ruin, is virtually inevitable, upon exposure of one's involvement in these kinds of frauds. It cannot be regarded as the kind of unusual circumstance meriting departure from the range".

The Committee puts limited weight on the impact of the proceedings and penalty on Dr. Attallah as a mitigating factor.

Application of penalty principles

The Committee is concerned first with the protection of the public and maintaining the public's confidence in the ability of the profession to regulate in the public interest. Dr. Attallah's misconduct has put the public at risk and has

damaged the public's confidence in the profession. Dr. Attallah demonstrates no understanding of his misconduct or meaningful plan for change, and the Committee has no basis to expect that a self-directed approach, any educational prescription, and/or any period of suspension or oversight of his practice will prevent misconduct in the long term.

Revocation is necessary.

The Committee finds that the facts and circumstances of Dr. Attallah's misconduct warrant revocation of his certificate of registration. Revocation is the only penalty that will adequately serve the critical goals of public protection and promoting public confidence in the profession. Importantly, it will, in addition, serve notice to the profession at large that dishonest and deceitful behaviour such as this will simply not be tolerated.
Prior cases, including the recent decision and appeal in *Taylor*, make clear that revocation is within the appropriate range of penalties for such misconduct.

The Committee recognizes that the misconduct in several of the prior cases put before it was even more serious than in the present matter, and that aggravating factors were present in some cases that are not present here. (The Committee also notes that important mitigating factors present in other cases are not present here.) However, revocation is not reserved solely for the most egregious misconduct. The Committee shares the view articulated in *Kitakufe* (page 23), *Patel* (page 25), and *Chandra* (page 36) of the relevance of *Adams v. Law Society of Alberta*, 2000 ABCA 240, where the court wrote:

> [11] It is therefore erroneous to suggest that in professional disciplinary matters, the range of sanctions may be compared to penal sentences and to suggest that only the most serious misconduct by the most serious offenders warrants disbarment. Indeed, that proposition has been rejected in criminal cases for the same reasons it should be rejected here. It will

> always be possible to find someone whose circumstances and conduct are more egregious than the case under consideration. Disbarment is but one disciplinary option available from a range of sanctions and as such, it is not reserved for only the very worst conduct engaged in by the very worst lawyers.

The Committee recognizes the seriousness of the penalty of revocation, but is aware that Dr. Attallah can apply for reinstatement of his certificate in one year. Should he do so, he will have the opportunity to demonstrate an understanding of his misconduct and its impact and to articulate changes that would allow him to return to practice with low risk for further misconduct. Many of the qualities attributed to Dr. Attallah in his character references are among those recognized by the public and the profession as desirable in a family physician.

Monitoring and suspension would not adequately serve the penalty principles.

Although not bound to direct a “least-restrictive” penalty, the Committee considered whether supervision and/or monitoring in some form could adequately serve the penalty principles while allowing Dr. Attallah to return to practice. The Committee finds that such an approach would not be realistic or sufficient.

First, although Dr. Attallah’s OHIP claims and medical records could be monitored, since Dr. Attallah created false or inaccurate chart entries (and even medical charts for individuals not his patients), effective oversight would need also to include a physical presence during all patient encounters or another means to ensure his patients received the services that he recorded and claimed.

Second, as Dr. Attallah appears not to believe he has acted improperly, there is no reason to expect any durable change in his behaviour, or to be reassured that he will not engage in further misconduct, once he completes a period of oversight. As a result, any period of oversight would have to be indefinite.

Similarly, the Committee concludes that, without Dr. Attallah having some degree of insight, there is no reason for confidence that he would not engage in further misconduct after a period of suspension of whatever length.

Additional considerations.

A reprimand will allow the Committee to express its denunciation of Dr. Attallah's conduct in a public forum. It will assist in general deterrence, i.e., awareness among the profession that such conduct will not be tolerated, and in promoting public confidence in the integrity of the profession and its ability to regulate in the public interest.

There is no basis to consider remediation in this matter. Dr. Attallah did not acknowledge and made no suggestion about any learning needs. His counsel submitted that an educational program related to ethics or other content would be appropriate, but made no specific proposal.

COSTS

The College sought an order of costs in the amount of $124,440.00, representing 12 hearing days at the tariff rate of $10,370.00 per day:

- Seven liability hearing days (September 4-6, November 4-6, and December 18, 2019).

- One hearing day (October 11, 2019) for a motion for adjournment brought by Dr. Attallah as he had retained new counsel. Scheduled hearing dates on October 23 and 24 were adjourned. His request to adjourn the November 4-8, 2019 hearing dates was denied and these dates were made peremptory. Dr. Attallah had had two previous adjournments. In addition, the Committee had found that Dr. Attallah was seeking to orchestrate delay by retaining counsel who he knew to be unavailable.

- Two hearing days not used (November 7 and 8, 2019) as the result of a late request for adjournment by Dr. Attallah, consistent with the Committee's rule 14.01.1.

- Two penalty hearing days (June 22 and 23, 2020)

Counsel for Dr. Attallah took no issue with the costs proposed by the College in respect of the liability phase but asked that consideration of costs in respect of the penalty phase be reserved until a decision was rendered.

Counsel for Dr. Attallah also submitted that, while calculated according to the tariff, the quantum of costs sought by the College is significantly higher than in many other cases. Further, counsel submitted that the award of costs should take into account Dr. Attallah's circumstances, specifically that he was "essentially not working" and had depleted his savings through legal fees.

The Committee finds that this is an appropriate case in which to award costs. The Committee had regard to *R v. Drabinsky*, 2011 ONCA 582 (see above) in accepting the quantum proposed by the College, but agreed that it would appropriate to allow a period longer than 30 days for costs to be paid.

ORDER

Therefore, the Committee orders and directs:

1. The Registrar is directed to revoke Dr. Attallah's certificate of registration effective immediately.

2. Dr. Attallah is to attend before the panel to be reprimanded.

3. Dr. Attallah is to pay costs to the College in the amount of $124,440 within 6 months of the date of this Order.

Reprimand delivered by Dr. M Davie on June 14, 2021 by videoconference

Dr. Attallah … it is a great privilege to practise medicine in Ontario.

Our health care system is based on honour and trust. Physicians must demonstrate their suitability to earn the privilege to practise and it is expectedthat they will carry out their responsibilities with honesty and integrity. This is especially true for the use of our collective OHIP funds.

Misinterpretation of the billing rules is not acceptable. It is the responsibility of every physician to understand and abide by the rules as set out in the Schedule ofBenefits, and to ensure that, when they provide services, their remuneration is submitted according to those rules.

You, Dr. Attallah, abused your privilege and power by billing the Ministry of Health for services you did not provide. Your received monies you were not entitled to. You knowingly continued to engage in this misconduct even after youwere notified that you were in the top 5% of physicians billing the K002 code.

You carried on collecting health card numbers which you were not entitled to collect from trusting relatives even when your staff voiced concern with your policies. You involved your staff in your improper scheme to bill for services andtime based codes already included in other general fee codes. You have some misguided ideas about what you call 'health economy'. We call it a shocking abuse of our honour system.

You created false records for the caregivers of your most vulnerable patients. You violated their trust. You potentially jeopardized their future health care with false information.

Your misconduct was not a mistake or clerical error. It was a calculated, intentional scheme. Your patients and their families deserved better.

You have shown no insight or acceptance of personal responsibility for your wrongdoing. You failed to tell us how you would resume practice and ensure youdid not repeat your misconduct. Perhaps in time you will learn to accept responsibility

and gain some insight into why your behaviour is so reprehensible to the profession and the public.

We must all be careful stewards of our valuable health care dollars.