NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Koshela Ranjith, this is notice that the Discipline Committee ordered that there be ban on publication or disclosure of the identity, and any information that would disclose the identity, of the patients who are referred to during the hearing or in any document filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than $10,000 for a first offence and not more than $20,000 for a subsequent offence.

Indexed as: Ranjith (Re)

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. KOSHELA RANJITH

PANEL MEMBERS:

DR. L. THURLING (CHAIR)
B. TAA (Ph.D.)
DR. M. DAVIE
E. ATTIA (Ph.D.)
DR. O. KOFMAN

Hearing Dates: June 25 & 26, 2007
Decision Date: August 28, 2007
Release of Written Reasons Date: August 28, 2007

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee of the College of Physicians and Surgeons (the "Committee") heard this matter at Toronto on June 25 and 26, 2007. At the conclusion of the hearing, the Committee reserved its decision.

PUBLICATION BAN

On June 25, 2007 the Committee made an order, with reasons, that there be ban on publication or disclosure of the identity, and any information that could disclose the identity, of the patients who are referred to during the hearing or in any document filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

THE ALLEGATIONS

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

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O. Reg. 856/93"), in that she failed to maintain the standard of practice of the profession;

2. under paragraph 1(1)(16) of O. Reg 856/93, in that she falsified a record relating to her practice; and

3. under paragraph 1(1)33 of O. Reg. 856/93, in that she has engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

RESPONSE TO THE ALLEGATIONS

At the outset of the hearing, Dr. Ranjith admitted to the allegation of professional

misconduct that she engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, pursuant to paragraph 1(1)33 of O. Reg. 856/93. Dr. Ranjith denied the allegations of professional misconduct in that she failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 and that she falsified a record relating to her practice under paragraph 1(1)(16) of O. Reg 856/93.

FACTS AND EVIDENCE

(a) Overview of the Issues

The allegations of the failure to maintain the standard of practice and falsification of patient records arise out of a complaint made by the wife of Patient A, the complainant, to the College of Physicians and Surgeons of Ontario alleging that Dr. Ranjith failed to examine patient A during a patient visit for chest pain and that her records were not an accurate representation of what occurred during that visit. Dr. Ranjith accepted the allegation of professional misconduct on the basis that she did recopy a portion of patient A's chart and submit it during the course of the College's investigation as the original patient chart and she discarded part of the original patient A's chart.

(b) Summary of the Evidence

The Committee admitted into evidence a joint document brief. This brief contained the Notice of Hearing, the complaint form, written statements by the complainant and Dr. Ranjith and the medical chart of patient A. While this brief was initially submitted for the proof of the truth of its contents, that position was later clarified to indicate that the Notice of Hearing (tab 1) and the competing versions of the events (tabs 2, 3, 4, 5, 6 and 7) were not admitted for their accuracy. The medical records at tab 8 were admitted, on consent, for the truth of their contents. There were also excerpts from two notebooks of the notes made by the complainant which were entered into evidence but their accuracy was in dispute. In addition, a day sheet from the doctor's office, a completed employment insurance form, the original pages of the complainant's notebook, the original patient

chart and correspondence from the College were submitted. The Committee heard testimony from the complainant and patient A on behalf of the College and testimony from Dr. Ranjith in her defense.

Evidence

The Complainant

The complainant testified that she and her husband, patient A, had been patients since early 2003 and had attended Dr. Ranjith's office on several occasions prior to the date in question, in mid May, 2005. She stated they were seen together and that her issues were discussed first. In mid May, 2005, the complainant brought an employment insurance form for Dr. Ranjith to complete, as she was in excruciating back pain and unable to work. Dr. Ranjith completed the form, a copy of which was entered as evidence. She stated that her appointment took about five minutes and then it was her husband's turn. Given her husband's long-term health issues, she testified that her main job had become caregiver to him and she always accompanied him on his doctor visits.

She characterized the office as a 'busy spot', and the atmosphere with the doctor as 'rushed'. She testified that on the visit in mid May, 2005, patient A was complaining of chest pain on exertion. He had recently had his long term seizure medication changed by his neurologist and had experienced an increase in number and change in type of seizures. She testified that the doctor did not examine patient A, asked few questions, stated the pain must be muscular given his recent bout of grand mal seizures and denied a request for a referral to an alternative neurologist. She testified that three days later her husband was in excruciating pain and they attended the hospital where, after multiple tests, he was transferred to another hospital where he underwent angioplasty.

Under cross-examination the complainant testified she had been generally satisfied with the care she and her husband had received from Dr. Ranjith up until the visit in mid May, 2005. She stated that she was upset that day for three reasons: she was dealing with pain; there was no exam of patient A; and Dr. Ranjith had refused to give them a referral to another doctor. She felt that Dr. Ranjith had neglected her duties as a physician.

She testified that the patient visits were always of short duration, two to five minutes, exams were rarely done, blood pressures were not taken and she observed the doctor making only one line notes in her charts. When cross-examined regarding the doctor's records she stated she believed that all the patient records had been falsified dating from the first encounter in February 2003.

Patient A

Patient A testified that he had long-term health issues arising from a stroke he suffered as a child with subsequent seizures and that he was a patient of Dr. Ranjith from 2003 to 2005. He acknowledged that he had problems with his memory. He stated he had been having chest pain on exertion for a couple of weeks prior to mid May, 2005 and he had been putting off seeing the doctor. He stated there was no exam done on that visit.

On cross-examination he remembered some tests, such as drug levels, bone density x-rays, electrocardiograms as well as physical exams and blood pressures, that were done on previous visits to Dr. Ranjith. In fact, he remembered that Dr. Ranjith did ask him detailed questions regarding chest pain in mid May, 2005, but he stated no physical exam occurred that day. He was unable to answer many of defense counsel's questions as he could not remember.

Dr. Ranjith

Dr. Ranjith gave testimony regarding her medical training and practice. She gave details about her practice and her daily routines, for example starting the office promptly at 8:30 a.m., allowing 10 to 15 minutes per patient appointment, encouraging one problem per visit and scheduling a regular lunch break to allow extra time for finishing up paper work or when appointments ran over time.

She gave a thorough explanation of the management of an office patient with chest pain, explaining her extensive experience with such a complaint given her training and practice.

She stated that Patient A was her patient since 2003, has a history of left hemiplegia, high blood pressure, a ventriculoperitoneal shunt for hydrocephalus and an accompanying seizure disorder. She testified he had no previous history of chest pain.

Dr. Ranjith admitted that she did recopy a portion of Patient A's chart when asked for the original chart notes pertaining to April and May 2005 by the College investigators in August 2005. She testified that she remembered the encounter in mid May, 2005 quite clearly but felt her charting was incomplete. She apologized and acknowledged that it was wrong to destroy the original notes from Patient A's chart. Dr. Ranjith felt that the contemporaneous charting was incomplete not only for the mid May, 2005 visit but also for a previous visit in mid March, 2005 when she had reviewed a consultation letter with the patient and his wife regarding plans for future medication changes by their neurologist. She admitted to recopying the patient file from mid March, 2005 onward and to adding explanatory comments to the chart for the dates in question (the appointments in March and May 2005) and sending photocopies of those pages to the College investigators after destroying the contemporaneously made original notes. The College seized the entire chart in March 2006 and it was noted at that time the patient chart contained a duplicate entry for the mid March, 2005 appointment.

Dr. Ranjith testified that on the appointment in May, 2005 she met with the complainant and her husband, Patient A, together. She first addressed the complainant's issues regarding her back pain and need for employment insurance benefits. She testified the complainant suggested a need for indefinite benefits but Dr. Ranjith only agreed to two weeks and ordered further testing and physiotherapy for the complainant. She testified that the discussion regarding the employment insurance form took 20 minutes at least. She then stated that the purpose of patient A's visit was chest pain. She testified that she asked about exertion, shortness of breath, nausea and palpitations which were all denied. She testified she examined the patient. She testified the other concerns raised during that visit pertained to the patient's medications. She felt the medications shouldn't be altered at that time and she stated they had an upcoming appointment with their neurologist and didn't need another referral.

On cross-examination Dr. Ranjith stated that when she recopied the patient chart she did not appreciate that it was wrong. She recopied the notes regarding the physical exam and only added explanatory notes regarding the medication discussions and referral request. She erroneously felt it would serve as the original, and she admitted she was incorrect and agreed that it was wrong.

FACTUAL FINDINGS AND REASONS

The Committee noted that this is a case of credibility given that the original contemporaneously made notes were destroyed. The issue in question is whether a physical examination of Patent A took place on the date in question or not. Had no exam taken place then the patient chart would have been falsified and Allegations 1 and 2 would be established.

The additional issue is whether, even if the physical examination did take place, there was falsification of the records because additions had been made to the records by Dr. Ranjith after the College had commenced its investigation.

The Committee carefully considered the evidence. Given Dr. Ranjith's careful complete records for all visits prior to the appointment in mid May, 2005, it would be consistent that a physical exam did occur. Looking to the duplicated note for the March, 2005 appointment, this was not falsified but only copied. There was also corroborative external evidence in the patient chart consisting of appropriate referrals, lab results and drug levels. Also, considering the day schedule, submitted as evidence, it revealed ample time in the morning for complete, thorough patient visits.

The Committee considered the credibility of the witnesses. The Committee found the complainant's testimony to be inconsistent, and giving answers of 'I don't recall' to straight forward questions from both counsel even on matters pertaining to this hearing, as well as discrepancies in her testimony, made it difficult for the panel to accept her story as being an accurate account of the events of the May, 2005 appointment.

The Committee determined that it was unable to place much weight on Patient A's testimony as he obviously had difficulties with his memory of the events.

The Committee found Dr. Ranjith to display no hesitancy in her answers; she was confident and forthright as well as apologetic and straightforward in her admission while accepting responsibility for her wrong doing with respect to recopying her patient's chart. She passionately, adamantly and believably denied any fabrication or falsification. Her manner as well as the documentary evidence enabled the Committee to accept her testimony as the most convincing and accurate account of the events of the May, 2005 appointment.

FINDINGS

The Committee therefore found that the evidence was insufficient to prove the allegations that Dr. Ranjith committed professional misconduct in that she failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93, and that she falsified a record relating to her practice under paragraph 1(1)(16) of O. Reg 856/93.

The Committee accepts Dr. Ranjith's admission and finds that Dr. Ranjith did commit an act of professional misconduct in that she engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, pursuant to paragraph 1(1)33 of O. Reg. 856/93, by recopying part of an original patient chart and destroying the true original.

It is necessary for the Committee to consider whether there was nevertheless a falsification of a record. The issue is whether the additions to the medical records in this case, after the investigation was underway by the College, constitute the falsification of a record. We are of the view that while the additions to the records, without dating the records to indicate when the additions were made and disposing of the original records, constitutes unprofessional conduct it does not, on the facts of this case, constitute the falsification of a record. We note that the word "falsify" in the Concise Oxford

dictionary is defined as “fraudulently alter or make false … misrepresent … make wrong; pervert”.

In this case the Committee found that the additions to the notes were merely explanatory of existing notes or were additions of matters that actually occurred. While the additions should have been dated when they were added, the additions to the notes do not misrepresent the facts and accordingly do not constitute falsification in the Committee’s view.

The Committee requests that the Hearings Office schedule a penalty hearing pertaining to the finding made.

NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Koshela Ranjith, this is notice that the Discipline Committee ordered that there be ban on publication or disclosure of the identity, and any information that would disclose the identity, of the patients who are referred to during the hearing or in any document filed at the hearing under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

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

> Every person who contravenes an order made under section 45 or 47 is guilty of an offence and on conviction is liable to a fine of not more than $10,000 for a first offence and not more than $20,000 for a subsequent offence.

Indexed as: Ranjith (Re)

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

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. KOSHELA RANJITH

PANEL MEMBERS:

DR. L. THURLING (CHAIR)
B. TAA (Ph.D.)
DR. M. DAVIE
E. ATTIA (Ph.D.)
DR. O. KOFMAN

Hearing Dates: December 3, 2007
Decision Date: December 3, 2007
Release of Written Penalty Reasons Date: February 19, 2008

PUBLICATION BAN

PENALTY AND REASONS FOR PENALTY

The Discipline Committee of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on June 25 and 26, 2007. At the conclusion of the hearing, the Committee reserved its decision. On August 28, 2007, the Committee delivered its written decision and found that Dr. Ranjith committed an act of professional misconduct in that she engaged in conduct or an act or acts relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, by recopying part of an original patient chart and destroying the true original.

The Committee found that the evidence was insufficient to prove the allegations that Dr. Ranjith committed professional misconduct in that she failed to maintain the standard of practice of the profession.

The Committee heard evidence and submissions on penalty on December 3, 2007, and delivered its order as to penalty and costs with written reasons to follow.

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for the member made a joint submission as to an appropriate penalty. The joint submission was as follows:

1. The Register suspend Dr. Ranjith's certificate of registration for a period of one (1) month, which suspension shall be suspended in its entirety if Dr. Ranjith successfully completes, at her own expense, the College's Medical Ethics and Informed Consent course and the follow-up portion of the College's Medical Record-Keeping for Physicians course within six (6) months from the date reasons are released in respect of this Order, and provides proof thereof to the College.

2. Dr. Ranjith appear before the panel to be reprimanded.

3. Dr. Ranjith pay the College costs in the amount of $2,500.00 within 60 days of the date of this Order.

4. The results of this proceeding be included in the register.

The Committee accepted this submission as it meets the principles of upholding the honour of the profession, specific deterrence for the member, public protection and general deterrence to the membership at large. This penalty is also in keeping with previous penalties in similar cases.

The Committee is mindful of Dr. Ranjith's cooperation with the College investigation and discipline hearing as well as her clear acceptance of responsibility for her conduct. Dr. Ranjith's actions of recreating a patient chart and destroying the original, even if just for clarification and completeness, were inappropriate and should be sanctioned to uphold the honour of the profession.

A month long suspension of Dr. Ranjith's certificate of registration will provide protection of the public.

With respect to remediation of the member, the inclusion of completion of the record-keeping course as well as an order to attend the College ethics course in a timely fashion will help to ensure Dr. Ranjith's future success and be in the public interest.

ORDER

Therefore, the Discipline Committee ordered and directed that:

1. The Register suspend Dr. Ranjith's certificate of registration for a period of one (1) month, which suspension shall be suspended in its entirety if Dr. Ranjith successfully completes, at her own expense, the College's Medical Ethics and Informed Consent course and the follow-up portion of the College's Medical Record-Keeping for Physicians course within six (6) months from the date

reasons are released in respect of this Order, and provides proof thereof to the College.

2. Dr. Ranjith appear before the panel to be reprimanded.

3. Dr. Ranjith pay the College costs in the amount of $2,500.00 within 60 days of the date of this Order.

4. The results of this proceeding be included in the register.

Dr. Ranjith waived her right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.