NOTICE OF PUBLICATION BAN

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

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

> Every person who contravenes an order made under … section 45 … is guilty of an offence and on conviction is liable,
>
> > (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
> >
> > (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Kakar, 2019 ONCPSD 20

THE DISC7IPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

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

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. RAVI KAKAR

PANEL MEMBERS:

DR. C. CLAPPERTON (CHAIR)
MS. E.M. MILLS
DR. E. SAMSON
MR. M. KANJI
DR. P. GARFINKEL

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS. S. DHAMRAIT-SOHI

COUNSEL FOR DR. KAKAR:

MS. M. HENEIN

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R.W. COSMAN

Hearing Date:	**November 16, 2018**
Decision Date:	**May 16, 2019**
Written Decision Date:	**May 16, 2019**

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on November 16, 2018. At the conclusion of the hearing, the Committee released a written order (the "Order") stating its finding that Dr. Ravi Kakar committed an act of professional misconduct. The Order also set out its penalty and costs order, with written reasons to follow.

THE ALLEGATIONS

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

1. under clause 51(1)(a) of the Health Professions Procedural Code (the "Code"), Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c.18 in that he has been found guilty of an offence that is relevant to his suitability to practise;

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

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

The Notice of Hearing also alleged that Dr. Kakar is incompetent as defined by subsection 52(1) of the Code.

RESPONSE TO THE ALLEGATIONS

Dr. Kakar admitted to allegation 3 in the Notice of Hearing, that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. The College withdrew the first and second allegation, and the allegation of incompetence in the Notice of Hearing.

THE FACTS

The following facts were set out in an Agreed Statement of Facts on Liability, which was filed as an exhibit at the hearing.

BACKGROUND

1. Dr. Kakar is a 59-year-old psychiatrist who practises in Markham, Ontario. Dr. Kakar graduated from the University of Delhi and obtained his independent practice certificate in Ontario in 1993.

DISGRACEFUL, DISHONOURABLE OR UNPROFESSIONAL CONDUCT

(i) Third Party Report Concerns

2. Patient A was referred to Dr. Kakar by her family physician to assess her mental health arising from her adjustment issues and alienation at school. Her family physician noted no history of mental health concerns or hospital admission although Patient A had previously been hospitalized in March of 2016.

3. Dr. Kakar first met Patient A on July 25, 2016. Patient A reported to Dr. Kakar a one-day hospitalization in March 2016 for depression resulting from alienation. Dr. Kakar concluded that Patient A was suffering from an adjustment disorder with depressed mood but saw no evidence that Patient A was suffering from psychosis. Dr. Kakar concluded that Patient A was not suffering from an identifiable mental disorder, but he continued to see and monitor Patient A.

4. Dr. Kakar next saw Patient A on August 8, 2016, for a follow up appointment. Patient A was a college student and requested a letter from Dr. Kakar to provide an opinion about whether she was fit to attend school for the fall semester. He provided a report which concluded that she was fit to attend school. Dr. Kakar did not obtain any of Patient A’s medical records or

additional information about her hospitalization prior to completing the third party report. He continued to treat Patient A with psychotherapy until December 2016.

5. On August 17, 2016, the College received information from Patient A's school regarding the psychiatric report prepared by Dr. Kakar on behalf of Patient A.

6. As a result of the concerns, the College retained Dr. Nicholas Delva as Medical Inspector to provide an opinion on the care Dr. Kakar provided to Patient A and on the third party report that had been prepared by Dr. Kakar on behalf of Patient A. Dr. Delva is a psychiatrist whose primary practice is located in the Department of Psychiatry, Hotel Dieu Hospital, Kingston, Ontario. Dr. Delva's Curriculum Vitae is attached at Tab A to the Agreed Statement of Facts.

7. In Dr. Delva's opinion, there were no issues with Dr. Kakar's clinical care of Patient A and no concerns about harm or injury to Patient A. Dr. Delva identified, however, deficiencies with Dr. Kakar's third party report and his record-keeping.

8. Specifically Dr. Delva found that :

- Dr. Kakar's report was not comprehensive and there was inadequate substantiation of facts because:
    a) Dr. Kakar should have obtained the hospital records reflecting Patient A's hospital admission prior to writing the report; and
    b) The report should have made it clear that it was based on information obtained directly from Patient A and that Dr. Kakar had failed to independently confirm information obtained from the patient.

9. Dr. Kakar admits that he was unprofessional in preparing the third party report on behalf of Patient A in that he did not obtain Patient A's hospital records prior to writing his report. Dr. Kakar's conduct is not consistent with professional obligations of a physician as articulated in the College Policy # 2-12, "Third Party Reports", attached at Tab B to the Agreed Statement of Facts.

(ii) Breach of February 10, 2016 Undertaking with the College

10. On February 16, 2016, Dr. Kakar entered into an undertaking with the College in lieu of an Order under (then) s. 37 of the Health Professions Procedural Code in respect of a prior discipline referral. The undertaking required, *inter alia*, that all third party reports authored by Dr. Kakar be reviewed and approved by his Clinical Supervisor before being provided to the third party. Attached at Tab C to the Agreed Statement of Facts is a copy of the undertaking dated February 10, 2016.

11. On October 13, 2016, College staff attended at Dr. Kakar's office to monitor his compliance with the terms on his certificate of registration. They identified four forms, for four different patients, from Dr. Kakar which were not approved by his Clinical Supervisor before being provided to the third party.

12. These four forms were:

- A Psychological Health Medical Update Form for Patient B;
- An Application for Determination of Catastrophic Impairment Form for Patient C;
- A Manulife Clinical Information Form for Patient D; and
- A Telus Medical Follow-Up Form for Patient E.

13. All of these four forms constituted Third Party Reports pursuant to the College's Third Party Reports Policy (Tab B to the Agreed Statement of Facts**).**

14. With respect to Patient C, Dr. Kakar, subsequent to his completion of the form above, also completed a more comprehensive third party report. This report was sent to his Clinical Supervisor for review and approval.

15. Dr. Kakar admits that the above four reports were not sent for approval to his Clinical Supervisor.

ADMISSION

16. Dr. Kakar admits the facts specified above in paragraphs 1 - 15, and admits that, based on these facts, he engaged in professional misconduct in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts on Liability. Having regard to those facts, the Committee found that Dr. Kakar committed an act of professional misconduct, in that he engaged in conduct or an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

PENALTY AND REASONS FOR PENALTY

While counsel for the College and counsel for Dr. Kakar had submitted an Agreed Statement of Facts on Liability, they had differing views on what should be the appropriate penalty. The College sought a reprimand, a two-month suspension of Dr. Kakar's certificate of registration, and the payment by Dr. Kakar of costs for a one-day hearing. Dr. Kakar's counsel agreed that a reprimand and costs were appropriate, but submitted there should be no suspension.

In considering the jointly proposed aspects of the submission, the Committee was mindful of what is known as the "public interest" test - a test that specifies that a tribunal or court should not depart from a jointly proposed penalty unless it would bring the administration of justice into disrepute or is otherwise not in the public interest. This is a "high hurdle" and has recently been affirmed by the Supreme Court of Canada (*R. v. Anthony-Cook*, (2016)).

The Committee considered the documents filed and joint submission made by the parties. The Committee also considered a number of aggravating and mitigating factors that exist in this case, and reviewed cases that the parties identified as similar cases.

The Committee took into account a number of principles that tribunals and courts must consider in assessing an appropriate penalty. Paramount is the protection of the public. Also important is a desire to express the abhorrence of the profession for the member's behavior, and to maintain public confidence in the profession and the College's ability to regulate the profession in the public interest. Deterrence both of the member and other physicians is also important in determining the penalty. When applicable, the penalty should also provide for rehabilitation of the member.

The weighing of these principles in light of the specific facts and circumstances of the case is the task undertaken by the Committee in arriving at its decision regarding penalty. The Committee recognizes that the penalty ordered must be proportionate to the misconduct finding.

Aggravating Factors

1. When a physician has signed an undertaking with the College, the College relies on the physician to regard this undertaking with utmost seriousness and to educate himself with respect to its scope, conditions and limitations. Dr. Kakar failed to comply with the terms set out in his undertaking with the College. Failure to fully comply with an undertaking undermines the public's confidence that the College is capable of regulating the profession in the public interest.

2. Dr. Kakar's assessment and treatment of Patient A reflected significant deficiencies. He learned from her of some of her past history of depression and a one-day hospitalization in March 2016, but did not seek or obtain her previous medical or hospital records. The College policy on third party reports is very clear on the need for objectivity and impartiality, and for comprehensiveness in reviewing "all available clinical notes, records and opinions…that could impact the findings of the report" (CPSO: Third Party Reports, 2002, revised 2009, and 2012). If

some clinical information is not available, despite efforts to obtain it, the physician is expected to note this in the report.

Mitigating Factors

1. Dr. Kakar has admitted to his misconduct and has expressed his acceptance of responsibility for his behaviour.

2. By agreeing to a statement of facts and admitting to liability, Dr. Kakar has saved considerable time and cost and alleviated the significant emotional burden that would occur for the witnesses in the case should they have had to testify.

3. Dr. Kakar has previously entered into undertakings with the College and has successfully completed most of their requirements. Even with regard to third party reports, he was mostly compliant with the terms of the undertaking. After the February 2016 undertaking, Dr. Kakar provided his supervisor, Dr. Hanick, with the vast majority of his third party reports for review. Of many reports reviewed by Dr. Hanick ("more than 180 clinical patient notes, hundreds of third party reports") four reports only had not been approved by his supervisor. One of these required Dr. Kakar to complete a comprehensive third party report, which was then sent to his supervisor, together with the earlier one which he had sent out a few days before.

4. Dr. Kakar's clinical supervisors and his course director (Ethics and Writing Third Party Records) have been consistently positive regarding his diligence in pursuing his work and his capabilities in assessing and treating psychiatric patients. They reported they had no concerns regarding any aspect of his psychiatric practice.

5. Counsel for Dr. Kakar raised a further factor as a potential mitigating factor – that Dr. Kakar's practice required his presence and any suspension would adversely affect many people who are very ill. Dr. Kakar treats very difficult patients, often those whom others will not accept. The Committee's view is that its duty is to determine a penalty proportionate to the finding. To send a message to the profession that the rules governing appropriate conduct are dependent on

where a physician practises, or whom he or she treats, would not be in the public interest. Earlier discipline committees have dealt with this issue in a similar fashion (*CPSO v Taylor (*2017); *CPSO v Deluco* (2005)). Hence, that was not accepted as a mitigating factor.

Prior Appearances before Committee of the College

The Committee reviewed the information provided regarding Dr. Kakar's previous involvement with the College. This began in March 2005 when a complaint was made about a patient Dr. Kakar had treated. This man had earlier been involved in an acrimonious separation, had become depressed and had made three suicide attempts between 1999 and 2002. Dr. Kakar did not ask for the medical records regarding earlier treatments and suicide attempts by this patient. He relied solely on the patient's history, which had noted only one of three earlier attempts. As a result, Dr. Kakar learned very little about the earlier suicide attempts.

Several years later, Dr. Kakar wrote a report for the legal proceedings that indicated his patient was not at risk to hurt his daughter. The patient committed suicide several months later, and involved his daughter, who was seriously hurt.

The College obtained the opinion of an expert who was critical both of Dr. Kakar's clinical notes and the letter he wrote. There were significant gaps in information gathered about the patient – not just from his medical history, but numerous calls to the police and problems the patient was accused of causing at his daughter's school. The opinion provider felt the patient was irrational in his calls to the police, the CAS and his ex-wife. The patient's ex–wife highlighted her concerns regarding the patient's safety and possible harm to her daughter. Dr. Kakar's clinical notes and later his letter did not reflect the clinical situation as reported from several sources. His report and notes were considered "unprofessional, unacceptably partisan, an abuse of the physician's role." The College's investigating committee gave him a caution in person in May 2006.

The Discipline Committee noted this ruling but were also aware of the limited use of a prior caution. This caution is based on allegations that have not been proven in disciplinary proceedings (see *CPSO v. Krishnalingam* (2016); *CPSO v. Yau* (2017)).

In June 2009, Dr. Kakar entered into an undertaking with the College in response to another patient's complaint. Pursuant to the terms of the undertaking, he was required to practise under the guidance of a clinical supervisor and take courses in psychopharmacology, assessment of suicide, communication skills and record keeping.

Dr. Kakar entered into another undertaking in October 2013 after a patient complained about his treatment of her gout. This resulted in a serious side effect. Dr. Kakar agreed that the treatment he had provided was outside his scope of practice and he agreed to limit his practice to psychiatry.

In response to several personal health concerns and situational circumstances involving the health of relatives, Dr. Kakar signed an undertaking to cease practice from February 2014 to January 2015.

Dr. Kakar later appeared in a discipline hearing which resulted in an undertaking by him in February 2016. The complaints at this hearing were multi factorial including: the earlier complaint about treating a patient outside his scope of practice (gout), and his record keeping with regard to that patient, and to a 17-year-old patient treated for depression. The College asked for a review of this latter patient's care by a psychiatrist. The psychiatrist assessor found serious deficiencies in the records and questions about the medical care. This led to a review of 24 of Dr. Kakar's patient charts. This review again found deficiencies in charting, for example, in documenting reasons for treatments or changes in treatments, and inadequate documentation regarding possible self- harm in patients with mood disorders. Further findings at the hearing included Dr. Kakar's plagiarizing a part of a report and changing a note after learning of a patient's complaint.

The Discipline Committee ordered a reprimand, a six-month suspension from practice, and the payment of costs. Dr. Kakar signed a further undertaking which imposed extensive terms, conditions and limitations on his practice, including having a clinical supervisor. Among other things, the supervisor was to review at least 15 patient charts per month and to review and approve all third party reports. Dr. Victor Feder served as clinical supervisor from October 2016 to February 2017; following this, Dr. Adrian Hanick was Dr. Kakar's supervisor from May 2017 to July 2018.

The Committee was aware that this hearing involving the undertaking from February 2016 antedates Dr. Kakar's involvement with Patient A which began in July 2016. The earlier discipline finding against Dr. Kakar cannot be considered an aggravating factor: "in dealing with other criminal conduct on the part of the convicted person the court must of course be careful that it sentences only for that offence of which the accused then stands convicted. It is of great importance that a convicted person not be sentenced for any other offense, prior or subsequent" (*R v. J* (1989)).

However, in the criminal law context the fact that a person convicted of an offence has since the date of that offence committed similar offences cannot be regarded as irrelevant to the sentencing process…"May well be of considerable importance in determining the character of the accused, the extent, if any, to which there has been rehabilitation, the likelihood of rehabilitation in the future" (*R v. J* (1989)). In an earlier College discipline hearing, the Committee similarly recognized "because this conviction took place after the events in question on this hearing, it cannot be considered as an aggravating factor in the present case. However, it can be used in considering rehabilitation, specific deterrence and protection of the public" (*CPSO v Marshall* (2016)). The Ontario Superior Court has noted such a finding can be taken into account to negate any mitigating circumstances and displace the presumption that the accused might be a good candidate for a rehabilitative sentence (*Finelli* (2008)).

Case Authorities

Although the Committee's prior decisions are not binding as precedent, the Committee accepts as a principle of fairness that like cases should be treated alike. As stated by the Divisional Court in *Re Stephens and Law Society of Upper Canada*, and adopted by the Ontario Court of Appeal in *CPSO v, Peirovy* (2018), "a conscious comparison should be made between the case under consideration and similar cases wherein sentences were imposed. If the comparison with other cases is not undertaken, there may well be such a wide variation in the results so as to constitute not simply unfairness but injustice."

Each case, however, is unique. There are no previous cases that have come before the Committee that are identical to the current case. Some do have similarities, in particular, regarding a breach of an undertaking.

Dr. Thomas Mayberry, a family medicine physician, had entered an undertaking with the College to not prescribe narcotics, narcotic preparations, controlled drugs, or benzodiazepines (*CPSO v Mayberry* (2017)). Subsequent to the undertaking, the College obtained Narcotics Monitoring System data, which indicated he had prescribed Alprazolam on two occasions in 2015. Dr. Mayberry admitted the allegations and received a two-month suspension of his certificate of registration.

Dr. James Maytham had undertaken not to prescribe any controlled drugs until he had successfully completed the College's Prescribing Skills course (*CPSO v. Maytham*, (2011)). He undertook to keep a register with respect to all controlled drugs. He breached the undertaking by failing to record the numbers of patients and doses of narcotics in his log. Fifteen charts were reviewed and, in nine instances, Dr. Maytham recorded the medication prescribed in the patient chart but did not document the medicine prescribed or administered in the register. He received a four-month suspension in a contested penalty hearing.

Dr. Bryan Carroll was subject to a discipline hearing in 2008. One of the orders that resulted from this hearing was that he was to have a Clinical Practice Assessment, which was conducted

the following year. He performed well in that assessment, except that the reviewer noted Dr. Carroll was not following current guidelines for colposcopy and uroflow studies. In 2010, he entered into an undertaking to follow current guidelines for these two procedures. On a concern raised by his supervisor, a number of files were reviewed by an independent physician who after studying 15 of Dr. Carroll's cases found that he was not complying with the order. He performed these without indication. The case proceeded on an agreed statement of facts and Dr. Carroll received a two-month suspension.

Dr. Tsai Yu, a general practitioner working at a walk-in clinic was found to have breached a 2016 undertaking by prescribing controlled substances for three patients on three occasions in late 2016 (*CPSO v. Yu*(2017)). While this was his first appearance before the Discipline Committee, it was his second breach of an undertaking. He had not been permitted to prescribe narcotics and controlled substances for over two decades. The case proceeded on an agreed statement of facts and a joint submission on penalty. Dr. Yu received a three-month suspension.

Dr. Wagdy Botros appeared before the Discipline Committee for repeatedly failing to comply with an ICRC order to complete the Communications Skills Course or an alternative course that is acceptable to the College. He was given six months from the date of the order to do so (*CPSO v Botros* (2016)). He took this decision to the Health Professions Appeal and Review Board (HPARB) and when they did not reverse the decision in the spring of 2012, and when Dr. Botros decided not to proceed with judicial review of HPARB's decision, the six month time period began again. He failed to comply again. He was given further opportunities to comply but repeatedly thwarted the College's attempts to assist him to comply. The Committee in that case found that there was ample evidence that Dr. Botros' failure to comply was deliberate and that he had displayed longstanding, persistent, unacceptable behavior in dealing with the College. In a contested hearing, Dr. Botros received a six-month suspension.

Dr. Daniel Sweet, an Ottawa family physician, failed to comply with an order from the College regarding prescribing narcotics (*CPSO v. Sweet* (2012)). The case proceeded on the basis of an agreed statement of facts. His involvement dated to a decade earlier when he signed an undertaking, only to have been found in breach of this. The 2012 hearing was his fourth

appearance: for prescribing controlled substances, for failing to have a sign in his office, and again for prescribing a controlled substance. He received a four–month suspension.

From the cases provided and reviewed, the Committee did not have before it a case involving a breach of an undertaking that did not include some period of suspension.

Conclusion

Dr. Kakar's actions of failing to comply with the terms of his undertaking represent a clear lack of responsibility on his part. The Committee takes breaches of its orders and undertakings very seriously.

The Committee expressed further concern regarding Dr. Kakar's assessment and treatment of Patient A, in neglecting to learn as much as he possibly could about this person's past history when embarking on a treatment and when producing a report to the community college.

After careful deliberation, the Committee determined that the appropriate order in this case was a one-month suspension, a reprimand, and the payment of costs.

The College had sought a two-month suspension. Dr. Kakar had sought no suspension. The Committee concluded that a two-month suspension was not warranted, given Dr. Kakar had made such excellent progress with his supervision and course work, and when it considered his breach relative to other cases it reviewed. On the other hand, the Committee concluded that a suspension was necessary to send a clear message to both the public and the profession that it is a serious matter when a physician does not fully abide by an undertaking with this College. A failure to comply challenges the professional regulation process. In order for the public to have confidence in professional regulation, a physician must scrupulously abide by his or her undertaking with the College.

While the Committee was impressed by the progress Dr. Kakar has made through his sincere involvement with his supervisors and the improvements to his entire practice, it does not take away from his responsibility to comply fully with the requirements of his undertaking. This

protects the public and maintains public confidence in the College's ability to regulate the profession effectively in the public interest.

The public are further protected by the requirement under the previous order for Dr. Kakar to have another practice assessment, which continues in force.

ORDER

The Committee stated its finding of professional misconduct in paragraph 1 of its written order of November 16, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

2. The Registrar suspend Dr. Kakar's certificate of registration for a period of one (1) month, commencing December 15, 2018 at 11:59 p.m.

3. Dr. Kakar appear before the panel to be reprimanded.

4. Dr. Kakar pay costs to the College in the amount of $10,180.00 within thirty (30) days from the date of this Order.

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