

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Khan*, 2022 ONPSDT 39

Date: November 9, 2022

Tribunal File No.: 20-003

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Akbar Nauman Khan

FINDING REASONS

Heard: June 20-24, June 29 and August 25, by videoconference

Panel:

Ms. Jennifer Scott (chair)

Dr. Madhu Azad

Mr. Jose Cordeiro

Mr. Paul Malette, K.C.

Dr. Joanne Nicholson

Appearances:

Ms. Morgana Kellythorne, Ms. Jessica Amey and Ms. Anna S. Wong, for the College

Mr. Uri Kogan, for Dr. Khan

RESTRICTION ON PUBLICATION

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

INTRODUCTION

- [1] The College of Physicians and Surgeons of Ontario alleges Dr. Khan failed to meet the standard of practice and was incompetent in his treatment of two patients, Patient A and Patient B. It asserts Dr. Khan treated Patient A for cancer when she did not have cancer and treated Patient B, who did have cancer, in a way that risked aggravating his cancer. It also alleges that Dr. Khan engaged in disgraceful, dishonourable or unprofessional conduct with Patient A in his billings, his communications with her during the College investigation and his use of the ONCOblot test, a test in which the College alleges he has a conflict of interest.
- [2] Dr. Khan contests the allegations. He submits the College is targeting him because he practises complementary/alternative medicine (CAM). He asserts the College's conduct during its investigation, and to a lesser extent during the hearing, has rendered the proceeding before this Tribunal an abuse of process. Finally, he requests that some or all members of the panel hearing this case recuse themselves because of bias. He has left it to the panel to determine which members should go.
- [3] We find that Dr. Khan failed to maintain the standard of practice of the profession and is incompetent in his treatment of Patient A and Patient B. We find further that he engaged in disgraceful, dishonourable or unprofessional conduct.

ISSUES OF FAIRNESS

The College's Investigation File

- [4] Lisa Mueller conducted the investigation into the complaints about Dr. Khan's treatment of Patient A and Patient B.
- [5] Ms. Mueller was on the College's list of witnesses for the hearing. On the first day of hearing, the College advised the panel and Dr. Khan that it may not call her. The College closed its case and did not call Ms. Mueller.
- [6] Following the College's case, Dr. Khan called his only witness, Humaira Khan, Dr. Khan's spouse. The College objected to its investigation documents being put into evidence through Ms. Khan. The panel asked whether Dr. Khan could call Ms. Mueller to introduce these documents. The parties then met and reached an

agreement concerning Ms. Mueller's investigation file and it was filed as an exhibit, on consent.

- [7] After the investigation file was filed, Dr. Khan's representative said he still wanted to call Ms. Mueller. When the panel asked why he wanted to call Ms. Mueller when the investigation file had been admitted into evidence, he said it was because Ms. Mueller had fabricated evidence. We asked him how she had fabricated evidence and Dr. Khan's representative said Ms. Mueller had obstructed justice when she redacted portions of Dr. Walker's report, an expert retained by the College. Dr. Khan's representative asserted this conduct was a criminal offence. We asked if there was further evidence to support his obstruction allegation and Dr. Khan's representative said there was a conversation between Ms. Mueller and a supplier that never happened. Dr. Khan's representative stated these were the only allegations that he was aware of relating to Ms. Mueller's alleged misconduct. We denied Dr. Khan's request to call Ms. Mueller for the following reasons.
- [8] First, fabrication of evidence and obstruction of justice are serious allegations to raise at the eleventh hour in a hearing. Dr. Khan was required to give notice to the College under s. 8 of the *Statutory Powers Procedure Act*, RSO 1990, c. S.22 (SPPA) and he failed to do so.
- [9] Second, Dr. Khan failed to provide a basis for such serious allegations. The College advised the panel that Dr. Walker's report contains redactions because it was no longer proceeding with certain allegations because they had been decided in another disciplinary hearing involving Dr. Khan. The College does not want to relitigate those allegations. Redacting an expert's report following a decision not to pursue certain allegations of misconduct and a disputed telephone call between Ms. Mueller and a supplier is not a sufficient basis upon which to assert evidence has been fabricated. A factual disagreement with evidence does not mean the evidence has been made up.
- [10] Third, the investigation file was admitted on the consent of both parties on the understanding that Ms. Mueller's evidence would not be required. Calling Ms. Mueller was nothing more than a fishing expedition by Dr. Khan. We held it was not fair to allow Dr. Khan to call Ms. Mueller under these circumstances.

Recusal

- [11] Following completion of the evidence and before final argument, Dr. Khan filed a motion asking that some or all of the panel members recuse themselves because of a reasonable apprehension of bias. Dr. Khan asserted that on multiple occasions, the panel appeared to not be sensitive to submissions that could be meritorious for Dr. Khan. Beyond this broad assertion, Dr. Khan gave two examples. First, when the panel chair repeated Dr. Walker's answer to a question from Dr. Khan's representative about whether a particular drug (DCA or dichloroacetate) could possibly affect thyroglobulin levels. The chair said Dr. Walker testified "he did not know." Second, he said that the panel chair allegedly commented "redacting is not a crime" during Dr. Khan's argument that the College had engaged in criminal conduct when it redacted Dr. Walker's report (as summarized above).
- [12] We heard the bias motion before the parties provided their submissions on the merits of the professional misconduct allegations. We dismissed the motion with reasons to follow. These are our reasons on the motion.
- [13] The test for bias is well established: would an informed person, viewing the matter realistically and practically after having thought the matter through think it is more likely than not that the decision-maker, whether consciously or unconsciously, would not decide fairly? See *Yukon Francophone School Board, Education Area #23 v. Yukon (Attorney General)*, 2015 SCC 25 at para. 20.
- [14] The threshold for bias is high because the administration of justice presumes fairness, impartiality and integrity in the performance of the adjudicative role. The impugned comments or conduct should not be looked at in isolation, but must be considered contextually in the given circumstances, having regard to the entire proceeding. It is a facts-driven inquiry. (*Yukon* at para. 26)
- [15] Adverse rulings, on their own, do not constitute bias and a mere counting of rulings for and against a party provides little insight into the fairness of a hearing. A party is entitled to their opinion about the correctness of certain rulings; however, their personal opinion does not count for much when assessing a bias claim. See *Beard Winter LLP v. Shekhdar*, 2016 ONCA 493 at para. 11.
- [16] The first allegation of bias as set out in the Notice of Motion is as follows:

...when Walker attempted to lie and deny that he said that DCA can possibly effect [sic] TG levels, the tribunal said that they think that Walker said that he “does not know”. The statement of the tribunal is true, Walker did say that he “does not know”, but he also said that it possibly can.

- [17] Dr. Khan appears to suggest that the panel chair demonstrated bias when she summarized evidence Dr. Walker gave during cross-examination that he did not know if DCA could affect thyroglobulin levels without also saying he testified that they could. Dr. Khan does not take issue with the accuracy of the chair’s comment, he simply states it is incomplete. Dr. Khan is attempting to draw a distinction without a difference. Even if there is difference and the chair’s summary was incomplete, that does not demonstrate bias. Dr. Khan had a full opportunity to cross-examine Dr. Walker on this point. A reasonably objective observer would give no weight to this claim of partiality.
- [18] The second allegation of bias relates to the panel chair’s statement “redacting is not a crime.” Dr. Khan asserts that he never alleged redacting is a crime: he alleged a completely different crime.
- [19] Dr. Khan appears to be suggesting that the statement of the panel chair, if made, demonstrates a lack of understanding or a closed mind to his arguments. There is no basis for this assertion. It was clear during the hearing that Dr. Khan was asserting the redactions in Dr. Walker’s report constitute fabrication of evidence and obstruction of justice. We heard these arguments when Dr. Khan sought permission to call Ms. Mueller.
- [20] During the hearing, Dr. Khan did not allege the panel had a closed mind about this issue. In fact, his representative said the opposite during his submissions:
- I am amazed by the consideration you are giving me. Because I realize that the nature of the allegations I am bringing to you are unusual to say the least, unexpected, obviously. I see you are heavily considering it, pros and cons, and I appreciate that you are heavily mindedly dealing with the issue.
- [21] We determined there was an insufficient basis for Dr. Khan’s assertion that Ms. Mueller had fabricated evidence and we denied his request to call her as a witness. Dr. Khan disagrees with our ruling. The fact that Dr. Khan disagrees with a ruling does not establish a reasonable apprehension of bias.

[22] Dr. Khan failed to meet the test for bias and his request that some or all members of the panel recuse themselves was dismissed for this reason.

Abuse of Process

[23] Prior to the start of the hearing, Dr. Khan filed a motion seeking a dismissal of the case because of abuse of process and requested a stay of the proceedings. The case management chair found the issues in the motion should be raised at the merits hearing. See *College of Physicians and Surgeons of Ontario v. Khan*, 2022 ONPSDT 7.

[24] Section 23(1) of the SPPA grants the Tribunal the authority to “make such orders or give such directions” as it “considers proper to prevent an abuse of its processes.”

[25] The doctrine of abuse of process engages the inherent power of the Tribunal to control its own processes. Fundamentally, it is a tool that allows the Tribunal to prevent the misuse of its procedure either because it is manifestly unfair to a party to the litigation or because it brings the administration of justice into disrepute in some other way. It is a flexible doctrine with the administration of justice and fairness at its heart. One remedy for abuse of process, if found, is a stay of proceedings. See *Law Society of Saskatchewan v. Abrametz*, 2022 SCC 29 at para. 35.

[26] In his written submissions on final argument, Dr. Khan states Ms. Mueller fabricated evidence in another Tribunal proceeding involving Dr. Khan. He complains that we denied him the opportunity to submit evidence about this during our hearing. Dr. Khan is correct that we denied his request to call this evidence because the allegation involved another disciplinary proceeding. If Dr. Khan believes evidence was fabricated in another disciplinary proceeding, he had to raise it there. If it was raised and dismissed, it cannot be relitigated before us. We have no jurisdiction to review decisions made by a different panel in a different proceeding. We gave our ruling on this issue during the hearing and will not reconsider it here.

[27] Dr. Khan submits further that his primary responsibility is to his patients; it is not to protect the reputation of the profession. He believes the regulator is trying to prevent him from giving treatment and he shared his belief with his patients. Dr. Khan states this is not professional misconduct. Rather, it is something that he is

entitled, if not obligated, to do. Dr. Khan submits it shows selflessness on his part because he is acting in his patients' best interests. Dr. Khan asserts the disciplinary proceeding has been driven by the bad faith of the College employees who edit and alter reports and by the College's expert witnesses.

[28] There is no evidence that the College has investigated or litigated this matter in a way that puts the administration of justice into disrepute. The fact that the College relies on an edited (redacted) report of Dr. Walker is not an abuse of process. The College redacted the report because it is not proceeding with certain allegations. It believes those allegations have been decided in the other proceeding involving Dr. Khan. It is not manifestly unfair to Dr. Khan to withdraw allegations against him. If anything, it is a benefit because there are fewer allegations for him to respond to.

[29] Underlying Dr. Khan's abuse of process motion is his submission that he is being unfairly targeted by the College for practising CAM. The College submits he failed to maintain the standard of practice and is incompetent in how he practises medicine. These conflicting positions lie at the heart of the merits of the allegations of professional misconduct against Dr. Khan and will be decided there. Disagreeing with the College's allegations does not mean the allegations are an abuse of process.

[30] For these reasons, we find no abuse of process. Given this finding, it is not necessary to address the question of a stay of proceedings. A stay of proceedings is a remedial tool that is considered by the panel only if an abuse of process has been found.

BACKGROUND

[31] Dr. Khan is a family physician. He is the founder and medical director of Medicor Cancer Centres (Medicor). His primary practice is cancer care.

[32] This case involves Dr. Khan's treatment of two patients, Patient A and Patient B. Their medical history and Dr. Khan's treatment of them are set out below.

Patient A

[33] Patient A lives in New Brunswick. She had a CT scan which showed an incidental finding of slight dilatation of the pancreatic ducts. She was then seen by Dr.

Lightfoot, who performed a clinical assessment and arranged for an endoscopic ultrasound in October 2015. This showed mild dilatation of the main pancreatic duct of up to 3.0 mm diameter and a branch dilatation with two 0.5 mm dots in the main duct at mid-body pancreas. Dr. Lightfoot diagnosed Patient A with early intraductal papillary mucinous neoplasm (IPMN) with no aggressive therapy (surgery) needed. IPMN is a pre-cancerous condition. Dr. Lightfoot recommended that Patient A receive endoscopic ultrasounds at 3, 9 and 21 months to ensure stability.

- [34] Patient A's naturopathic doctor, Dr. Anhorn, completed a requisition for an ONCOblot test on December 14, 2015. The ONCOblot test measures the presence of certain proteins called ENOX2. The owner of the test, MorNuCo Laboratories (MorNuCo), states the existence of these proteins indicates the presence of cancer and the organ site determines the primary source of the malignant cells. Patient A's ONCOblot test found ENOX2 proteins and identified the pancreas as the primary source.
- [35] Dr. Anhorn's requisition contained certain information. Under the question "Type of cancer or suspected type of cancer," the answer "pancreatic" was given. Under the question, "Is the cancer Active or in Remission," the answer "active" was given. The basis for the diagnosis was an endoscopic ultrasound and CT. Under the section "Payment Options & Instructions," Dr. Khan's name was inserted beside the section "Credit Card: No."
- [36] Patient A had a follow up endoscopic ultrasound through Dr. Lightfoot in January 2016. There were no changes in her IPMN.
- [37] Dr. Anhorn requisitioned a second ONCOblot test from MorNuCo on July 26, 2016. The form directed MorNuCo to bill Medicor. The results of this test were the same as the first test.
- [38] Dr. Khan saw Patient A in August 2016. On Medicor's "SAFE" Chemo New Patient Checklist form, Patient A was diagnosed with stage 0 or stage 1 pancreatic cancer. In the section on cancer history, Patient A was found to be "ONCOblot positive for pancreatic cancer" because the presence of ENOX2 proteins indicates the cells have undergone malignant transformation.

- [39] Dr. Khan ordered several abdominal ultrasounds for Patient A and used this modality to follow his treatment of her. His diagnosis of stage 0/1 pancreatic cancer was repeated in his first request for an abdominal ultrasound.
- [40] Patient A commenced side-effect free chemotherapy (SEF or SAFE chemotherapy) of carboplatin and mesna every two weeks. Dr. Khan uses SEF chemotherapy to treat cancer. Patient A received 17 cycles of this treatment between August 2016 and September 2017.
- [41] Dr. Khan wrote a letter on December 23, 2016, addressed "To Whom It May Concern" stating Patient A had received SEF chemotherapy and that it was a medically necessary treatment for advanced pancreatic cancer with poor conventional treatment options.
- [42] Patient A had a follow up endoscopy and endoscopic ultrasound in August 2017. Her IPMN had not changed when compared with the January 2016 and October 2015 test results. Dr. Lightfoot recommended a yearly follow up by endoscopic ultrasound or alternatively, by MRI.
- [43] Dr. Anhorn requisitioned a third ONCOblot test from MorNuCo on October 30, 2017. The form directed MorNuCo to bill Medicor.
- [44] Dr. Khan billed the New Brunswick health care system for his care of Patient A from September 2016 to February 2018. He billed \$6,467.10 using predominantly palliative care and chemotherapy supervision fee codes for patient assessment, case management and supervision of her chemotherapy.
- [45] Patient A's daughter filed a complaint against Dr. Khan with the College. She complained that Dr. Khan was treating her mother for pancreatic cancer that no other medical professional had diagnosed. Patient A's daughter stated Patient A had paid out almost \$100,000 for various blood tests, SEF chemotherapy, hyper therapy, plus the cost of flights and accommodations to receive those treatments. She stated Dr. Khan is operating a cancer clinic without oncology training and pushing treatments that serve no purpose other than increasing cash flow. She asked whether there is a governing body to stop and regulate these practices or whether it is buyer beware when patients "are pushed into private health care traps."

Patient B

- [46] Patient B was diagnosed with papillary thyroid cancer in 2009. He had a total thyroidectomy and right neck dissection from Dr. Young, a general surgeon, head and neck surgeon and surgical oncologist. Following surgery, Patient B received radioactive iodine therapy.
- [47] Patient B was disease free from 2009 to 2013. He continued to be followed by Dr. Young and a team of thyroid cancer specialists at St. Joseph's Healthcare.
- [48] Patient B was diagnosed with right level III and IV node metastases and metastatic disease in both lungs in 2013. He underwent right cervical lymph node surgery and had a second radioactive iodine therapy dose.
- [49] Patient B's lung metastases progressed in 2015. The increase in size and number of lesions in both lungs were believed to be consistent with metastatic disease from the papillary thyroid carcinoma. Overall, there was no significant change in tumour burden.
- [50] Patient B referred himself to Dr. Khan in April 2015. Dr. Khan offered systemic therapies including intravenous dichloroacetate (10 cycles), dimethylsulfoxide (12 cycles) and SEF chemotherapy (10 cycles). Dr. Khan monitored disease activity using circulating epithelial tumour cell counts provided by a private laboratory in Germany.
- [51] Dr. Young saw Patient B in November 2016. Dr. Young found no evidence of disease in his neck, although he noted two small nodes in the right side of his neck. Dr. Young felt there was no need to change his care at that time.
- [52] Dr. Young saw Patient B in May 2017 for follow up. Dr. Young increased Patient B's thyroid medication to lower his TSH levels because TSH can stimulate cancer tumours. Dr. Young's clinical notes indicate that for metastatic thyroid cancer, TSH levels should be about 1.0, or ideally, 0.1.
- [53] Dr. Young saw Patient B in December 2017 for follow up. There were no changes in his care.

- [54] Dr. Khan instructed Patient B to discontinue T4 and use T3 (L-triiodothyronine) instead in May 2018. Patient B's bloodwork during this period indicated that his T4 levels were declining, however his TSH levels were increasing rapidly. His TSH level on May 1, 2018, was 1.22. It was 35.34 on June 29, 2018.
- [55] Dr. Khan wrote to Patient B in early July and advised him that his thyroglobulin was creeping up and wanted to do a new chest CT scan to make sure there was no growth. Thyroglobulin is a sign that Patient B's thyroid cells were being stimulated. There was no mention of Patient B's elevated TSH.
- [56] Dr. Young saw Patient B in July 2018. In his clinical record, Dr. Young notes a growth of Patient B's metastatic papillary follicular carcinoma of the thyroid. His thyroglobulin had increased to 28.8 in June and his tumour was no longer sensitive to radioactive iodine. Patient B advised Dr. Young that he had been seeing Dr. Khan. Patient B gave Dr. Young an article that he had received from Dr. Khan which suggested that some brain tumours respond to low doses of thyroid hormone and as a result, Dr. Khan stopped his T4 medication and switched it to T3. Dr. Young advised Patient B that thyroid tumours are often TSH-sensitive and putting him on a low dose of thyroid hormone when he needed a high dose will cause increased levels of TSH, which will stimulate his tumour. Dr. Young advised Patient B to return to his previous thyroid hormone levels.
- [57] Patient B returned to his previous T4 medication.
- [58] Dr. Young filed a complaint against Dr. Khan with the College. His complaint centered on Dr. Khan instructing Patient B to stop taking T4 and take T3 instead. Dr. Young did bloodwork on Patient B and while his T3 was in the normal range, his TSH was very high and his T4 was not measurable. Dr. Young was concerned about Dr. Khan representing himself as a cancer specialist and giving patients advice about their malignancy. Dr. Young noted in his complaint that Patient B also saw a medical oncologist who had not yet recommended him for chemotherapy for his metastatic lung malignancy and that he remains asymptomatic.

College Policies

- [59] This case involves Dr. Khan's use of complementary, alternative and conventional medicine when providing care to Patient A and Patient B. The College's policy on

Complementary/Alternative Medicine (CAM Policy) and Consent to Treatment Policy are relevant to this issue.

CAM Policy

[60] The version of the CAM Policy that is relevant to this case was created in November 1997 and updated in February 2000 and November 2011. It defines conventional medicine as the type of medicine that is generally provided in hospitals and in specialty or primary care practice. It is the type of treatment, diagnostic analysis and conceptualization of disease or ailment that is the primary focus of the curricula of university faculties of medicine. Complementary/Alternative Medicine is defined as a group of diverse medical practices and products that are not generally considered part of conventional medicine.

[61] The CAM Policy sets out the following general expectations for physician conduct:

- a. Physicians must act in patients' best interests. They must always be motivated by a regard for what is best for the patient.
- b. Physicians must respect patient autonomy. Patients are entitled to make treatment decisions and set health care goals that accord with their wishes, values and beliefs.
- c. Physicians must refrain from exploitation. Exploitation occurs when a physician, in his or her professional capacity, dominates and influences patients to further the physician's own interests.
- d. Physicians must place the interests of their patients over their own personal interests.

[62] The CAM Policy sets out the following specific expectations for physicians practising CAM:

- a. Physicians must always act within the limits of their knowledge, skill and judgment and never provide care that is beyond the scope of their clinical competence.
- b. All patient assessments and diagnoses must be consistent with the standard of conventional medicine and be informed by evidence and science.

- i. Physicians providing CAM must conduct a clinical assessment of the patient. The clinical assessment must involve taking an appropriate patient history and performing or ordering any necessary medical or laboratory examinations or investigations that are required to obtain relevant and comprehensive information about the patient's ailment or condition. If the patient has seen other health-care practitioners for the same ailment and has had a clinical assessment completed, physicians may be able to rely on this clinical assessment. To do so, physicians must have reviewed the assessment and must be satisfied that it meets the standard of conventional medicine.
- ii. Physicians providing CAM must reach a conventional diagnosis. If physicians also reach a CAM diagnosis, that diagnosis must be based on the clinical assessment conducted and other relevant information, be supported by sound clinical judgment and informed by evidence and science.
- c. Physicians must always have valid informed patient consent to authorize therapeutic intervention.
 - i. Any CAM therapeutic option that is recommended must be informed by evidence and science and it must:
 - 1. Have a logical connection to the diagnosis reached;
 - 2. Have a reasonable expectation of remedying or alleviating the patient's health condition or symptom; and
 - 3. Possess a favourable risk/benefit ratio based on the merits of the option, the potential interactions with other treatments the patient is receiving, the conventional therapeutic options available, and other considerations the physician deems relevant.
 - ii. Physicians must never recommend therapeutic options that have been proven to be ineffective through scientific study.
- d. The provision of CAM must be authorized by valid informed consent. The College expects the physician will convey the following to patients:

- i. The extent to which the CAM diagnosis reached is supported by the conventional medical community;
 - ii. Their rationale for recommending the therapeutic option in question;
 - iii. Reasonable expectations about the clinical efficacy of the therapeutic option;
 - iv. Whether the therapeutic option is supported by the conventional medical community, along with the level of support provided by the CAM community;
 - v. A description of how the therapeutic option compares to conventional medical interventions that would be offered to treat the same symptoms or condition (comparison of risks, side effects, therapeutic efficacy, etc.); and
 - vi. Accurate information about the conventional therapeutic options that would be offered to treat the same symptoms or condition.
- e. The details of the consent process, including the above information, should be documented in the patient's medical record.

[63] The CAM Policy is clear that for patients to provide informed consent, physicians must provide them with accurate and objective information about the available therapeutic options and they must never inflate or exaggerate the potential therapeutic outcome that can be achieved, misrepresent or malign the proven benefits of conventional or CAM treatment or make claims regarding therapeutic efficacy that are not substantiated by evidence.

Consent to Treatment Policy

[64] The College approved a Consent to Treatment Policy in February 2001, which was updated in September 2005 and May 2015. Under this policy, the physician must obtain valid consent before treatment is provided. For consent to be valid, it must be obtained from the patient if they are capable with respect to the treatment, be related to the treatment, be informed, be given voluntarily and must not be obtained through misrepresentation or fraud.

[65] The following elements are required for consent to treatment:

- a. The consent must relate to the specific treatment being proposed and provided.
- b. The consent must be informed. The physician must provide information about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action and the likely consequences of not having the treatment.

[66] Physicians must obtain consent for all treatment, that is, anything that is done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan.

[67] Consent may also need to be revisited after it has been obtained if there are any significant changes in the patient (e.g., health status, health care needs, specific circumstances, etc.) or treatment (e.g., the nature of expected benefits, material risks and material side effects). Physicians are advised that the passage of time may increase the risk that these changes will arise, and that consent may need to be obtained again.

ANALYSIS

[68] The College must prove the allegations against Dr. Khan on a balance of probabilities. The evidence that it relies upon to meet its burden of proof must be clear, convincing and cogent. See *F.H. v. McDougall*, 2008 SCC 53 at para. 40.

[69] The College has made several allegations of professional misconduct by Dr. Khan. It alleges he failed to maintain the standard of practice and is incompetent in relation to his care of Patient A and Patient B. It alleges further that he engaged in disgraceful, dishonourable or unprofessional conduct with Patient A in his billings, his communications with her during the College investigation and his use of the ONCOblot test, a test in which the College alleges he has a conflict of interest.

Standard of Practice and Incompetence

[70] Standard of practice has been defined as that which is reasonably expected of the ordinary, competent practitioner in the member's field of practice. It is not necessary to find harm to find a breach of the standard of practice. Failing to maintain the standard of practice of the profession is an act of professional

misconduct under paragraph 1(1)(2) of Ontario Regulation 856/93 under the *Medicine Act, 1991*, SO 1991, c. 30.

[71] Incompetence is defined in s. 52(1) of the Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act, 1991*, SO 1991, c. 18 (Code). To find incompetence, the panel must be satisfied that the member's professional care of the patient displayed a lack of knowledge, skill or judgment or disregard for the welfare of the patient of a nature or to an extent that demonstrates that the member is unfit to practise or that his practice should be restricted.

[72] Incompetence differs from professional misconduct. A finding of professional misconduct will be based purely on events that occurred in the past. Incompetence is assessed based on the member's care of patients in the past, but the panel must also be satisfied that the member is presently incompetent. See *College of Physicians and Surgeons of Ontario v. Depass*, 2009 ONCPSD 27 at pp. 24-25.

Expert Evidence

[73] The College relies on the evidence of two experts in support of its case. Dr. Younus is an expert in the diagnosis and treatment of cancer. He gave evidence about the care Dr. Khan provided to Patient A and provided an opinion on whether Dr. Khan breached the standard of care. Dr. Walker is an expert in treating thyroid disorders, including malignancies, and gave evidence on the care provided by Dr. Khan to Patient B. He gave an opinion on whether Dr. Khan breached the standard of practice.

[74] Expert opinion evidence is admissible when the issues call for specialized knowledge beyond the knowledge and expertise of the panel hearing the case, often because of the technical nature of the facts before it. The expert may draw inferences from the facts and state their opinion. The panel scrutinizes the expert evidence for credibility and reliability, and for the evidentiary basis and factual assumptions relied upon by the expert. It must be careful not to inappropriately defer to the expert and must evaluate the expert's opinion carefully. In turn, the expert has a duty of independence, impartiality and freedom from bias. See *R. v. Abbey*, 1982 CanLII 25 (SCC) at p. 42 and *White Burgess Langille Inman v. Abbott and Haliburton Co.*, 2015 SCC 23 at paras. 17 and 26-32.

[75] The evidence of Drs. Younus and Walker is set out below.

Dr. Jawaid Younus

[76] Dr. Younus is a medical oncologist working at the London Regional Cancer Program. He is an associate professor with the Faculty of Medicine at Western University and holds Royal College certification in both internal medicine and medical oncology.

[77] Dr. Khan disputed Dr. Younus's expertise on the basis that he does not practise CAM. We qualified Dr. Younus as an expert in the diagnosis and treatment of cancer. We ruled that there were no restrictions on the parties' ability to ask Dr. Younus questions about CAM and his answers would be given the appropriate weight by the panel considering his expertise.

[78] Dr. Younus testified the diagnosis of pancreatic cancer, noted by Dr. Khan throughout Patient A's chart, is incorrect. The correct diagnosis for Patient A is IPMN. IPMN is not cancer. It may be a precursor to cancer and careful follow up is required.

[79] Dr. Younus testified a progression of IPMN to pancreatic cancer is not diagnosed until certain criteria are met, namely, that the main pancreatic ductal dilatation is greater than 10 mm or that any concerning lesions or spots have a diameter of 30 mm or greater. At that point, Dr. Younus said, it is more likely cancer. He said surgery is the appropriate treatment for pancreatic cancer.

[80] Dr. Younus testified the basis for Dr. Khan's diagnosis of pancreatic cancer is unclear. The only test that shows pancreatic cancer is the ONCOblot test. Dr. Younus said the ONCOblot test is not a conventional tool to diagnose any cancer, including pancreatic cancer.

No informed consent to treatment

[81] Dr. Younus gave evidence on the consent to treatment form signed by Patient A for Dr. Khan. He testified the diagnosis of cancer on the consent form was not justified on conventional grounds and the specific diagnosis of "stage 1" on the new patient checklist was not accurate. He said the notes do not show that Patient A was informed that she did not have cancer on conventional grounds nor was she

provided with a rationale for the treatment of SEF chemotherapy. The consent did not include a comparison of conventional versus alternative treatment. In fact, there was no mention of conventional treatment at all.

- [82] Dr. Younus stated this is not a case where a conventional diagnosis (IPMN) could exist alongside a complementary or alternative diagnosis (cancer). Patient A could not have both IPMN and cancer because IPMN is, by definition, not cancer. It is a precancerous condition.

Patient A received treatment not informed by evidence and science and was exposed to harm

- [83] Dr. Younus testified Patient A did not have pancreatic cancer and yet she received carboplatin, a conventional chemotherapy drug, from Dr. Khan. Carboplatin stops the reproduction of cancer cells. Dr. Younus stated carboplatin is not used to treat IPMN and is not used to treat pancreatic cancer.

- [84] Patient A had regular bloodwork taken while she was receiving carboplatin. Dr. Younus testified one of the side effects of carboplatin is low platelets. He said carboplatin should not be used when platelet levels are below 100,000. On December 13, 2016, Patient A's platelets were 72,000. On December 21, 2016, Dr. Khan recommended eight more cycles of chemotherapy because of the aggressive nature her pancreatic cancer (which she did not have).

- [85] Dr. Younus testified that as platelet counts begin to drop, the patient may bruise easily, experience gum bleeding and it will take longer to stop a minor trauma. Dr. Younus said surgery is not possible and spontaneous bleeding may occur when platelets fall below 20,000.

- [86] Patient A also received mesna from Dr. Khan. Mesna is a drug used to prevent hemorrhagic cystitis. Dr. Younus was unable to explain why Dr. Khan used mesna with Patient A. The consent form describes mesna as protecting Patient A's body from the side effects of chemotherapy. Dr. Younus testified there is no evidence or science to support this assertion nor is there evidence or science to support its use with carboplatin.

- [87] Dr. Khan prescribed phenylbutarate to Patient A. Dr. Younus did not know why Dr. Khan used this drug with carboplatin and mesna. He testified its use in oncology

has been limited to testing in the lab and he has not seen any human trials with this drug. Its only approved use is with urea cycle disorders. Dr. Younus stated phenylbutarate is not used to treat IPMN or pancreatic cancer. There are also risks involved when taking this drug including fevers, skin rashes and abdominal pain.

- [88] Around this time, Dr. Khan ordered a maintrac test conducted by a blood sample that measures circulating tumour cells (CTCs) and tests sensitivity to chemotherapy. Dr. Younus testified the use of CTCs in the management of oncology patients in general is not a standard of care procedure. It is still in its experimental phase of research. In addition, the sensitivity component is not a standard test.

Flawed efficacy of treatment

- [89] In February 2017, Patient A had an abdominal ultrasound ordered by Dr. Khan. The ultrasound showed the pancreatic lesions had increased in size. Dr. Younus testified that Dr. Khan had ordered a series of abdominal ultrasounds for Patient A and stated they are less sensitive than endoscopic ultrasounds or MRIs for following pancreatic lesions.
- [90] Dr. Khan wrote to Patient A on February 26, 2017. He told her one tumour was dead and the other tumour was dying. Dr. Younus testified an increase in tumour size with multiple tumours means the tumour is growing and multiplying, thereby putting into question the efficacy of the chemotherapy. That said, Dr. Younus did not place much weight on the ultrasound results. He testified the endoscopic test ordered by Dr. Lightfoot in August 2017 is a more accurate measure of pancreatic ducts and IPMN and it showed no change.
- [91] In August 2017, Dr. Khan contacted Patient A with the subject line “further safe chemo” and recommended she “consolidate the gains”, saying that there was “imaging efficacy” and that she had likely “killed all the cancer cells in the smaller lesion”. This is not what the ultrasound showed. Dr. Younus stated Dr. Khan had no reliable way of monitoring the efficacy of the treatment he was providing to a patient who did not have cancer.
- [92] Dr. Younus concluded that Dr. Khan failed to maintain the standard of practice of the profession, including with respect to:

- a. assessing and diagnosing Patient A without a conventional diagnosis,
- b. lack of informed consent,
- c. treating Patient A with therapeutic options that were not informed by evidence and science,
- d. evaluating and monitoring her efficacy of treatment.

[93] In his written report, Dr. Younus expressed the opinion that Dr. Khan had incorrectly diagnosed Patient A with breast cancer. Dr. Younus was cross-examined on this opinion, and it was pointed out to him that the breast cancer diagnosis pertained to another patient whose clinical note was misfiled in Patient A's records. Dr. Younus accepted that the document was misfiled but said it did not change his opinion regarding Dr. Khan's treatment of Patient A for pancreatic cancer, a condition which Dr. Younus concluded she did not have.

Dr. Peter Walker

[94] Dr. Walker practised clinical endocrinology for 39 years until his retirement in December 2019. His practice focused on thyroid disorders including thyroid malignancies. He has held academic positions including Chair of the Division of Endocrinology & Metabolism and Physician-In-Chief and Vice-Chair of the Department of Medicine at the Ottawa Civic Hospital and the University of Ottawa, and Dean of the Faculty of Medicine at the University of Ottawa. Dr. Khan did not oppose Dr. Walker's qualifications. We qualified Dr. Walker as an expert in treating thyroid disorders including malignancy.

[95] Dr. Walker interviewed Dr. Khan before preparing his report.

[96] In his testimony and in his report, Dr. Walker gave the opinion that Dr. Khan's treatment of Patient B did not meet the standard of the profession and exposed Patient B to risk of harm and injury. He testified to the following.

Dr. Khan's intake assessment

[97] Dr. Khan's notes reflect that he failed to complete a careful physical examination of Patient B at intake. He did not chart any physical examination of the head and neck and there was no medication review. Dr. Khan did not conduct his own independent

assessment and instead relied on the notes of a naturopath at Medicor. In the naturopath's assessment examination, Patient B's thyroid was described as normal and no cervical scars were reported, even though his thyroid had been removed.

[98] Dr. Khan arrived at a conventional diagnosis of metastatic thyroid carcinoma in the absence of a pathology report. Dr. Khan explained in his interview with Dr. Walker that he does not require a pathology report for the types of cancers he treats and the metabolic approach to therapy that he takes.

Dr. Khan's treatment not informed by evidence and science and exposed Patient B to harm

[99] Dr. Khan has little experience with thyroid cancer. In his interview with Dr. Walker, Dr. Khan said he did not follow Cancer Care Ontario guidelines because he is not actively engaged in conventional cancer care and that he assumed Patient B's other physicians followed those guidelines. Dr. Khan said he did not use recommended TSH targets for ongoing management and paid little attention to TSH levels even though TSH is a growth factor for thyroid tissue and thyroid cancer. Dr. Walker stated in his evidence that control of TSH levels in thyroid cancer patients is critical.

[100] Dr. Khan told Dr. Walker he substituted T3 for T4 because a study suggested low T4 levels were associated with longer survival rates in patients with a variety of solid tumour malignancies. Dr. Walker stated in his report that this study has no institutional research, ethics review or oversight. Dr. Khan failed to recognize that hypothyroidism can result from the reduction of T4. His failure to recognize substantial hypothyroidism put Patient B at risk of aggravating his metastatic disease burden.

[101] After Dr. Khan substituted T3 for T4, he interpreted biochemistry results as appropriate and an indication that the medications were working. He told Patient B his T4 was suppressed (good) and T3 was okay. The actual results showed Patient B was significantly hypothyroid. In addition to the hypothyroidism, Patient B's thyroglobulin had risen significantly, which can be an indication of residual tumor or disease progression. Dr. Khan told Patient B the increase might be a "false reading." Dr. Walker testified it likely reflected hypothyroidism and the effect of increased TSH on thyroid tumour cells.

[102]Dr. Walker stated Dr. Khan's decision to substitute T3 for T4 is not supported by appropriate levels of evidence and science and is not recommended by current clinical treatment guidelines. In addition to not meeting the standard of the profession, Dr. Walker opined that Dr. Khan's treatment of Patient B displayed a lack of knowledge, skill and judgment.

Decision not to join circle of care delayed intervention

[103]Dr. Khan elected not to join Patient B's circle of care, the team of physicians providing his care. As a result, no physician was aware of Dr. Khan's treatment. It took three years for Dr. Young to learn of this and to intervene. When asked by Dr. Walker in his interview why he did not enter the patient's circle of care, Dr. Khan said he did so early in his practice but stopped because the specialty physicians were either uninterested or opposed to his care. As a result, he ceased integrating into the patient's circle of care as a matter of routine. In his report, Dr. Walker states this demonstrates a serious lack of judgment that interferes with the patient's continuity of care and leads to potential significant gaps and errors in care.

Record keeping, examinations and communications

[104]Dr. Walker testified Dr. Khan's charts are rudimentary and poorly organized. His notes are frequently illegible and very superficial. There are no medication reviews integrated into the chart. The prescription log does not reflect other medications Patient B was taking, including medications his other treating physicians prescribed.

[105]Physical examinations for Patient B were infrequent and treatment plans were non-existent or illegible. When Patient B attended Dr. Khan's clinic in May 2018, Dr. Khan's notes suggest he conducted a cursory physical examination, including the head and neck, for the first time since Patient B's intake examination with the naturopath in 2015. He noted Patient B's problems as "met thyroid ca" and "recent progression" and identified the plan as being to "re-start meds" and "continue regular follow up including thyroglobulin, CTC and CT scans."

[106]Dr. Khan communicated with Patient B by email. Emails were used to transmit information regarding laboratory and imaging that Patient B had or was receiving.

During the latter part of Dr. Khan's care of Patient B in 2017, he saw Patient B infrequently and communicated extensively by email.

[107]Some of the email communications from Dr. Khan were confusing. For example, in April 2017, Patient B's TSH levels were too high. Dr. Khan emailed Patient B and told him his TSH levels were "a little high" and noted he might need an increase of thyroid hormone and asked the strength of the medication he was taking (as prescribed by his other physician). Dr. Walker stated Dr. Khan should have known this information. A confusing email exchange followed about the dosage and frequency of the medication. Patient B became puzzled when Dr. Khan, who initially indicated the dosage might need to be increased, recommended that it be decreased. This exchange put Patient B at risk without resulting in any change to his high TSH levels.

[108]Dr. Walker concluded Dr. Khan failed to maintain the standard of practice of the profession in his care and treatment of Patient B in:

- a. relying on an inadequate intake assessment of Patient B,
- b. failing to keep adequate medical records and failing to physically examine Patient B often enough or adequately,
- c. relying on email to communicate with Patient B, leading to confusion,
- d. failing to join Patient B's circle of care, and
- e. making changes to Patient B's thyroid replacement therapy that were not informed by evidence or science, without charting appropriate consent discussions, and without appropriate monitoring and communication.

[109]Dr. Walker opined Dr. Khan displayed a lack of knowledge, skill and judgment in his care and treatment of Patient B, which exposed him to harm or injury.

Findings on Standard of Practice and Incompetence

[110]Dr. Khan did not call any expert evidence to refute the findings of Drs. Younus and Walker and did not testify himself. As a result, there is no conflicting evidence for the panel to consider when deciding if Dr. Khan failed to maintain the standard of practice and is incompetent in relation to his care of Patient A and Patient B. The

cross-examination of Drs. Younus and Walker by Dr. Khan's representative did not undermine their opinions for several reasons.

[111]Dr. Khan's representative did not touch on the issues that are important in his case. For example, he did not cross-examine Dr. Younus on his opinion that Patient A should not have received cancer treatment when she did not have cancer. He did not cross-examine Dr. Walker on his opinion that Patient B should not have received hormone depletion therapy (the substitution of T3 for T4).

[112]In cross-examination of Dr. Walker, Dr. Khan's representative appeared to suggest that there could be another cause for Patient B's rising thyroglobulin levels, putting him at risk for an increased cancer burden. Dr. Khan suggested it could be DCA. Beyond this assertion in cross-examination, there is no evidence that DCA does, in fact, increase thyroglobulin. At best, Dr. Walker said it is possible. Even if DCA does increase thyroglobulin, it is unclear how this helps Dr. Khan when he was the physician that used DCA with Patient B. It does not matter if it was DCA or hormone depletion therapy that caused Patient B's TSH or thyroglobulin to rise. Either put Patient B at risk of harm.

[113]Dr. Khan's representative cross-examined Dr. Walker about his opinion on Dr. Khan's decision not to join Patient B's circle of care. He suggested this was Patient B's decision, not Dr. Khan's. This misses the point. It was Dr. Khan's responsibility to ensure that the physicians providing cancer care to Patient B knew about the treatment Dr. Khan provided. It is unfair to put that responsibility on Patient B.

[114]Dr. Khan's representative disagrees with the opinions of Drs. Younus and Walker. For the most part, he highlights minor inconsistencies in their evidence to suggest they have engaged in criminal conduct that justifies jail time. His written submissions contain hyperbolic and deeply offensive statements that have no place in a proceeding before this Tribunal.

[115]Dr. Khan's main argument is that these two experts are not experts in CAM. In our view, this ignores the central issue in the proceeding. The question is whether Dr. Khan met the standard of practice that applies to all physicians, whether they are practising CAM, conventional medicine or both.

[116]We have reviewed the evidence of Drs. Younus and Walker carefully and accept their findings. Drs. Younus and Walker are experts in the treatment of cancer in their respective fields. Their opinions have a strong evidentiary basis, are logical and make sense. There is no conflicting expert evidence to consider. For these reasons, we accept their expert evidence and make the following findings, dealing first with Patient A and then with Patient B.

Patient A

[117]In his treatment of Patient A, Dr. Khan failed to maintain the standard of practice reasonably expected of the ordinary, competent practitioner providing cancer care. We make this finding for the following reasons.

[118]Both conventional medicine and CAM require a conventional diagnosis before treatment. Patient A's conventional diagnosis is IPMN. Dr. Khan ignored Patient A's conventional diagnosis and treated her for cancer.

[119]Dr. Khan diagnosed Patient A with cancer based on the ONCOblot test. We agree with Dr. Younus's evidence that the ONCOblot is not an accepted test to diagnose cancer. It does not constitute a conventional diagnosis under the CAM Policy.

[120]Dr. Khan suggests the diagnoses of IPMN and cancer can stand together. We disagree. IPMN is a pre-cancerous condition. One cannot have a pre-cancerous condition and cancer at the same time.

[121]Patient A did not have cancer. Despite that, Dr. Khan provided an extensive course of chemotherapy. This treatment exposed Patient A to harm. She experienced harm by having treatment for a condition that she did not have and harm from the treatment itself. Carboplatin, mesna and phenylbutyrate all have side effects. Carboplatin can cause patients to develop low platelet counts resulting in easy bruising and bleeding at certain platelet levels. Patient A's platelet counts decreased repeatedly during her treatment. At times, Dr. Khan provided chemotherapy despite Patient A's low platelet levels.

[122]Dr. Khan failed to accurately monitor Patient A's medical condition. He used abdominal ultrasounds to monitor her cancer, a condition that she did not have, and failed to use the right tool (endoscopic ultrasounds) to monitor the condition that she did have.

[123]The bottom line is Dr. Khan was unable to monitor the efficacy of his treatment. If a patient receives treatment for a condition the patient does not have, the efficacy of that treatment cannot be measured.

[124]Based on these findings, Dr. Khan has failed to maintain the standard of practice of the profession.

[125]These facts also lead to the conclusion that Dr. Khan is incompetent. He diagnosed and followed Patient A using an unverified test (ONCOblot) and the less sensitive abdominal ultrasound when she had a conventional diagnosis of a benign pancreatic lesion. This led Dr. Khan to treat Patient A for pancreatic cancer, thus exposing her to the harmful side effects of chemotherapy. He promoted his SEF chemotherapy as side-effect free and then disregarded the side effect of low platelets and continued to recommend chemotherapy for a cancer that she did not have. He did this over a prolonged period of time. Dr. Khan's treatment of Patient A displayed a lack of knowledge, skill or judgment or disregard for her welfare of a nature or to an extent that demonstrates he is unfit to practise.

Patient B

[126]In his treatment of Patient B, Dr. Khan failed to maintain the standard of practice reasonably expected of the ordinary, competent practitioner providing cancer care. We make this finding for the following reasons.

[127]Dr. Khan discontinued T4 therapy provided by another member of Patient B's treatment team and substituted it for T3. This caused Patient B to become profoundly hypothyroid and put him at risk for a proliferation in his cancer cells. Dr. Khan failed to join Patient B's circle of care. As a result, Patient B's cancer specialists did not know that Dr. Khan had changed their treatment regime and they did not have the opportunity to intervene quickly to correct the harm that resulted from Dr. Khan's care.

[128]Dr. Khan relied on an inadequate intake assessment, failed to physically examine Patient B often enough or adequately and relied on email to communicate with Patient B. Dr. Khan's email communications were inadequate and led to Patient B not understanding his medical advice.

[129]Dr. Khan's failure to manage Patient B's thyroid hormone replacement appropriately when he had metastatic papillary cancer showed a lack of knowledge, skill or judgment or disregard for his welfare of a nature or to an extent that demonstrates Dr. Khan is incompetent and unfit to practise. In his emails to Patient B regarding his thyroid replacement, it is apparent that Dr. Khan did not understand even the basics of thyroid physiology. He admitted to Dr. Walker that he has little or no experience treating thyroid malignancies. He displayed a lack of judgment in his decision not to join Patient B's circle of care. Dr. Khan's lack of communication with Dr. Young regarding the changes he had made to Patient B's management exposed him to harm. Dr. Khan's explanation for not notifying Dr. Young was self-serving and not focused on Patient B's well-being.

[130]Dr. Khan had a casual disregard for the welfare of Patient A and Patient B. Patient A received unnecessary treatment and Patient B received the wrong treatment. Despite these two central facts, Dr. Khan continued to treat them. This raises the question of whether Dr. Khan was more concerned about providing treatment than he was about the efficacy of his treatment or its potential harm. Dr. Khan's casual disregard is further evident in his intake, record-keeping, lack of physical examinations and communications with Patient B.

[131]Dr. Khan defends the breach of the standard of care allegations by asserting he was targeted by the College for practising CAM. Practising CAM does not give physicians free rein to practise medicine any way that they see fit. The professional expectations set out in the CAM Policy reflect the same obligations that guide all medical practice.

[132]Physicians practising CAM must act within the limits of their knowledge, skill and judgment and must not provide care beyond the scope of their clinical competence. Patient assessments and diagnoses must be consistent with the standards of conventional medicine and be informed by evidence and science. Similarly, all therapeutic options recommended by the physician practising CAM must be informed by evidence and science. This means the therapeutic option has:

- a. a logical connection to the diagnosis reached,
- b. a reasonable expectation of remedying or alleviating the patient's health condition or symptoms, and

- c. a favourable risk/benefit ratio based on the merits of the option, the potential interactions with other treatments the patient is receiving, the conventional therapeutic options available and other considerations the physician deems relevant.

[133]Dr. Khan failed to abide by the CAM requirements.

[134]The College did not target Dr. Khan because he practised CAM. The College investigated Dr. Khan because it received complaints that his treatment of Patient A and Patient B exposed them to harm. The evidence we heard has shown that this was the case. Treating Patient A for a cancer that she did not have and treating Patient B with hormone depletion therapy risking a proliferation of his cancer cells are contrary to the CAM Policy and contrary to the competent practice of medicine.

[135]For these reasons, we find Dr. Khan failed to maintain the standard of practice of the profession and is incompetent in his treatment of Patient A and Patient B.

Disgraceful, Dishonourable or Unprofessional Conduct

[136]Disgraceful, dishonourable or unprofessional conduct is defined in paragraph 1(1)33 of Ontario Regulation 856/93 as 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. It is an act of professional misconduct.

[137]Disgraceful, dishonourable or unprofessional conduct is often referred to as a broad catch-all provision and “is intended to capture any improper misconduct that is not caught by the wording of the specific definitions of professional misconduct.” Conduct does not have to be dishonest or immoral to fall within the definition: a serious or persistent disregard for one’s professional obligations is sufficient. See *College of Physicians and Surgeons of Ontario v. Rabiou*, 2020 ONCPSD 15 at p. 26.

[138]The College’s allegations of disgraceful, dishonourable or unprofessional conduct relate to Patient A.

Billings

[139]James Ayles, the Director of Health Analytics at New Brunswick Medicare, testified about reciprocal billing practices between provinces when patients receive health care out of province. He said physicians can submit a claim to the physician's home jurisdiction for care provided to the patient, even though the patient's home province is responsible for the cost of that care. The physician uses the billing codes that apply in the physician's home jurisdiction.

[140]Between September 16, 2016, and February 2, 2018, Dr. Khan billed the Ontario Health Insurance Plan (OHIP) 68 times for care provided to Patient A using service code G512A. This code is for palliative care.

[141]Dr. Jude Coutinho, a medical advisor with the OHIP, testified code G512A allows physicians most responsible for a patient's palliative care to bill a weekly fee for coordinating any care that the patient might require. Palliative care is defined in the Schedule of Benefits as "care provided to a terminally patient in the final year of life where the decision has been made that there will be no aggressive treatment of the underlying disease and care is to be directed to maintaining the comfort of the patient until death occurs."

[142]Patient A was not terminal when she received treatment from Dr. Khan. She did not have cancer and was not in the final year of her life. Humaira Khan testified Patient A is alive and well today, six years after she commenced treatment with Dr. Khan.

[143]In final argument, Dr. Khan's representative suggested that Dr. Khan simply used the wrong billing code and that he was entitled to be paid for his services. There are several pieces of evidence that lead us to conclude that Dr. Khan's use of the palliative care billing code was intentional, not inadvertent.

[144]Dr. Khan used the palliative care code for Patient A on an almost weekly basis. He did not provide weekly services to Patient A. Billing for services not provided is not an inadvertent use of the wrong billing code. In addition, the wrong billing code was used 68 times over a 15-month period. We cannot accept that using the wrong billing code this many times was inadvertent.

[145]Dr. Khan did not testify so there is nothing to explain evidence that suggests intentionality on his part. Based on the evidence before us, we conclude the

College has proven, on a balance of probabilities, that Dr. Khan acted intentionally in his billing.

[146]For these reasons, we find Dr. Khan's billing for palliative care that was not provided to Patient A and was not needed by her constitutes disgraceful, dishonourable or unprofessional conduct.

Interference with the Investigation

[147]Patient A's daughter filed a complaint with the College. After it was filed, Dr. Khan texted Patient A and told her that her daughter had made a very serious complaint against him, a complaint which put the SEF chemotherapy program in jeopardy. Dr. Khan asked Patient A to speak to her daughter.

[148]Dr. Khan texted Patient A again and asked if her daughter had retracted her complaint. A few days later, Dr. Khan asked Patient A to send him an email stating she did not consent to the College looking at her medical chart and did not want the College interfering with her doctor or her therapy.

[149]The public must be confident that when complaints are filed with the College, they will be dealt with on their merits. When a member interferes with the complaints process, they bring discredit on the profession as a self-regulating profession. Dr. Khan interfered with the regulatory process when he asked Patient A to get her daughter to retract her complaint, a complaint that we have substantiated. Dr. Khan's communications with Patient A are disgraceful, dishonourable or unprofessional.

Conflict of Interest

[150]Under s. 16 of Ontario Regulation 114/94, a member has a conflict of interest where the member, or a member of their family, or a corporation wholly, substantially, or actually owned or controlled by the member or a member of their family receives any benefit, directly or indirectly, from a supplier to whom the member refers their patients, or a supplier who sells or otherwise supplies any medical goods or services to the member's patients. Supplier, includes anyone who sells or supplies medical goods or services, including laboratory services.

[151]Dr. Khan is the medical director of Medicor. Humaira Khan is the shareholder of Medicor, and its president and CEO.

[152]Medicor entered into a distributorship agreement with 500 Medical Labs, Inc., acting on behalf of the ONCOblot test, and MorNuCo, the owner of the ONCOblot test in January 2016. Under the agreement, Medicor is the distributor of ONCOblot tests in Canada, and agrees to pay \$700 USD for each ONCOblot test and to invoice individual physicians for the test at a price that is appropriate for the Canadian market.

[153]Patient A spoke to Dr. Khan about Dr. Lightfoot's findings in October 2015. Following that discussion, Dr. Khan spoke with Dr. Anhorn, Patient A's naturopath, about the ONCOblot test. Dr. Anhorn then requested three ONCOblot tests for Patient A. On the test requisitions, MorNuCo was directed to bill Medicor or Dr. Khan.

[154]Medicor invoiced Dr. Anhorn \$1,460 for the July 2016 ONCOblot test. It is reasonable to conclude that he was billed the same amount for the other ONCOblot tests, although those invoices are not in evidence.

[155]In his final submissions, Dr. Khan's representative acknowledged that Dr. Khan had a discussion with Dr. Anhorn about the ONCOblot test. He submits that a discussion about the test does not constitute a recommendation or referral. Without a referral, he submits, there is no conflict of interest. We disagree and find Dr. Khan referred Patient A to the ONCOblot test through his discussions with Dr. Anhorn.

[156]There is no dispute that Dr. Khan spoke to Dr. Anhorn about the ONCOblot test. Following that discussion, Dr. Anhorn ordered three ONCOblot tests for Patient A. In telling Patient A's doctor about the ONCOblot test, Dr. Khan made a referral. It is not necessary to find that Dr. Khan made a referral to Patient A directly. Nor is it necessary to find that Dr. Khan recommended the ONCOblot test, although that is a reasonable conclusion to make given the number of tests that Dr. Anhorn ordered.

[157]Dr. Khan was in a conflict of interest when Patient A was given the ONCOblot test. He received a direct benefit from the supplier of the ONCOblot test because it resulted in Patient A receiving extensive cancer treatment from Dr. Khan (as discussed above). It is unlikely Patient A would have undergone such treatment

without the positive finding of pancreatic cancer on the ONCOblot test. He also received an indirect benefit when Medicor, a company substantially owned by his spouse, profited from the sale of the two tests that were purchased after the date of the distributorship agreement. A conflict of interest arises when a physician or their family member receives a benefit, directly or indirectly, from a supplier who supplies medical goods or services to the physician's patients. It does not matter that the ONCOblot test was requisitioned by Dr. Anhorn.

[158]We find Dr. Khan had a conflict of interest when the ONCOblot test was provided to Patient A.

Conclusion

[159]Dr. Khan failed to maintain the standard of practice of the profession and is incompetent in his treatment of Patient A and Patient B. Dr. Khan diagnosed Patient A with pancreatic cancer, a condition that she did not have. She then underwent extensive chemotherapy which she did not need. He discontinued therapy (T4) provided by Patient B's treatment team causing him to become profoundly hypothyroid and risking the proliferation of cancer cells. Both patients were exposed to harm because of Dr. Khan's care.

[160]Dr. Khan engaged in disgraceful, dishonourable or unprofessional conduct when he billed OHIP for palliative care for Patient A, care that she did not need or receive. He interfered with the College's investigation when he asked Patient A to get her daughter to retract her complaint and to withhold her consent for the College to review her chart. Finally, Dr. Khan engaged in disgraceful, dishonourable or unprofessional conduct when he benefited directly and indirectly from the ONCOblot test, a test which led to extensive cancer treatment by Dr. Khan to Patient A and a profit to Medicor for the distribution of that test.

[161]The College has established its allegations of professional misconduct and incompetence against Dr. Khan. A penalty hearing will be scheduled.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Citation: *College of Physicians and Surgeons of Ontario v. Khan*, 2023 ONPSDT 6

Date: February 9, 2023

Tribunal File No.: 20-003

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Akbar Nauman Khan

PENALTY REASONS

Corrected Reasons: The text of the original reasons for decision dated February 9, 2023, was corrected on February 17, 2023. A description of the correction is appended.

Heard: January 17, 2023, by videoconference

Panel:

Ms. Jennifer Scott (chair)

Dr. Madhu Azad

Mr. Jose Cordeiro

Mr. Paul Malette, K.C.

Dr. Joanne Nicholson

Appearances:

Ms. Morgana Kellythorne, for the College

Mr. Uri Kogan, for Dr. Khan

RESTRICTION ON PUBLICATION

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

Introduction

- [1] We found Dr. Khan failed to meet the standard of practice and was incompetent when he treated Patient A for cancer, which she did not have, and treated Patient B, who did have cancer, in a way that risked aggravating his cancer. We also found Dr. Khan engaged in disgraceful, dishonourable and unprofessional conduct with Patient A in his billings, in his communications with her during the College investigation and in his use of an unconventional test to diagnose cancer, a test in which he had a conflict of interest. See *College of Physicians and Surgeons of Ontario v. Khan*, 2022 ONPSDT 39.
- [2] Dr. Khan had a casual disregard for the welfare of these patients. He provided them with treatment which exposed them to harm and resulted in financial gain to him. The appropriate penalty for this misconduct is revocation of his certificate of registration and a reprimand.
- [3] We order Dr. Khan to pay the College \$72,590 in costs, calculated under the Tariff in the Tribunal's Rules of Procedure.

Decision by Dr. Khan to not Participate in the Penalty Hearing

- [4] At the commencement of the penalty hearing, Dr. Khan's representative, Mr. Kogan, said it was unfair and unreasonable for him to waste his client's money on the penalty hearing and his presence at the hearing was unnecessary. He explained his client's position as follows.
- [5] Mr. Kogan spoke about the historical persecution of a Jewish man who had been accused of slaughtering a Christian child. Mr. Kogan said much evidence was led to exonerate this man and although he was ultimately acquitted, the court said, "Jews are capable of doing such things." Mr. Kogan said he is Jewish.
- [6] Mr. Kogan said such barbaric practices are not done in Canada; here, the system allows for a different process. Instead of beating out a confession, judges and adjudicators can simply compose it and say this is what the accused said. Mr. Kogan said this panel felt the liberty of saying things that Mr. Kogan never said and therefore, to save time, the panel could compose something on Mr. Kogan's behalf and enter the decision.

- [7] Immediately after this statement, Mr. Kogan terminated his connection to the virtual hearing. Dr. Khan remained connected. The panel chair advised the parties that she was unsure whether Mr. Kogan had intentionally disconnected from the hearing or whether he had a technical issue. The panel chair said she was reluctant to call on Dr. Khan, who remained connected, because Mr. Kogan represented him. Dr. Khan then disconnected from the hearing.
- [8] At the panel's request, the Tribunal Office sent an email to Mr. Kogan and asked whether he intentionally left the hearing or had a technical problem. The Tribunal asked Mr. Kogan whether he intended to reconnect. Mr. Kogan responded to this email and said, "Dear, your question is insulting and indicates that neither you, nor the panelist listened to what I said." Neither Mr. Kogan nor Dr. Khan reconnected to the hearing.
- [9] Dr. Khan had no intention of participating in the penalty hearing. Mr. Kogan made that clear in his statement and subsequent communication to the Tribunal. Before turning to the issue of penalty, it is important to address Mr. Kogan's submissions to the panel.
- [10] Mr. Kogan, on behalf of Dr. Khan, said the Tribunal beats out false confessions by finding admissions that were not made. He analogizes this conduct to the historic persecution of a teacher of the Jewish faith. Although Mr. Kogan said he was not casting aspersions on this panel, he went on to make allegations of wrongdoing against it. His comments were deeply offensive and have no place before the Tribunal.
- [11] This is not the first time that Mr. Kogan has said things that are hyperbolic and offensive. Mr. Kogan's written submissions on liability contained allegations against Dr. Walker, the College's expert witness, which had no basis in fact or in law. Mr. Kogan asserted Dr. Walker produced a false report that violated the *Criminal Code*. He said Dr. Walker was either drunk when he wrote the report, did not write the report or wrote the report with the intent of making "bad imaging of Dr. Khan by making inflammatory meaningless remarks." He said Dr. Walker's actions are the actions of a swindler. He went on to say:

Walker falsely claimed that Dr Khan has admitted his guilt. This shows that Walker is not just a swindler. He acts like a Hong

Weibing. Like a Gestapo. Or like an Inquisition. With only difference that Hong Weibings and Gestapo and Inquisition were beating confessions out of their victims, while Walker just falsely alleged that confession was made. This not only berries [sic] the credibility of Walker somewhere deep in the ground. This is absolutely nauseating.

[12] Mr. Kogan called Dr. Walker a charlatan and said he is a reckless and dangerous man who should be removed from medical practice. He suggested treating his report as genuine warrants up to ten years in jail time. Presumably, he meant jail time for the panel members if they gave Dr. Walker's report any weight. Mr. Kogan repeated these comments in his oral submissions.

[13] Mr. Kogan's comments, on behalf of his client, are inappropriate. Dr. Khan chose to defend this matter by making spurious claims of wrongdoing against the College and its expert rather than focusing on the merits of the misconduct allegations. He made claims of wrongdoing by the panel at the penalty hearing. Dr. Khan has a full right of appeal. If he feels the Tribunal has erred, he can challenge the Tribunal's decision on appeal.

Penalty Principles

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

[15] Protection of the public has two central components. The public must be protected from further misconduct by the physician and the public must have confidence in the ability of the College, and the Tribunal as an entity within it, to govern the profession effectively and maintain public trust.

[16] The Tribunal has recently summarized the factors to consider when deciding penalty: the seriousness of the misconduct, the physician's discipline history, the physician's actions since the misconduct and the physician's personal circumstances. See *College of Physicians and Surgeons of Ontario v. Fagbemigun*, 2022 ONPSDT 22 at paras. 12-18.

[17] Seriousness of the misconduct is usually the most important factor to consider. The Tribunal will examine what the physician did, the physician's motivation, the number of times the misconduct happened, how long it lasted and the effects or potential effects of the misconduct on others. Misconduct done for financial gain makes it more serious. See *Fagbemigun* at para. 13.

Application to this Case

No Evidence on Actions Since the Misconduct or Personal Circumstances

[18] Dr. Khan chose not to participate in the penalty hearing. Because he did not participate, we have no evidence of any mitigating factors relating to his personal circumstances or his actions since the misconduct that could reduce the penalty.

[19] The only relevant considerations on which we have evidence are the seriousness of the misconduct and the fact that Dr. Khan has no discipline finding that predates the misconduct in this matter.

Seriousness of the Misconduct

[20] Dr. Khan's misconduct is extremely serious. With Patient A, he used an unconventional test, in which he had a conflict of interest, to diagnose cancer. Patient A did not have cancer. He then treated Patient A for cancer for more than 13 months and ignored the adverse side effects she experienced from the treatment. Dr. Khan billed the Ontario Health Insurance Plan for providing palliative care when Patient A was not palliative. When the College investigated a complaint filed by Patient A's daughter, Dr. Khan tried to interfere with the complaint.

[21] Dr. Khan treated Patient B with chemotherapy even though Patient B's cancer specialists determined this treatment was not required. Dr. Khan changed Patient B's medication, which put him at risk of aggravating his cancer. Dr. Khan did not join Patient B's circle of care and as a result, Patient B's cancer specialists did not have the opportunity to intervene quickly to address the potential harm that resulted from Dr. Khan's care. Patient B was under Dr. Khan's care for more than three years.

[22] Dr. Khan defended the allegations of misconduct by asserting he was targeted by the College for practising complementary/alternative medicine (CAM). Practising

CAM did not give Dr. Khan free rein to practise medicine any way that he saw fit. Patients A and B were exposed to potential harm from Dr. Khan's treatment and yet he continued to treat them. In both cases, his treatment decisions were intentional and not the result of a sincere mistake. Dr. Khan's actions demonstrate that he is incompetent and unfit to practise.

[23] Revocation is appropriate here. Revocation is necessary to send the message to the profession and the public that a physician cannot do what Dr. Khan did and continue to practise medicine. We do not believe Dr. Khan will practise medicine safely and the Tribunal would be failing in its duty to protect the public if it allowed Dr. Khan to continue to practise.

[24] This finding is consistent with the Tribunal's approach in other cases. The Tribunal ordered revocation where the physician failed to meet the standard of practice and was incompetent in his care of a single patient. See *College of Physicians and Surgeons of Ontario v. Liberman*, 2012 ONCPSD 12; aff'd *Liberman v. College of Physicians*, 2013 ONSC 4066. Where the Tribunal makes a finding of incompetence, it must consider the physician's entire practice because the failure to do so could expose the public to harm. See *Kamermans R. J. (Re)*, 2014 CanLII 99715; aff'd *Kamermans v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 529. If there is no evidence of insight or steps taken to address the physician's incompetence, then remediation is not possible. See *College of Physicians and Surgeons of Ontario v. Hill*, 2017 ONCPSD 21; aff'd *Hill v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 5833. Finally, the Tribunal ordered revocation in a case like this one, where there was a multiplicity of bad judgments, lack of knowledge, lack of integrity and lack of professionalism. See *Liberman*.

Costs

[25] The College asks for a costs order of \$72,590, representing seven days at the tariff rate of \$10,370. We agree this is the proper costs order.

Order

[26] Therefore we order:

- a. The Registrar to revoke Dr. Khan's certificate of registration effective immediately;
- b. Dr. Khan to appear before the panel to be reprimanded by March 15, 2023;
- c. Dr. Khan to pay the College costs of \$72,590 no later than March 15, 2023.

Corrections were made to para. 5.

ONTARIO PHYSICIANS AND SURGEONS DISCIPLINE TRIBUNAL

Tribunal File Nos.: 17-002-I and 20-003

BETWEEN:

College of Physicians and Surgeons of Ontario

- and -

Dr. Akbar Nauman Khan

The Tribunal delivered the following Reprimand
in writing on Monday, May 29, 2023.

Dr. Khan,

The College of Physicians and Surgeons of Ontario, your regulatory body, uses its policies to inform the standard of practice and expectations of professionalism for its members. All physicians are expected to practise within the limits of their knowledge, skills and judgment. To treat patients outside of one's scope of clinical competence exhibits a lack of judgement that can be harmful. The practice of medicine in Ontario is regulated to ensure the public is protected from such harm.

This reprimand is being delivered in writing as you have refused to participate in this portion of the OPSDT regulatory process. It addresses the findings and penalties in two proceedings: Tribunal File Nos. 17-002-I and 20-003. In both, all allegations of professional misconduct and incompetence against you were proven and resulted in your certificate of registration being revoked. It is also noted that you chose not to participate in your most recent penalty hearing held January 17, 2023.

You displayed a lack of knowledge, skill and judgment in your care and treatment of patients, including children, who were at their most vulnerable, facing diagnoses of serious illness such as cancer. You profited personally from improper billings, displayed a disregard for evidence-based medicine and have even diagnosed and treated patients inappropriately for cancer they did not have. You falsely claimed these medications were safe, and side-effect free. You gained financially by providing false hope for people at the end of their lives and often in the most tragic of circumstances.

One should remember that a physician must always prioritize a patient's interests. You failed to do so and have, therefore, breached the trust that society expects from the medical profession. We consider your lack of medical knowledge and disdain for even the most basic requirements of obtaining informed consent, good record-keeping and the expectation of honesty in billing OHIP, as well as your contempt for the regulatory process itself, to be dangerous.

We also find your lack of insight to be disturbing, with little hope of remediation. In our view, you are unfit to continue to practise medicine.