IN THE MATTER OF:	*An Inquiry under The Medical Act C.C.S.M. c.M90*
AND IN THE MATTER OF:	*Dr. Naseer Ahmed Warraich, a member of the College of Physicians and Surgeons of Manitoba*
AND IN THE MATTER OF:	*An Amended Notice of Inquiry dated December 7, 2018.*

INQUIRY PANEL:

Dr. Carry Martens-Barnes, Chairperson

Dr. Valerie St. John

Russ Toews, Public Representative

REASONS FOR DECISION OF AN INQUIRY PANEL
OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

Counsel for The Investigation Committee
of The College of Physicians and Surgeons of Manitoba:

Lynne Arnason

Jeremy de Jong

Counsel for the Member Dr. Naseer Ahmed Warraich:

Helga Van Iderstine

Martin Minuk

Kelsey Schade

Counsel for the Inquiry Panel:

Blair Graham

REASONS FOR DECISION OF THE INQUIRY PANEL

INTRODUCTION

A Notice of Inquiry dated December 7, 2018 was issued with respect to the matters which are the subject of these proceedings. The Notice of Inquiry alleged that Dr. Naseer Ahmed Warraich ("Dr. Warraich") had contravened By-Law 1 and By-Law 11 of the By-Laws of the College of Physicians and Surgeons of Manitoba (the "College"), had displayed a lack of knowledge of, or a lack of skill and judgment in the practice of medicine and/or had been guilty of professional misconduct. The Notice of Inquiry contained six sets of allegations (or "Counts") against Dr. Warraich, which can be summarized as follows:

> 1. "Since in or about 2013, Dr. Warraich failed to create and maintain adequate medical records which would allow for a comprehensive assessment of the nature and extent of the care he was providing to patients. Count 1 alleged that Dr. Warraich had failed to meet the standard of the profession and/or breached the recordkeeping requirements of College By-Laws 1 and 11 and had displayed a lack of knowledge, skill or judgment in the practice of medicine. Count 1 also contained extensive factual particulars relating to those allegations.
>
> 2. Dr. Warraich failed to meet the standard of care in his management and treatment of a specific patient (referred to as "Patient 1") between in or about November, 2017 and March, 2018 in that he failed to adequately diagnose, manage and treat Patient 1's tuberculosis and congestive heart failure. Count 2 also alleged that Dr. Warraich failed to create and maintain adequate medical records, thereby breaching the recordkeeping requirements of College By-Laws 1 and 11 and/or displaying a lack of knowledge, skill and/or judgment in the practice of medicine.
>
> 3. Between on or about May 7 and May 15, 2015, when Dr. Warraich was the most responsible physician for the care and management of another specific patient (referred to as "Patient 2"), in his capacity as a hospitalist during Patient 2's admission to hospital, he displayed a lack of knowledge, skill

and/or judgment in the practice of medicine and/or created false and misleading medical records, thereby breaching the recordkeeping requirements of By-Law 1 of the College and/or committed acts of professional misconduct. The particulars referred to in relation to Count 3 were that Dr. Warraich failed to adequately examine or assess Patient 2 when she was admitted to hospital under his care, that he failed to adequately monitor and/or assess Patient 2 while she was admitted under his care by failing to consider additional information and not revisiting a presumptive diagnosis, and that he had documented a complete physical examination of Patient 2 as part of Patient 2's admission history when he had not examined Patient 2 on admission, or at all.

4. During the period between September, 2013 and September, 2016, Dr. Warraich engaged in unethical and inappropriate billing practices in relation to claims for services purportedly provided by him to residents in personal care homes, thereby committing acts of professional misconduct. Count 4 contained extensive factual particulars relating to those allegations.

5. During the period between September, 2013 and September, 2016, in relation to Dr. Warraich's attendances at one personal care home, he created medical records which were misleading as to the nature and extent of his involvement in visits, thereby breaching the recordkeeping requirement of College By-Laws 1 or 11 and committing acts of professional misconduct, in that Dr. Warraich documented information in the chart that suggested he conducted assessments, examinations and/or provided care to patients when he did not. Count 5 contained extensive factual particulars relating to those allegations.

6. By reason of the foregoing, individually or cumulatively, Dr. Warraich displayed a lack of knowledge of or a lack of skill and judgment in the practice of medicine".

On May 15, 2019, Dr. Warraich made a motion to be heard by a Panel of the Inquiry Committee of the College (the "Inquiry Panel") for an order that Counts 2 and 3 in the Notice of Inquiry be severed from Counts 1, 4 and 5. On May 16, the Investigation Committee of the College (the "Investigation Committee") made a motion to be heard by the Inquiry Panel, amending Count 1 in the Notice of Inquiry.

Both motions were heard by the Inquiry Panel on June 3, 2019.

An order granting an amendment to Count 1 in the Notice of Inquiry was issued by the Inquiry Panel on consent on June 3, 2019. The amendment added certain words to the first sentence of Count 1 in the Notice of Inquiry (as shown below):

> "1. Since in or about 2013, despite attempts to remediate deficiencies, you (Dr. Warraich) have failed to **demonstrate that you are providing adequate care to your patients and/or to** create and maintain adequate medical records such that your records do not allow for a comprehensive assessment of the nature and extent of the care you are providing to your patients. . . ."

The Amended Notice of Inquiry was marked as an exhibit in these proceedings.

Dr. Warraich's motion for severance was contested by the Investigation Committee. The Inquiry Panel heard oral submissions on the motion for severance from counsel for Dr. Warraich and counsel for the Investigation Committee, and after reserving and considering its decision, ultimately dismissed Dr. Warraich's motion for severance of Counts 2 and 3 of the Amended Notice of Inquiry from the remainder of the Counts. It provided written reasons for doing so dated June 11, 2019.

At the hearing on June 3, 2019, certain other preliminary matters were determined. Dr. Warraich admitted his membership in the College. The jurisdiction of the Inquiry Panel was acknowledged by Dr. Warraich and both the Investigation Committee and Dr. Warraich confirmed that they had no objection to any members of the Inquiry Panel sitting on the Inquiry Panel. Dr. Warraich waived the reading of the charges/allegations outlined in the Amended Notice of Inquiry.

Counsel for the Investigation Committee also made a motion on June 3, 2019, for an order under s.56(3) of *The Medical Act*, protecting the identity of patients who might be called as witnesses in the proceedings or who might be referred to in the proceedings, including the patients referred to in allegations 2 and 3 of the Amended

Notice of Inquiry (Patients 1 and 2). Dr. Warraich, through his counsel, consented to such an order.

The Inquiry Panel granted the order requested by the Investigation Committee pursuant to s.56(3) of *The Medical Act* and directed that any patients testifying in the proceedings, or any patients referred to in the proceedings, be identified only by initials or in some other non-identifying manner. In granting the order, the Inquiry Panel was satisfied that such an order was appropriate because some of the personal and other private matters relating to patients, which may be disclosed at the hearing, would be of such a nature that the disclosure of such matters may adversely affect the interests of those patients and outweigh the desirability of adhering to the principle that hearings be open to the public.

Counsel for the Investigation Committee also made a motion for an order under s.56(3) of *The Medical Act*, relating to certain other individuals who might be called as witnesses in the proceedings, or who might be referred to in the proceedings, such as nurses and employees of Manitoba Health. The Inquiry Panel reserved its decision with respect to an order relating to those witnesses and ultimately made no such order.

At the hearing of June 3, 2019, Dr. Warraich, through his counsel, entered a plea of guilty to Counts 1, 4 and 5 in the Amended Notice of Inquiry and to count 6 (displaying a lack of knowledge of or a lack of skill and judgment in the practice of medicine). Counsel for Dr. Warraich made it clear that the plea of guilty to count 6 was in specific relation to and as a consequence of the guilty plea to Counts 1, 4 and 5.

Counsel for Dr. Warraich also indicated that some of the background facts relating to Counts 1, 4 and 5 of the Amended Notice of Inquiry remained contentious. Therefore, notwithstanding Dr. Warraich's plea of guilty to Counts 1, 4, 5 and 6, the Inquiry Panel was alerted to the possibility that it might be necessary for some contentious evidence to be introduced to establish the background facts relating to those Counts.

The hearing before the Inquiry Panel reconvened on January 14, 2020, at which time various additional exhibits were introduced into evidence, including a 56-page

Statement of Agreed Facts relating to counts 1 to 5 in the Amended Notice of Inquiry, and a Book of Documents consisting of 54 tabs, including the patient's chart, doctor's note, lab results, diagnostic imaging reports and the requisitions and test results relating to Patient 1, and also including the patient history, physician's orders, lab results, diagnostic imaging reports and discharge documents relating to Patient 2. The Book of Documents also contained two expert reports relied upon by the Investigation Committee and one expert report relied upon by Dr. Warraich.

On January 14, 2020, Dr. Warraich, through his counsel confirmed his plea of guilty to Counts 1, 4, 5 and 6 and entered a plea of not guilty to Counts 2 and 3 in the Amended Notice of Inquiry.

Evidence in these proceedings was introduced before the Inquiry Panel on January 14, 15, 16 and 17, 2020. Extensive and very helpful written submissions were provided by the parties in February, March and early April, 2020.

The evidence in these proceedings consisted of ten exhibits, including the Statement of Agreed Facts and the Book of Documents, and the testimony of the following witnesses:

- Patient 2;
- Dr. Carol Scurfield, an expert called by the Investigation Committee in relation to count 2 (with respect to the management and treatment of Patient 1);
- Dr. Gurswinder Jawanda, an expert called by the Investigation Committee in relation to count 3 (with respect to the care and management of Patient 2);
- Kiranj Gill, an employee of the medical centre with which Dr. Warraich was associated in early December, 2017, (with respect to the management and treatment of Patient 1);

- Dr. Larry Reynolds, an expert called by Dr. Warraich in relation to count 2 (with respect to the management and treatment of Patient 1);

- Dr. Warraich.

The above noted witnesses testified in the sequence noted above, with Dr. Warraich being the last witness to testify.

Patient 1 did not testify.

THE BACKGROUND FACTS

The Statement of Agreed Facts outlines facts specifically relating to Counts 1 to 5 inclusive in the Amended Notice of Inquiry. Therefore, the Statement of Agreed Facts contains facts relating to the Counts to which Dr. Warraich has pled guilty and also contains facts relating to the Counts to which Dr. Warraich has pled not guilty.

Most of the testimony from the witnesses who testified before the Inquiry Panel on January 14, 15, 16 and 17, 2020 related to Counts 2 and 3. Such testimony supplemented the facts outlined in the Statement of Agreed Facts with respect to those Counts.

In order to provide the factual basis for the analysis which follows, the first paragraph of the “Introduction” section, the “Background” section, and the sections relating to Counts 2 and 3 of the Statement of Agreed Facts are reproduced below. The tab references in the Statement of Agreed Facts are to the same tabs comprising the Book of Documents, marked as Exhibit 4 in these proceedings.

In addition to the above-noted noted excerpts from the Statement of Agreed Facts, a summary will be provided of some of the oral evidence given by Patient 2, Ms Gill, and Dr. Warraich. A summary will also be provided of some of the additional evidence provided by the experts in their testimony.

Excerpts from the Statement of Agreed Facts

"**I. INTRODUCTION**

1. The parties have agreed that the contents of this document constitute admissible evidence to establish the facts stated herein and form the basis of findings of fact by the Panel as proof of the allegations set out in the Amended Notice of Inquiry, except where it is expressly stated that there are conflicting versions of events. Where there are conflicting versions of events, the source of each version will be identified, and it will be made clear as to whether additional evidence will be adduced at the hearing and as to whether a finding of fact will be sought from the Panel. …

II. BACKGROUND

7. Dr. Warraich is 65 years old. He graduated from the Allama Iqbal Medical College University of the Punjab, Pakistan, in 1987. He obtained licensure from the Medical Council of Canada in 1998.

8. Dr. Warraich was licensed and registered as a physician in Manitoba on February 28, 2001 with the College of Physicians and Surgeons of Manitoba (the "College"). He has been a member of the College since that date.

9. During the period between 2007 and 2015, Dr. Warraich worked as a hospitalist at the Seven Oaks General Hospital ("SOAG") under contract with the Winnipeg Regional Health Authority ("WRHA").

10. During the period between 2004 - 2007 Dr. Warraich worked as a hospitalist at the Victoria General Hospital.

11. During the period between 2007 - 2012 Dr. Warraich worked as a hospitalist at the Concordia Hospital.

12. From 2014 - 2015, Dr. Warraich worked at the Northgate Clinic in Winnipeg.

13. Commencing in 2014, Dr. Warraich practiced as a family practitioner at Keewatin Medical Centre and at a new clinic in the process of being established on St. Mary's Road in Winnipeg, Manitoba. He left the St Mary's Road clinic in or about late 2015.

14 Commencing in 2012, Dr. Warraich practiced as a family practitioner at the NorWest Clinic. He ceased practice at the NorWest Clinic in mid-2014.

15. The Middlechurch Home of Winnipeg ("Middlechurch") is a 197-bed personal care home which operates as part of the Long-Term Care Program of the Winnipeg Regional Health Authority ("WRHA"). Dr. Warraich began working as one of the community physicians who attended to residents of Middlechurch from in or about 2007 through much of 2016. His contract was not renewed, and he continued to provide services until September of 2016. Generally, he attended Middlechurch every Friday. There were 4 - 5 other physicians who were also contracted to provide the same services to patients residing in other units in Middlechurch at all relevant times.

16. Riverview Health Centre ("Riverview") is a 387-bed health care facility which includes hospital and personal care home units. Dr. Warraich worked under three separate contracts with the WHRA's Long Term Health Program at Riverview from in or about January 2008 until in or about June 2016. During this time:

    a. He was the attending physician in 2 West, 30 bed hospital Complex Continuing Care Unit, which he attended at bi-weekly (Tuesdays and Thursdays).

    b. He was the attending physician in CD3 (starting in July 2009) and CD4, both of which are personal care home units with a combined total of 42 beds, which he attended once a week.

    c. Dr. Warraich states that:

        i. he does not recall receiving the job description at Riverview; and

        ii. he recalls a former physician providing him with an orientation.

17. Dr. Warraich currently practices at the Keewatin Medical Centre under the supervision of Dr. Kanwal and subject to the conditions set out in an undertaking signed by Dr. W dated September 30, 2016.

18. In order to address the concerns raised about his charting and documentation in January 2015 Dr. Warraich took a record keeping course offered through the University of Toronto.

19. In January 2019 Dr. Warraich took a course offered by the College of Physicians and Surgeons of Manitoba normally attended by people seeking to be a practice supervisor. Dr. Warraich states that he took the course so that he could better understand what the College was looking for in his charting.

. . .

IV. COUNT 2

52. Patient 1 is a woman born in 1963 who was first seen by Dr. Warraich in his clinic in April 2017. She had previously been seen by other physicians in the same clinic. She is a health care worker at the Health Sciences Centre and that was known to Dr. Warraich at all relevant times. He saw her on several occasions between November 2017 and May 2018, during which time she was diagnosed with tuberculosis ("TB") and congestive heart failure by two other physicians.

53. The Registrar of the College referred to the Investigation Committee concerns about Dr. Warraich's management of Patient 1's care after receiving an email expressing concerns. The e-mail was from the Medical Director, Integrated Tuberculosis Services of the Winnipeg Regional Health Authority.

54. Dr. Warraich's documentation of the care he provided to Patient 1 is located at **TAB 31**. A letter from Dr. Warraich dated June 8, 2018 in which he responded to concerns about him failing to adequately act on information in a chest x-ray report regarding the need to rule out TB is at **TAB 32**.

55. When Patient 1 attended Dr. Warraich on November 24, 2017 she was complaining of a dry cough, mostly at night and sometimes with production of sputum for over one month. She was examined by Dr. Warraich and a history taken, both of which were recorded in his EMR. His diagnosis was either Upper Airway Cough Syndrome or

Acute or Chronic Bronchitis. He ordered blood work, pulmonary function tests and a chest x-ray.

56. The chest x-ray was done on December 1, 2017. The radiologist called the clinic to speak to Dr. Warraich, who was unavailable to speak to him at the time. The receptionist agreed to bring the report to the attention of Dr. Warraich as soon as possible. The report stated:

> Bilateral consolidation, greatest on the left, was noted and was “most likely inflammatory and both infectious and non-infectious causes are possible. If this is pneumonia, an atypical source such as tuberculosis would need to be considered given the distribution. Correlation with the clinical setting and sputum cultures are recommended.” An attempt to reach the referring physician by phone and it is noted that his receptionist would bring the report to his attention as soon as possible.

57. There is a note in the EMR dated December 3, 2017 indicating that Dr. Warraich called Patient 1 on that date to ask how she was doing and that she said that she had no cough from last 2 days. There is no mention of TB in the note, including whether he questioned her about possible exposure to TB or that he educated her about the risks of untreated TB or the highly infectious nature of TB. Dr. Warraich states that:

    a. Patient 1 was asked to come back to the Clinic and was advised that she would require a sputum sample.

    b. She did not want to come in to the Clinic. Instead the patient sent a family member who was given a prescription for antibiotics.

    c. the requisitions for sputum AFBx3 and C&S together with the prescription were picked up by someone in Patient 1’s family.

58. On December 6, 2017, Dr. Warraich saw Patient 1 in his clinic. There is a lengthy note regarding follow up for her diabetes. The note does not mention the cough or follow up of sputum samples, nor does it reference TB. In his response, Dr. Warraich advised that he provided a work note on this day. Dr. Warraich states that he reminded the patient that she needed to have the lab work

performed, including the need to get the sputum samples. This is not referenced in the encounter note, but a copy of a note completed on that day shows that Patient 1 was to be absent December 5 - 10, 2017. Dr. Warraich states that it was to allow her time to get the tests completed and to recover from the respiratory illness if it was a transient illness. This is not documented.

59. The next visit was January 1, 2018, and the reason for the visit is listed as follow up for type 2 diabetes. There is a note about leg edema, shortness of breath, cough and known asthma and that symptoms were better when on levofloxacin. Her BP was elevated at 160/101, her chest was noted to be clear and heart sounds were noted to be normal. Her feet appear to have been examined and noted to be normal with normal pedal pulses. No notation was made specifically about the presence or absence of the concern about edema in the recording of the physical examination. An ACE inhibitor was prescribed. A chest x-ray was ordered.

60. On January 9, 2018, there is another lengthy note from a visit by Patient 1 to Dr. Warraich on that date. The note appears to be entered using a template, regarding a follow up for hypertension. Patient 1 is noted as presenting with"++ leg edema". There is no other history related to this complaint. There is a note documenting no shortness of breath and no dyspnea. There is no mention of cough. The previously ordered chest x-ray had not yet been done.

61. On January 26, 2018 a chest x-ray was performed. The report included the comment, *"Progressive nodular opacification and new: volume loss of the left upper lobe. CT is recommended for further evaluation."*

62. Following a request made by Dr. Warraich on January 29, 2018 for Patient 1 to attend for a follow up, she was seen by him on February 4, 2018. The February 4 visit note indicates that she told Dr. Warraich that she continues to cough intermittently since November, and the chest x-ray had been completed, showing progressive nodular opacification and new volume loss in the left upper lobe. Much of the note appears to be a reproduction of the original November 24, 2017 visit note, including the reference to education about

unrelated matters and reference to supportive treatment for acute bronchitis. One difference in the documentation is that Patient 1's chest examination was noted to be normal at the January 9th visit and now she had bilateral wheezing. Despite his assessment of acute bronchitis, Dr. Warraich ordered a CT chest but there is no mention of the sputum samples.

63. Neither the January 26, 2018 x-ray report nor the CT scan later performed mention tuberculosis.

64. When Patient 1 was next seen on February 23, 2018, it was for what appears to be an unrelated upper respiratory tract infection, the need to do sputum cultures and cytology was referenced but there is no reference in the chart to the AFB sputum or the concern about TB. Dr. Warraich states that he reminded the patient again to get the sputum tests performed, but that is not reflected in the chart

65. On Feb 28, 2018, the CT of Patient 1's chest was performed and reported as follows:

> Clinical Hx = cough. CXR shows progressive nodular opacification left upper lobe. It showed a mass-like consolidation within the lingual and left upper lobe with associated volume loss with multiple enlarged supraclavicular, mediastinal and bilateral hilar lymph nodes. "*While the above findings could be explained by diffuse infection, the degree of lymph node enlargement and extent raises strong concern for an underlying malignancy.*" Bronchoscopy was advised.

66. The report of the CT was faxed to Dr. Warraich on February 28th, but the patient was not called about it until March 8, 2018. The note in the EMR states that:

> *Pt was called urgently and Her CT scan report were discussed and were given a copy to her, She works at HSC, and Her consults to Thoracic surgeon and Respirologist are send. Pt, HTN RX is refilled "*

67. Consult letters were written to respirology and thoracic surgery, which noted her Hx of cough and PMHx hypertension. The results of the CT were provided. No consideration as to the original concern of TB is referenced in Dr. Warraich' s record or the referrals.

68. On March 13, 2018 the thoracic surgeon assessed Patient 1. The assessment was a presumed diagnosis of TB. That same day, sputum was obtained and tested for AFB and the results were positive. Further management of Patient 1's diagnosed TB was guided/provided by respirology.

69. On March 14, 2018, treatment for TB was started and Patient 1 was put on home isolation.

70. On March 27, 2018, Dr. Warraich saw Patient 1 in relation to leg swelling and significant shortness of breath. It was noted by him that she was not ambulating and that she was being treated for TB and was in isolation. Her legs had "++ edema" but the remainder of her cardiovascular exam was noted to be normal, with the exception of "decreased respiratory movements secondary to obesity" which had not been previously noted as problematic. She was placed on furosemide without any notation or documented plan regarding the underlying etiology.

71. When Patient 1 was seen one week later, on April 3, 2018, there was no follow up to the serious issues from the March 27th visit. On April 4, 2018, forms were completed for requirement to be off work. This is the last documented involvement between Patient 1 and Dr. Warraich in his EMR.

72. On April 18, 2018, Patient 1 was seen by respirology for a follow up visit. At that time, multiple symptoms were noted, including the following:

    - Bilateral pedal edema, intermittent since 2016 for which she takes furosemide intermittently. After treatment, getting worse.

    - Has longstanding orthopnea and PND.

    - Previously diagnosed with asthma in Philippines in 2016 but no PFTs.

    - Also noted was T2DM for approximately ten years.

    - There were vague symptoms of unsteadiness and visual disturbance since starting the medication.

Ongoing weight loss without other constitutional symptoms was noted. There was ongoing dysphagia.

- On examination, the lungs were clear and there was bilateral pitting edema. JVP was not clearly elevated.

- Concern was raised re possible CHF and further investigations were ordered.

73. On May 2, 2018, an echocardiogram requisitioned by the respirologist showed severe dilated cardiomyopathy (EF 20-25%) with mitral valve regurgitation and on May 4, 2018, following a respirology follow up and management of CHF secondary to the cardiomyopathy, there was a referral sent to cardiology.

74. A report dated January 10, 2019 from a consultant ("Dr. Scurfield") who reviewed Dr. Warraich's care of Patient 1 is at **TAB 33**. The conclusion is that Dr. Warraich did not meet the standard of care expected of a family physician in his treatment and management of Patient 1's TB or congestive heart failure and that his record keeping did not meet the requisite standard. The consultant's opinion follows:

> In my opinion the care and management of this patient was not consistent with what would be expected of a family physician. The mismanagement of this case not only delayed the treatment of this patient to her detriment but also has put the public at risk.
>
> Once the word tuberculosis is mentioned in that first chest x-ray a whole string of events should have taken place that did not. This is important not only to the management of the patient's health but also to protect the public. It did not seem that the significance and the potential severity of the situation was recognized. It also does not appear that he ever discussed the possibility and the importance of ascertaining whether or not she had tuberculosis with the patient which may have motivated her to follow up with testing. An urgent process to rule out tuberculosis should have been put into place considering the impact of her continuing on with potentially untreated tuberculosis. The sputum should have been done and followed up with. He

should have consulted urgently with respiratory by phone to ensure that he was following protocol with respect to her immediate care as it does not appear he knew what to do in this case.

He does not appear to have a process that keeps track of tests that were ordered, and no results have been returned. If he did it would not have taken over 3 months for the patient to finally have her sputum tested (which was done by the specialist).His electronic record keeps track of all requisitions created and if properly used also reconciles those that have results returned. It should have been possible for him to realize that she did not have sputum results back and follow that up in a short period of time.

As well he does not take the opportunity to follow up appropriately with respect to ongoing diagnoses at subsequent visits. For example, focusing on what foods have Vitamin D in them instead of following up with respect to significant and severe symptoms that she presented with the week before. He repeatedly missed opportunities to remind her about the need for the sputum testing on numerous occasions when she was in his office.

His management and diagnosis of her leg edema as also very concerning. I am concerned that she was showing signs of another significant disease process ongoing (which was diagnosed as a cardiomyopathy and heart failure by the specialist) which was missed by Dr. Warraich.

Dr. Warraich’s notes are poor. His reliance on poorly developed scripted notes (macros) makes for notes that are confusing and disorganized. It is very difficult to follow his train of thought. The history and physical findings and assessment are interspersed and don’t seem to flow one to the other in a cohesive manner. Some aspects of the record raise concern that he is relying too heavily on macros. For example, he records that he did a foot exam on this particular patient June 10, Sept 29, December 6, 2018 and January 1st and 9th, 2018. Five foot exams in seven months when there is no primary foot complaint is very unusual. If this is accurate it is not clear why he

> is doing these exams. If this is showing up in the record simply because it is part of the macro and does not accurately represent what is happening in the visit that is more problematic. If a macro is being used it is critical that it be modified to accurately reflect the care given.
>
> It appears, in the records reviewed, that Dr. Warraich is neither gathering the necessary data nor synthesizing the data he does gather to consistently make plausible working diagnoses and plans for testing and treatment. For example: stating someone has controlled diabetes when their blood work doesn't support this, or saying they have acute on chronic bronchitis when it is clear on x-ray that this is not the diagnosis. Another example is when the patient complained of edema with no further history being recorded and no mention of this aspect of her exam recorded on the chart. This was evident time and time again in the notes reviewed.

75. Dr. Warraich has had the care reviewed by Dr. Reynolds. His report is at **TAB 34**. He states:

> Dr. Warraich saw the patient with what seemed like a respiratory illness and sent the patient for a chest X-ray.
>
> This was reported as suspicious of pulmonary TB. This information was transmitted in the radiology report and in a telephone call from the radiologist to Dr. Warraich's receptionist. A reasonable clinician would correlate the radiologic finding with the clinical picture of the patient's presentation. The patient did not appear to be systemically unwell and there were no red flags of weight loss or blood stained sputum. The patient was also improving with oral levofloxacin. It is reasonable in these circumstances to continue the patient on oral antibiotics and plan for sputum samples for TB testing. Most primary care physicians would not be aware that levofloxacin has some anti-tuberculosis effect.
>
> Dr. Warraich then contacted the patient and made arrangements for the patient to undergo sputum testing for TB and gave the patient a work note to facilitate the collection of the specimens. Apparently the patient did

not comply with the sputum collection or the specimens were lost. Most family physicians would assume-positive testing for TB would trigger automatic public health notification. There can also be considerable delay in reporting negative samples.

Subsequent diagnostic imaging reporting seemed to suggest diffuse pulmonary malignancy not TB.

I understand there has been some concern about not recognizing congestive heart failure early in this complex patient's trajectory. There is no mention of heart failure or cardiac enlargement in the initial chest X-ray. The follow up x-ray states "The cardiac silhouette remains enlarged".

The CT chest does not suggest heart failure as there is a trace pleural effusion and a small pericardial effusion that can been incidental to a pulmonary infection or malignancy.

It appears that Dr. Warraich has been singled out for criticism when this seems to be a series of system issues. The doctor raising the complaint suggests that he reviewed Dr. Warraich's profile before his complaint. This does not seem to suggest impartiality and evenhandedness.

V. COUNT 3

76. Patient 2 is a woman who was born in 1994. She was admitted to SOGH with abdominal pain, with a working diagnosis of pyelonephritis following an attendance at the SOGH emergency department on May 7, 2015 complaining of abdominal discomfort. She remained in hospital until May 15, 2015. The hospital record of her admission is at **TAB 35.**

77. While in the emergency department, intravenous antibiotics were initiated, and Patient 2 was admitted under the care of the Hospitalist. On May 8, 2015 Dr. Warraich, acting in a Hospitalist role, attended Patient 2 for the first time. An admission examination is documented by Dr. Warraich on that date and a renal ultrasound was ordered by Dr. Warraich.

78. From May 9-13, 2015-Dr. Warraich is recorded as having attended Patient 2 daily. On May 14, 2015 Patient 2 had her renal ultrasound performed, which was normal.

79. On May 15, 2015, Dr. Warraich discussed with Patient 2 his recommendation to order a CT scan of her abdomen, which would be expedited if Patient 2 remained an in-patient. Patient 2 agreed to stay in hospital until the CT was performed. Later that evening Patient 2 decided she wanted to go home. She spoke with Dr. Warraich over the phone and agreed to return to hospital in the morning. A pass was provided by Dr. Warraich. He did not see her again after May 15, 2015.

80. In her letter of complaint dated June 13, 2015, Patient 2 described Dr. Warraich's visits while she was in hospital as follows:

> During his visit he would stand by the entrance of the room and ask how I was feeling and give me more pain medication and walk out. No physical examination was done. The nurses had even told me I was lucky Dr. Warraich even came into my room and didn't just look at the chart.

81. Patient 2 has further explained that she was in isolation for a "superbug" concern and that anyone coming in needed to gown and glove. The nurses did this each time but Dr. Warraich never did. He came to the door and spoke with her but never gowned or gloved and never entered the room. He never examined her in any way.

82. Dr. Warraich responded to the complaint by letter dated August 24, 2015 **(TAB 36).** As to his visits with Patient 2 while she was admitted to hospital under his care, he stated:

> My first note of having seen the patient is on May 8, 2015, at which time I would have examined her and reviewed all of the test results which had been performed. My notes reflect that I saw her on May 9, 10, 11, 12, 13 and 15, 2015.

83. On May 8, 2015, Dr. Warraich documented a complete history and physical which includes vital signs from ER the previous day as well as comments such as "patient is normocephalic and heart sounds are audible". He also

documents a CNS examination including motor sensory and cranial nerves to be intact and a musculoskeletal examination which is intact.

84. Dr. Warraich has a note in the record for each day the patient was admitted in the hospital, however, there is no subsequent physical examination documented.

85. On May 16, 2015, Patient 2 did not return to the ward. Patient 2 requested that the CT be performed as an outpatient, and that a prescription be called to a pharmacy. Dr. Warraich complied with this request.

86. The CT which was not performed until May 21, 205 showed probable appendicitis. Surgical referral was facilitated that day by the SOGH.

87. An operative report received from Grace Hospital showed the patient had a ruptured appendix with adhesions. That report is at **TAB 37.**

88. The pathology report from that surgery does not specifically confirm appendicitis. It identifies a finding compatible with an evolving periappendiceal abscess. The report is **TAB 38.**

89. The discharge summary from the May 2015 admission was not completed by Dr. Warraich until October 12, 2015.

90. Dr. Warraich maintains that he examined Patient 2 and that he provided appropriate care.

91. Patient 2 maintains that Dr. Warraich did not examine her during her admission and that he did not provide her with appropriate care."

Summary of Additional Factual Evidence from Witness Testimony

Patient 2

Patient 2 testified at the hearing in January, 2020. At the time of her testimony, she was enrolled in an undergraduate program studying to become a health

professional. When the incidents referred to in Count 3 of the Amended Notice of Inquiry occurred, she had received no medical training.

In late April, 2015, approximately two weeks prior to the incidents referred to in Count 3, Patient 2 had attended at the Seven Oaks Hospital and had been diagnosed as likely having a kidney infection. She had been prescribed a course of antibiotics which she completed. She saw her family physician on May 6, 2015, and on the basis of a urine test he had ordered in late April, he expressed concern she may have been infected by a “superbug”.

On May 7, 2015, she became nauseated and vomited at work. Her employer drove her to the Emergency Department at Seven Oaks Hospital. Patient 2 testified that she did not remember being examined by an Emergency Department physician on May 7, but may have been. She was admitted to the Seven Oaks Hospital on the evening of May 7, 2015 and remained in the hospital until May 15, 2015.

In her direct examination, Patient 2, among other things testified that:

(a) She had never met Dr. Warraich prior to May, 2015 and has had no dealings with him since May, 2015;

(b) In preparing for her testimony at the hearing, she had reviewed her medical chart, which was made available to her by the College. She had not reviewed her medical chart prior to submitting her complaints to the College in June, 2015, or when further communicating with the College in July, 2017;

(c) On admission to hospital on May 7, 2015 she had pain in her abdomen and was experiencing flank pain and was nauseous and vomiting;

(d) Dr. Warraich did not physically examine her upon admission, or at any time during her stay in the hospital. She did not see Dr. Warraich during the evening of May 7, 2015;

(e) She had originally been placed in “isolation” meaning that people who would come into her room, such as nurses, were required to “gown and glove”. Dr. Warraich attended at her room, typically during the evenings. He would stay at the entranceway of the room and would ask her questions, without entering the room;

(f) During her stay in the hospital, Patient 2 was “in a lot of pain”, and was receiving various pain medications, one of which was effective, namely Percocet. However, Patient 2 was concerned about becoming addicted to Percocet. Other pain medications she received were less effective;

(g) During her stay in the hospital, Patient 2 received an ultrasound of her kidneys and bladder, but not of her appendix;

(h) Towards the end of her stay, Dr. Warraich recommended that a CT scan be conducted. Patient 2 did not want to stay in the hospital any longer waiting on a CT scan. She attempted to contact Dr. Warraich by telephone and waited for several hours before being able to speak to him by telephone. Dr. Warraich indicated he wanted her to stay in the hospital and wait for the CT scan to be conducted. She left the hospital on Friday, May 15, 2015 and had the CT scan performed the following Thursday. She then had a follow up appointment with her family physician who diagnosed appendicitis. She underwent surgery at the Grace Hospital later in May, 2015.

In her cross examination, Patient 2, among other things, testified that:

(a) On May 6, 2015, her family doctor suspected she had a kidney or a urinary tract infection;

(b) There were many things she could not remember about her admission and stay at the Seven Oaks Hospital, such as whether she was examined by an emergency room physician prior to or around the time of her admission, what “vitals” were taken on admission, the reason why she was removed from isolation, and the

specific details of various communications with nurses which were referenced in her chart;

(c) She left the hospital on May 15, 2015, although she recognized Dr. Warraich wanted her to stay in the hospital;

(d) Dr. Warraich replied to Patient 2's complaint to the College in August, 2015. She did not respond to his reply until July, 2017. Patient 2 "didn't have a specific reason" for taking almost two years to respond to Dr. Warraich's reply. She recalled receiving a request from the College to respond to Dr. Warraich's reply in May, 2017 and testified that she "was always planning on responding".

Kiranj Gill

Ms Gill was employed at the Keewatin Medical Centre (the "Centre") in November and December, 2017. Dr. Warraich was associated with the Centre at that time.

On December 1, 2017, Ms Gill received the phone call from the radiologist who had reviewed the x-ray which had been performed on Patient 1. The radiologist was calling the Centre to speak to Dr. Warraich. Ms Gill took the message, and the radiologist then faxed the report to the Centre. Ms Gill advised Dr. Warraich of the call and brought the radiological report to his attention.

Both Dr. Warraich and Ms Gill were working at the Centre on December 2, 2017, which was a Saturday. Both Ms Gill and Dr. Warraich attempted to contact Patient 1 "several times" by telephone on December 2, but without success.

Dr. Warraich accordingly directed that the Centre be open on Sunday, December 3 in order to continue efforts to contact Patient 1. Both Ms Gill and Dr. Warraich attended to the Centre on December 3 and again attempted to contact Patient 1. Dr. Warraich was ultimately successful in reaching Patient 1 by telephone.

Ms Gill also testified that she remembered the above noted facts clearly because December 3, 2017 was the only time in her experience the Centre had been opened on a Sunday.

In cross examination, Ms Gill indicated that Patient 1's husband attended at the Centre on December 3. He came in to see Dr. Warraich and spent approximately 10 to 15 minutes meeting with Dr. Warraich. Patient 1 attended at the Centre a few days later.

Ms Gill could not recall if she was ever asked by Dr. Warraich to call Patient 1 on an urgent basis at any time after December 3, 2017.

Dr. Warraich

Dr. Warraich's testimony at the hearing was more detailed and expansive with respect to his actions relating to Patient 1 than the information contained in the Statement of Agreed Facts. In his testimony he outlined his various conversations with Patient 1, and the actions which he took and his thought process relating to his management and treatment of Patient 1 on a visit by visit basis between late November, 2017 and April, 2018.

The most significant parts of Dr. Warraich's testimony with respect to Patient 1 related to the following matters:

(a) Following the radiologist's telephone call to Dr. Warraich's office on December 1, 2017 and the receipt of the radiological report on the same day indicating "an atypical source such as tuberculosis . . .", Dr. Warraich opened his office on Sunday, December 3, 2017 in order to contact Patient 1. Both Dr. Warraich and Ms Gill made numerous efforts to contact Patient 1 that day and Dr. Warraich was ultimately successful in speaking to her. He testified that he told Patient 1 that the x-ray showed infection which could be pneumonia, tuberculosis or another type of infection. He tried to convince her to come to the Centre that day, but she was working

and did not wish to do so. Dr. Warraich was able to convince her to send her husband to the Centre. Patient 1's husband came in that day and picked up a requisition for a sputum sample (re the possibility of tuberculosis) and a prescription for an antibiotic (in case pneumonia was the source of her infection);

(b) On December 6, Dr. Warraich saw Patient 1 as a regular follow up relating to her diabetes. Dr. Warraich provided her with a sick note permitting her to be off work for five days, explaining in his testimony that he wanted to give her ample time to get the sputum testing done;

(c) On January 1, 2018, Dr. Warraich saw Patient 1. He testified that at that visit she advised him that she had gone for the sputum testing and that her cough had improved but that she was still coughing "off and on". Dr. Warraich also decided to order another x-ray and urged Patient 1 to have it done quickly;

(d) Dr. Warraich testified as to another visit by Patient 1 on January 9, 2018 in which she reported to him that she had not gone for the sputum testing;

(e) Patient 1 did not go for the x-ray which had been discussed on January 1, 2018 until January 26, 2018;

(f) With respect to the remainder of Dr. Warraich's testimony, he elaborated on some of his notations in Patient 1's chart relating to leg edema and explained why, on the basis of his examinations of Patient 1, and on the basis of the diagnostic imaging and the test results he was receiving, he did not have serious concerns about her heart, or the possibility of congestive heart failure. He also explained that he thought Patient 1 had gone for the sputum testing and was reassured that no positive test results had been received, based on his understanding that a positive test result would come back quickly, but a negative result might take much longer. He was also reassured with respect to tuberculosis by the results of the January 26,

2018 x-ray and the results of a CT scan (which were available to him by February 28). Neither of those results referred to tuberculosis. However they did heighten concern about a possible underlying malignancy. As a result, Dr. Warraich wrote consult letters to Dr. Ainslie (a respirologist) and Dr. Tan (a thoracic surgeon).

With respect to his interactions with Patient 2, Dr. Warraich testified that:

(a) Patient 2 had not been a patient of his prior to her admission to Seven Oaks Hospital on May 7, 2015, and has not been a patient of his since her discharge from the hospital on May 15, 2015;

(b) Dr. Warraich had his first direct interaction with Patient 2 on May 8, 2015 at which time he talked to her to obtain a history and conducted a physical examination of her. The nurses took the “vital signs” and he “did everything else”;

(c) He physically examined her everyday between May 8 and May 15, except on May 10;

(d) Initially, all indications were that Patient 2 had a kidney infection for which he prescribed antibiotics. Nonetheless, Dr. Warraich had blood work performed everyday. Although she was generally getting better, she continued to experience some pain and she developed respiratory problems on May 10 and 11. Accordingly he was concerned about pneumonia, a kidney infection, and possible sepsis. As a result of his concern about sepsis, he ordered a renal ultrasound on May 13;

(e) According to Dr. Warraich, Patient 2 never complained of right lower quadrant pain, and when he physically examined her abdomen, and specifically the right lower quadrant, it was not tender or sensitive to his touch;

(f) Towards the end of her hospital stay, the hospital wanted to discharge Patient 2, but Dr. Warraich wanted to do a CT scan of her abdomen and he wanted her to stay in the hospital until the CT scan was done. According to Dr. Warraich, Patient 2 was agreeable on the morning of May 14 to staying in the hospital until the CT scan was done, but later that day she changed her mind. Notwithstanding a phone call between Dr. Warraich and Patient 2, in which he advised her to stay in the hospital, Patient 2 left the hospital on May 15, 2015;

In his cross examination, Dr. Warraich testified, among other things, that:

(a) Other than on May 8, the results of his physical examination of Patient 2 were not recorded in her medical chart, because those results were the same as his examination on May 8 and therefore he didn't record them. He now recognizes that he should have done so;

(b) He did not order the CT scan on May 14 because he wanted to see the results of the renal ultrasound, and although he was advised that the results of the renal ultrasound were negative on May 14, he wanted to see the report from the ultrasound before ordering the CT scan.

Summary of Additional Expert Evidence

Each of the experts who had been retained by one or other of the parties provided reports outlining their respective opinions. They also testified at the hearing.

Dr. Scurfield

Dr. Scurfield was the external consultant engaged by the College to comment on Dr. Warraich's care and management of Patient 1. In Dr. Scurfield's testimony, she elaborated upon the contents of her report dated January 10, 2019.

In Dr. Scurfield's direct examination, she testified, among other things, that:

(a) She graduated from a three-year family practice residency program at the University of Manitoba in 1983 and has practiced as a family practitioner from 1983 to the present. As early as 1983, Dr. Scurfield began doing audits at the St. Boniface Hospital Family Practice Ward and has performed audits for the College on a regular and continuous basis from the early stages of her career to the present;

(b) Dr. Scurfield had audited Dr. Warraich's practice several times prior to being engaged to provide an expert opinion in this case. She did not believe that the fact she had performed several audits of Dr. Warraich's practice influenced her opinion. She explained that she has done so many audits that once she has finished an audit, she quickly forgets the details of that particular audit. She also indicated that she did not recall the details of her prior audits relating to Dr. Warraich's practice;

(c) With respect to Patient 1, Dr. Scurfield was critical of Dr. Warraich's record keeping. One of her criticisms related to Dr. Warraich's extensive use of Macros. Dr. Scurfield opined that Dr. Warraich was overly reliant on Macros and as a result there was inadequate information in the charts relating to Patient 1's individual circumstances and that Dr. Warraich had failed to adapt the use of Macros to properly reflect Patient 1's actual history or to adequately explain or follow up on the unique characteristics of her case;

(d) Dr. Scurfield provided several examples of specific questions or types of questions which were <u>not</u> reflected in Patient 1's chart, such as questions relating to her recent travel history, the colour of her sputum, or the nature of her employment position at the hospital;

(e) Dr. Scurfield observed that Dr. Warraich's initial diagnosis of Patient 1 as having "acute bronchitis" was not supported by the history or the results of his physical examination of Patient 1;

(f) Dr. Scurfield indicated that the chest x-ray ordered by Dr. Warraich in late November 2017 was appropriate for a patient who had been coughing for a month;

(g) A call from a radiologist, such as the one received on December 1, 2017 by Dr. Warraich's office was noteworthy because radiologists do not call family physicians "all that frequently". Dr. Scurfield indicated that the word "tuberculosis" in the Diagnostic Imaging Report dated December 1, 2017 (the "D.I. Report") was very important and would have prompted most family physicians "to spring into action";

(h) Although family physicians are not expected to be experts in tuberculosis, they are expected to know:

(i) It is infectious and therefore there are broader community concerns which need to be addressed;

(ii) It is serious, i.e. can be potentially fatal;

(i) Dr. Scurfield also opined that in this case, there were other warning signs. Patient 1 worked in a hospital, therefore giving rise to concerns about spreading the disease in the hospital. Patient 1 was from the Philippines, a country in which tuberculosis infections are much more common than in Canada;

(j) Dr. Scurfield's opinion was that the D.I. Report should have triggered a series of events, which did not occur, including a consultation with a respirologist and efforts to stress the urgency of the situation to Patient 1, i.e. the need to get tested immediately because of concerns about the spread of the disease;

(k) It was Dr. Scurfield's opinion that the December 3 and December 6, 2017 visits of Patient 1 were missed opportunities to obtain more information and to have a thorough discussion with the patient about the seriousness of the

situation and the urgency of getting tested. It was Dr. Scurfield's view that there were insufficient notations in Dr. Warraich's chart notes for December 3 and December 6 with respect to her medical history, her travel history and the urgency related to providing sputum samples. Dr. Scurfield also commented that having ordered certain tests, it was Dr. Warraich's responsibility to follow up on the test results and to ensure that he had a system for following up on pending test results;

(l) Dr. Scurfield was of the opinion that Dr. Warraich's conduct with respect to the December 3 and the December 6, 2017 visits did not meet the standard of care for family physicians in Manitoba;

(m) With respect to the issue of Patient 1's leg edema, Dr. Scurfield stated that although Dr. Warraich's notes referred to that issue, his notes did not reflect how much discussion he had with Patient 1 about leg edema. There is no indication with respect to what questions were asked and what information was given. Leg edema can be potentially very serious because of the risk of blood clots, or because the edema may be a sign of congestive heart failure. The potential seriousness of the condition means that it is necessary to obtain a detailed history and to record what follow up is planned;

(n) Dr. Scurfield commented that Dr. Warraich's February 4 note with respect to Patient 1 appears to be essentially a duplication of the previous note, repeating the diagnosis of "acute bronchitis", which was not supported by the rest of the information in the chart;

(o) Dr. Scurfield opined that Dr. Warraich's ordering of a CT Scan on February 4 was helpful and appropriate;

(p) The results from the x-ray which had been ordered in early January (available on January 28), and the results of the CT Scan (available on February 28) contained some very unusual and interesting findings.

Dr. Scurfield commented that those findings should have prompted Dr. Warraich to speak to the radiologist;

(q) Dr. Warraich's referrals to the respirologist and the thoracic surgeon on or about March 8 were appropriate;

(r) With respect to the chart references in late March and early April 2018, Dr. Scurfield stated that more information about the leg edema should have been obtained and referenced in Patient 1's chart because of the potential seriousness of that condition. Dr. Scurfield commented that in view of the seriousness of the leg edema issue, Dr. Warraich's inclusion of information on much less important matters such as advice about vitamin D appeared "very strange";

(s) Dr. Scurfield characterized Patient 1's symptoms relating to heart issues in March and early April 2018 as "vague", and recognized that a diagnosis of heart issues after the second x-ray would have been "a tough call".

In her cross-examination, Dr. Scurfield, among other things testified that:

(a) Her family practice is very different from the practice of Dr. Warraich. She will typically see fewer patients than Dr. Warraich in any given time period and also will frequently have people to assist her with charting, such as medical residents or nurse practitioners. Those supports are likely not available to Dr. Warraich;

(b) When reviewing charts and doctor's notes, Dr. Scurfield will generally assume that if something is not mentioned in the chart, it was not done. Her exact words in relation to a chart audit were she would make that assumption "for the most part". She also acknowledged that there will be instances in which physicians do things which are not documented in the chart;

(c) When Dr. Scurfield was engaged to perform audits of Dr. Warraich's practice, she was not aware that Dr. Warraich had acknowledged he was having problems with charting;

(d) In undertaking her work in relation to providing her report in this case, Dr. Scurfield reviewed the records with which she had been provided relating to their adequacy from a patient care perspective on a visit by visit basis. She also attempted to answer the specific questions outlined in the College's letter dated December 18, 2018 (pursuant to which she had been retained by the College to act as a consultant with respect to Dr. Warraich's care and treatment of Patient 1);

(e) Prior to providing her report dated January 10, 2019, Dr. Scurfield did not interview either Dr. Warraich or Patient 1;

(f) Dr. Scurfield acknowledged that not all of Dr. Warraich's chart notes relating to Patient 1 were from a Macro;

(g) The D.I. Report of December 1, 2017 did not say that Patient 1 was suffering from tuberculosis. The report merely indicated that tuberculosis may be one possible source of infection;

(h) Dr. Scurfield acknowledged that Dr. Warraich was obviously concerned about tuberculosis as evidenced by the fact that he ordered sputum cultures;

(i) Dr. Scurfield acknowledged that Dr. Warraich generally followed the Manitoba Tuberculosis Protocol. The Protocol does not say that a respirologist ought to be consulted in the type of circumstances which existed on December 1, 2017;

(j) A reporting obligation with respect to tuberculosis arises once the diagnosis of the disease has been confirmed, but in this case, a diagnosis was not

made until March 14, 2018, at which time Patient 1 was under the care of a respirologist;

(k) There was nothing in the D.I. Report of December 1st to suggest Patient 1 was experiencing serious heart issues;

(l) There was nothing in the report of the radiologist with respect to the second x-ray (late January 2018) or of the CT scan (late February 2018) mentioning tuberculosis. It could be assumed that the radiologist(s) reading those results would have also been aware of the December 1st, 2017 D.I. results.

Dr. Reynolds

Dr. Reynolds was retained on behalf of Dr. Warraich to comment on the care provided by Dr. Warraich to Patient 1. In Dr. Reynolds' testimony, he elaborated upon the contents of his report dated May 28, 2019.

In his direct examination, Dr. Reynolds testified, among other things, that:

(a) He has been a family physician for over 40 years, practicing for 11 years in London, Ontario and the remainder of his career in Winnipeg. Dr. Reynolds is a Professor of Family Medicine and a Professor of Obstetrics and Gynecology at the University of Manitoba, and for a time was the Dean of Students and the Department Head of Family Medicine at the University of Manitoba;

(b) He approached the task of providing his opinion in this case by looking at "systems issues" such as whether or not there were "gaps in communications" between various components of the health care system;

(c) With respect to the D.I. Report of December 1, 2017, the report identified multiple possible causes of infection, including pneumonia. Dr. Reynolds observed that Dr. Warraich had made several attempts to contact Patient 1 on a priority basis on a weekend and had been ultimately successful in doing so. Immediately thereafter he ordered a sputum sample to investigate

the possibility of tuberculosis and an antibiotic for pneumonia. Dr. Reynolds indicated that he would not have expected most family physicians to know that the antibiotic which was ordered could mask tuberculosis symptoms;

(d) Dr. Reynolds opined that the actions which Dr. Warraich took upon reviewing the D.I. Report of December 1, met the reasonable standard of care for family physicians. Dr. Reynolds noted that tuberculosis is a very unusual infection in urban Canada;

(e) Moreover, throughout December 2017, Patient 1 did not appear to be particularly unwell. She was being treated for pneumonia and was improving;

(f) In terms of whether or not Dr. Warraich should have made a report to any public health authorities in December or some time in January, no results were available at that time from the sputum samples. Dr. Reynolds noted that obtaining sputum specimen results of the type in question could take up to six weeks. Furthermore, Patient 1 was employed at a hospital, had been directed to provide a sputum sample and had been given time off work in order to do so. In terms of defining the nature and extent of Dr. Warraich's responsibility, the situation falls in the grey area between "patient autonomy" and "paternalism";

(g) The results of the second x-ray were available in late January. No mention was made by the radiologist at that time of tuberculosis. Presumably the second radiologist was aware of the December 1, 2017 D.I. Report;

(h) With respect to the issue of congestive heart failure, Dr. Reynolds indicated that these problems emerged quite quickly "out of left field";

(i) Leg swelling is not a reliable indicator of heart failure, and leg edema can be caused by many things;

(j) The diagnostic imaging report of February 28, 2018 although raising issues of serious concern does not provide any evidence of heart failure or a serious heart issue;

(k) There were several systemic issues present with respect to Patient 1's case. For example, Dr. Reynolds said this case raises questions such as:

(i) Was there a way of getting a public health nurse to visit with and interview Patient 1 much earlier in the process?

(ii) Did radiology have a greater role to play in terms of communication with both Dr. Warraich and others, such as the Public Health Authorities?

(iii) What is a doctor's responsibility to ensure that a patient is following that doctor's recommendations and directions?

In his cross examination, Dr. Reynolds testified, among other things, that:

(a) Dr. Warraich's approach had been imperfect but from a broader perspective, there were other systemic issues which were larger contributors to the problem;

(b) He did not comment on Dr. Warraich's record keeping in his report but acknowledged that Dr. Warraich's record keeping with respect to Patient 1 was deficient;

(c) Dr. Reynolds conceded that he did not know precisely what communications had taken place between Dr. Warraich and Patient 1 and to make assumptions about what information had been provided to Patient 1, would be speculation;

(d) Dr. Reynolds was asked whether Dr. Warraich's failure to review Patient 1's travel history was an omission. Dr. Reynold's response was: "Not necessarily, not with someone presenting with quite common 'bread and

butter complaints". Dr. Reynolds was asked a follow up question about whether Dr. Warraich should have reviewed Patient 1's travel history after the possibility of tuberculosis had arisen. Dr. Reynolds response was that most family practitioners would not have much, if any experience with tuberculosis and might not consider reviewing a patient's travel history;

(e) When asked questions about Dr. Warraich's responsibility for follow up on the testing of sputum samples, Dr. Reynolds replied that it would be difficult to place responsibility for that on the physician, particularly since Dr. Warraich had contacted Patient 1 on a weekend, had directed her to provide a sample and had provided a medical note giving her time off work in order to provide the sample;

(f) Dr. Reynolds was asked whether or not, given the multiple visits of Patient 1 to Dr. Warraich throughout January and February, there had been multiple missed opportunities to follow up with Patient 1 relating to the possibility that she was suffering from tuberculosis. Dr. Reynolds responded that "there were missed opportunities everywhere" but this situation was a grey area involving the atypical presentation of a rare illness during a period of time when the patient was showing some signs of improvement;

(g) When asked whether he believed Patient 1 was being treated by Dr. Warraich for pneumonia in January 2018, Dr. Reynolds responded affirmatively based on the antibiotic which Dr. Warraich had prescribed. It was pointed out to Dr. Reynolds that the diagnosis contained in Dr. Warraich's chart notes for that period was "acute bronchitis". Dr. Reynolds replied that "acute bronchitis" was a term which could be used to cover a wide variety of specific conditions;

(h) It was pointed out to Dr. Reynolds that there were instances in Dr. Warraich's notes of various visits with Patient 1, in which there was nothing recorded about reminding her to attend to give sputum samples. Dr. Reynolds responded that family physicians will not always document the

reminders which they have given to patients to submit specimens. Dr. Reynolds acknowledged that it would have been helpful in this case,if Dr. Warraich had documented such reminders.

Dr. Jawanda

Dr. Jawanda was retained by the College to comment upon the care and treatment of Patient 2 by Dr. Warraich between May 7 and May 15, 2015. Dr. Jawanda provided a report dated January 2, 2019 outlining his opinion.

In the concluding portions of his report, Dr. Jawanda wrote:

> *"Overall I can appreciate the complexities of this case. In retrospect we know the diagnosis of appendicitis, however this patient had many aspects to her presentation that made this diagnosis difficult to arrive to both in her presenting history, ER assessment, lack of physical examination/abdominal examination findings that clearly suggested appendicitis including focal RLQ tenderness, psoas sign, rosving sign, etc. (those that were documented), and non-suggestive lab work, i.e. lack of leukocytosis or left shift.*
>
> *In the context of what Dr. Warraich knew at the time, I feel that his care was appropriate in terms of his initial assessment and plan, his choice of antibiotics/analgesia, and imaging choices for an ultrasound and CT scan. I feel these aspects meet standard of care. According to his (limited) documentation, I did not get an obvious impression that he lacks skill or is deficient in knowledge.*
>
> *However, his documentation in the medical record is deficient and does not meet standard of care. Clear documentation of daily rounds including subjective and objective findings including presence of a physical examination, or presence of a differential diagnosis may have assisted him in arriving at the diagnosis sooner. Further, there is no clear documentation of clinical and patient assessments during the hospital admission. Lack of clinical/patient assessments and reassessments during a hospital admission would not meet standard of care. However, it is my understanding that whether assessments occurred or not is a difference in perspective between Dr. Warraich and Patient 2*

> *and not within the scope of this report for me to provide an opinion.*
>
> *Dr. Warraich eventually ordered the appropriate imaging tests, however could have requested/ordered urgent imaging in the early days of Patient 2's admission and therefore is deficient in his judgment in the timing of his investigations. His treatment plan is not clearly documented from May 11-13, and there is no documentation on May 14. A renal ultrasound was eventually performed on May 14, and CT abdomen was ordered on May 15, however had this been performed sooner, he would have arrived at an earlier diagnosis.*
>
> *In my report, I have outlined that the ultimate delay in Patient 2's diagnosis was delay in obtaining a CT abdomen. As I discussed, there was a delay during that patient's hospital stay that should have been expedited. I would like to mention that there are several reasons/contributing factors for this ultimate delay in diagnosis aside from her admission from May 7-15, 2018: …"*

In his direct examination, Dr. Jawanda elaborated upon the contents of his report. Among other things, he testified that:

(a) Dr. Warraich's "admission note" and the Emergency Physician's note of his examination of Patient 2 on May 7th were similar, but the Emergency Physician's note contained greater detail;

(b) An abdominal examination with personal contact is probably the most important step to take with respect to a patient presenting with complaints such as those of Patient 2;

(c) Patient 2 should have been physically examined at least once by the responsible physician, and perhaps daily, depending on the presentation;

(d) If it is established that Dr. Warraich did conduct such a physical examination or examinations of Patient 2, he met the applicable standard of care. If it is established that he did not conduct such examinations, he did not meet the standard of care;

(e) The diagnostics which Dr. Warraich ordered were appropriate and arguably met the standard of care, but there was a delay in ordering the CT Scan and the renal ultrasound. By May 11, the patient had been experiencing serious pain for at least 72 hours and the pain was persisting. The CT Scan and renal ultrasound probably should have been performed on May 11;

(f) With respect to "charting", Dr. Jawanda opined that Dr. Warraich's progress notes with respect to Patient 2 did not meet the standard of care. Another physician picking up the case would not know exactly what had been going on with the patient.

In cross-examination, Dr. Jawanda testified, among other things, that:

(a) Dr. Warraich was a poor note taker. However he prescribed the correct medications during Patient 2's hospital stay and ordered the correct diagnostic tests;

(b) Prior to providing his report dated January 2, 2019, Dr. Jawanda had not been provided with either the operative report from the Grace Hospital or the surgical pathology report relating to Patient 2's surgery in late May 2015.

ANALYSIS

The Contentious Issues

Within the above-noted factual context, there are several contentious issues between the parties. Those issues are summarized below.

1. Were there deficiencies in the College's investigation of the matters alleged in Counts 2 and 3 of the Amended Notice of Inquiry? If so, were those deficiencies sufficiently serious so as to deprive Dr. Warraich of his right to be treated fairly in these proceedings. Counsel for Dr. Warraich argued that there were several such deficiencies in the College's investigation. Those deficiencies were that:

(a) The Investigation Committee did not adequately investigate Count 2 before issuing the Notice of Inquiry on December 7, 2018;

(b) Patient 1 ought to have been interviewed as part of the Investigation Committee's investigation of matters relating to Count 2;

(c) Dr. Warraich was not initially provided with the e-mail from Dr. Plourde, the Medical Director, Integrated Tuberculosis Services of the Winnipeg Regional Health Authority, which initiated the College's inquiries into the matters referred to in Count 2;

(d) The initial concern of the Investigation Committee related to an alleged failure on the part of Dr. Warraich to follow up on the reference to tuberculosis in the D.I. Report dated December 1, 2017. However Count 2, as ultimately issued, contained additional allegations relating to congestive heart failure. Dr. Warraich was not given an adequate opportunity to respond to the issues relating to congestive heart failure prior to the issuance of the Notice of Inquiry;

(e) Dr. Scurfield was retained to provide an expert opinion with respect to issues relating to Count 2 after the Notice of Inquiry had been issued, indicating that the College had not obtained an opinion relating to Dr. Warraich's care and management of Patient 1 until after the Investigation Committee had decided to refer matters to the inquiry Committee for a hearing. This suggests that the opinion sought was not truly objective, but rather was obtained to support the Investigation Committee's theory of the case;

(f) Dr. Jawanda was retained to provide an expert opinion with respect to issues relating to Count 3 after the Notice of Inquiry had issued, indicating that the College had not obtained an opinion relating to Dr. Warraich's conduct with respect to Patient 2 until after the Investigation Committee had decided to refer matters to the Inquiry Committee for a hearing. This

suggests that the opinion sought was not truly objective but rather was obtained to support the Investigation Committee's theory of the case;

(g) Dr. Jawanda was given incorrect or incomplete information relating to Patient 2's surgery in late May 2015.

2. Did Dr. Scurfield have sufficient independence, impartiality and lack of bias to provide expert evidence in these proceedings given that she had previously performed many audits for the College and had previously audited many of Dr. Warraich's charts and records on multiple occasions?

3. Did the Investigation Committee utilize an improper standard when assessing the care being provided by Dr. Warraich to Patient 1, namely a standard of "not documented, not done"?

4. What is the proper basis on which to assess whether or not a physician has committed professional misconduct or breached applicable standards of care? Is some "quality of blatancy" or some "cavalier disregard" of a patient's wellness required in order to find a physician guilty of professional misconduct or to find that a physician has breached an applicable standard of care?

5. What is the proper approach to making the credibility assessments which will likely be necessary in this case? Is Dr. Warraich's overall credibility questionable in view of the difference between the written response he provided to the College in June 2018 and the very detailed testimony which he gave at the hearing, which went beyond what was contained in the chart relating to Patient 1? Should Dr. Warraich's evidence with respect to his communications with Patient 1 be accepted, given that Patient 1 was not interviewed and was not called as a witness in these proceedings? What approach should the Inquiry Panel take to a comparative credibility assessment as between Dr. Warraich and Patient 2 on the issue of whether Dr. Warraich ever physically examined Patient 2 during her hospital stay in May 2015?

The resolution of the above-noted issues will significantly impact the Inquiry Panel's decision relating to whether the allegations against Dr. Warraich in Counts 2 and 3 of the Amended Notice of Inquiry have been proven.

1. The Alleged Deficiencies in the College's Investigation

The issue of the alleged deficiencies in the College's investigation of the matters referred to in Counts 2 and 3 of the Amended Notice of Inquiry involves a consideration of three issues:

i. What duty of fairness was owed by the College to Dr. Warraich during the investigation of the matters which ultimately resulted in the allegations against Dr. Warraich contained in Counts 2 and 3 of the Amended Notice of Inquiry?

ii. Were there deficiencies in the College's investigation of those matters?

iii. Were those deficiencies sufficiently serious so as to breach any duty of fairness owed to Dr. Warraich?

With respect to whether a regulatory body such as the College owes a duty of fairness to a member when investigating a complaint against that member, the traditional view has been that no such duty is owed. Two primary arguments are usually advanced in support of the proposition that no duty of fairness is owed to a member during an investigation, namely:

(a) Regulators perform an important role in maintaining standards and otherwise protecting the public interest. They should not be impeded or restricted in being able to effectively investigate potential professional misconduct by their members;

(b) The interests of the members being investigated will be properly protected by the rules of natural justice and administrative fairness, during a

subsequent stage of the complaints process, if charges are issued against the member and a hearing is convened.

However, a contrary argument is that a duty of fairness is owed at the investigation stage because the initiation of an investigation can have serious financial, reputational and professional consequences for the member being investigated.

It is not particularly helpful in this case to generalize as to whether or not a professional regulator owes a duty of fairness to a member during the investigation stage of the complaints process, because each case must be considered with reference to the provisions of the legislation involved, and the manner in which the investigator or investigation committee has conducted the investigation in question.

The investigation in this case was conducted pursuant to the provisions of sections 45, 46, and 47 of *The Medical Act*.

The College's Investigation Committee is comprised of two members of the College and a public representative. Investigators are appointed pursuant to subsection 45(1) of *The Medical Act*. In this case, the investigator was Dr. Karen Bullock Pries.

Subsection 45(3)(d) of *The Medical Act* provides that: "A person conducting an investigation may direct an inspection of or audit of the practice of the member who is the subject of the investigation". In this case, the auditors in relation to Count 1 were Dr. Scurfield and two other physicians.

Subsection 45(5) stipulates that: "A person conducting an investigation may investigate any other matter related to the professional conduct or the skill and practice of the member that arises in the course of the investigation".

Section 46 states that: "At the conclusion of the investigation the person conducting it shall report his or her findings to the Investigation Committee." Subsection 47(1)(a) provides that after a review of an investigation, the Investigation Committee may "direct that the matter be referred, in whole or in part, to the Inquiry Committee".

In this case, the Investigation Committee decided to refer various matters to the Inquiry Committee, and did so by way of the Notice of Inquiry issued on December 7, 2018.

Dr. Bullock Pries, on behalf of the Investigation Committee retained Dr. Scurfield and Dr. Jawanda as experts following the issuance of the Notice of Inquiry.

Dr. Warraich's specific criticisms of the deficiencies in the College's investigation will be considered with reference to the above-noted statutory provisions, and the manner in which Dr. Bullock Pries conducted the investigation on behalf of the Investigation Committee.

The first criticism of the investigation was that inadequate investigative work was done before the Notice of Inquiry was issued on December 7, 2018. This is a general criticism primarily relating to Count 2 but also encompasses specific complaints, such as the decision not to interview Patient 1.

The Panel is unable to accept the general argument that the Investigation Committee's investigation of the matters referred to in Count 2 was inadequate. The argument is based on the speculative proposition that the Investigation Committee and/or Dr. Bullock Pries ought to have taken additional steps following receipt of Dr. Warraich's written response dated June 8, 2018, and if they had done so, Dr. Warraich would have provided more detailed information, as he did in his testimony at the hearing, with respect to his communications with Patient 1 relating to concerns about tuberculosis.

Apart from the speculative nature of that argument, the general criticism that the investigation was inadequate is rebutted by the fact that Dr. Warraich had provided a written response to the College's inquiries on June 8, 2018, and was represented by counsel at that time. It was reasonable for Dr. Bullock Pries to assume that Dr. Warraich had provided a complete response containing the details which he considered relevant and important with respect to the College's inquiries. Furthermore, before Dr. Bullock Pries submitted her findings to the Investigation Committee, she had obtained and reviewed Dr. Warraich's complete medical record relating to Patient 1. The medical

record was consistent with Dr. Warraich's written response of June 8, 2018. In such circumstances, there was no practical reason for further investigative steps to be taken, nor was Dr. Bullock Pries under any duty to take such steps.

A more specific criticism of the adequacy of the investigation relating to Count 2 was the decision by Dr. Bullock Pries and/or the Investigation Committee not to interview Patient 1. As a challenge to the adequacy of the investigation, this critique is misplaced. The written response received from Dr. Warraich dated June 8, 2018 and the medical records submitted by Dr. Warraich relating to Patient 1 were consistent with each other. Those materials did not identify any potentially contentious issues relating to the communications between Dr. Warraich and Patient 1 as being germane to an assessment of Dr. Warraich's management and treatment of Patient 1.

In addition, the Investigation Committee would have been reluctant to undermine the ongoing relationship which existed between Dr. Warraich and Patient 1. This was particularly so since Patient 1 had not complained to the College about Dr. Warraich and continued to be his patient.

Given the foregoing, the Panel does not agree that the College's investigation was flawed as a result of not interviewing Patient 1. The Panel recognizes however that there is an important issue in these proceedings relating to Patient 1 not being called as a witness at the hearing. Since she was not called as a witness, the Panel does not know what Patient 1's evidence would have been with respect to her communications with Dr. Warraich from early December, 2017 to March, 2018. Although that issue is important, it is separate and distinct from the adequacy of the College's investigation prior to the issuance of the Notice of Inquiry. Accordingly, that issue will be dealt with in a separate portion of these Reasons.

Another of Dr. Warraich's specific criticisms of the investigation is that he was not provided with the e-mail from Dr. Plourde in the spring of 2018, which effectively initiated the College's investigation into the matters referred to in Count 2.

One notable feature of the Dr. Plourde's e-mail was his statement that: "normally, I would not be concerned about a specific physician, but in this instance it would appear that the physician in question is under some kind of probationary restricted practice if I understand the information I have accessed on your website."

Dr. Plourde's e-mail also contained the following statements:

- "At this time, I have not reviewed the case in detail, but am relaying to you preliminary information from a summary report that I received from TB Infection Control and Prevention Practitioner at HSC, who has led an extensive contact investigation."

- "So there were several missed opportunities in radiology that need to be followed up;. . ."

The focus of Dr. Plourde's complaint was that Dr. Warraich had failed to properly follow up on the possibility of tuberculosis which had been identified in the D.I. Report dated December 1, 2017. Dr. Warraich was well aware of that significant concern of the College from the spring of 2018, when the College first wrote to him relating to Patient 1.

Therefore, not receiving a copy of Dr. Plourde's e-mail during the investigation stage of these proceedings did not prevent Dr. Warraich from fully understanding the complaint. The statement of Dr. Plourde that he had been prompted to file the complaint as a result of information on the College's website, was not directly relevant to the substance of the complaint and did not detract from Dr. Warraich's ability to respond to the substance of the complaint.

Dr. Plourde's e-mail also indicated that he understood there may have been broader systemic issues contributing to the delay in diagnosing tuberculosis in Patient 1. Dr. Warraich ultimately received Dr. Plourde's e-mail (in December, 2019) as part of the disclosure made by the Investigation Committee after the Notice of Inquiry was issued and well before the hearing proceeded. As part of his defence to Count 2 at the hearing,

Dr. Warraich raised broader systemic issues which may have contributed to the delays in the diagnosis of tuberculosis, through the expert evidence of Dr. Reynolds.

The Panel therefore does not accept that the non-disclosure of Dr. Plourde's e-mail during the investigation stage of these proceedings was a serious flaw in the investigation or that it represented a breach by the Investigation Committee of any duty of fairness owed by the Investigation Committee to Dr. Warraich during the investigation phase of the proceedings.

Another specific and pointed criticism of the investigation with respect to matters relating to Patient 1, was that the initial concern of the College (to which Dr. Warraich responded by his letter dated June 8, 2018) was relatively narrow, namely that he failed to adequately follow up on the possibility of tuberculosis mentioned in the D.I. Report dated December 1, 2017. However, the allegations in Count 2 of the Notice of Inquiry were broader and included allegations relating to congestive heart failure. Dr. Warraich's counsel argued that Dr. Warraich was not asked to respond to the congestive heart failure allegations as part of the College's investigation, and he should have been given the opportunity to do so. Indeed, counsel for Dr. Warraich stated that he received no notice of the congestive heart failure allegations until he received the Notice of Inquiry in December 2018.

The Investigation Committee strongly disputed that statement and referred to a letter dated September 27, 2018 from counsel for the Investigation Committee to Dr. Warraich's counsel, which specifically mentioned entries in Patient 1's medical chart commenting on symptoms of dyspnea and leg edema and a subsequent diagnosis of cardiomyopathy and resultant congestive heart failure.

Regardless of whatever information was exchanged between counsel prior to the issuance and service of the Notice of Inquiry, s.45(5) of *The Medical Act* contemplates and permits an investigation of "any other matter related to the professional conduct or the skill and practice of the member that arises in the course of the investigation". It was therefore appropriate and permissible for the Investigation

Committee to consider issues relating to the congestive heart failure issue as part of its investigation.

With respect to the argument that Dr. Warraich should have been given the opportunity to respond to the congestive heart failure issue, Dr. Warraich was not disadvantaged or prejudiced by the inclusion of the allegations relating to congestive heart failure in Count 2. He was able to effectively respond and to vigorously defend those allegations after the Notice of Inquiry had issued. He tendered expert evidence on that issue from Dr. Reynolds and his counsel cross-examined Dr. Scurfield on her opinions with respect to leg edema and congestive heart failure.

The Panel has therefore concluded that the Investigation Committee's inclusion of allegations with respect to congestive heart failure in Count 2 of the Notice of Inquiry did not constitute a breach of any duty of fairness owed to Dr. Warraich during the investigation phase of the proceedings.

The final specific criticism from Dr. Warraich of the College's investigation of matters relating to Count 2 is that Dr. Scurfield was not retained to provide an expert opinion with respect to issues relating to Count 2, until after the Notice of Inquiry was issued. According to Dr. Warraich and his counsel, the timing of Dr. Scurfield's retainer suggests that the decision to refer these matters to a hearing was taken without the benefit of any analysis by an expert, and that Dr. Scurfield's opinion was not truly objective, but was obtained to support the Investigation Committee's theory of the case.

The investigation was conducted pursuant to sections 44 to 47 of *The Medical Act*. Subsection 45(2) permits an investigator to engage legal counsel "and employ any other experts that the person considers necessary." *The Medical Act* is silent as to when any such experts are to be employed. It follows that decisions as to whether to retain an expert, and when to do so are at the discretion of the Investigator and/or the Investigation Committee.

In particular cases, it may be appropriate to engage an expert to provide his or her analysis and opinion prior to a decision being made to refer a matter, in whole or

in part, to the Inquiry Committee. Such cases may include those involving a subject matter relating to a medical speciality beyond the expertise of the Investigator, or cases in which the applicable professional standards are unclear or are not well established, or cases in which the ways in which the applicable professional standards might apply to the specific facts of the case are not straightforward. In other cases, it will not be necessary to engage an expert prior to referring a matter to the Inquiry Committee.

At the time the Investigation Committee made its decision to refer the matters mentioned in Count 2 of the Notice of Inquiry to the Inquiry Committee, an expert opinion from Dr. Scurfield had not been obtained, although Dr. Scurfield was involved as an auditor of Dr. Warraich's records relating to matters that became the subject of the allegations particularized in Count 1 of the Notice of Inquiry.

It is noteworthy that two members of the Investigation Committee and Dr. Bullock Pries were physicians. They were capable of understanding the medical issues that had arisen during the investigation. There is no basis for the Panel to conclude that the decision not to seek an expert opinion relating to the matters referred to in Count 2 was anything but a legitimate exercise of the Investigation Committee's decision that an expert opinion was not necessary at that time. It would not be appropriate for this Panel, with the benefit of hindsight, to second guess, or criticize the Investigation Committee's exercise of that discretion.

Very shortly after the Notice of Inquiry was issued on December 7, 2018, Dr. Scurfield was retained as an expert (external consultant) by Dr. Bullock Pries to provide an analysis and to express an opinion on various issues and to provide a report outlining her opinion.

With respect to whether or not the opinion sought from Dr. Scurfield was objective, or was rather specifically obtained to support the Investigation Committee's theory of the case, the letter dated December 18, 2018, pursuant to which Dr. Scurfield was retained as an expert by Dr. Bullock Pries, is significant.

The letter was marked as Exhibit 7 in the proceedings. It is slightly over five pages in length. It requests that Dr. Scurfield provide a written opinion addressing five issues, two of which included multiple sub-issues. Various of the issues and sub-issues were expressed as a series of questions. The questions were specific and detailed but objectively stated. They did not suggest that a particular answer was preferred. In other words it was open to Dr. Scurfield to answer the questions either affirmatively or negatively, and to answer some of the questions in one way and others in another way. The letter also requested Dr. Scurfield to describe the facts or assumptions on which her opinions were based and to identify every document relied upon.

Exhibit 7 also contained a specific subsection entitled “duty of consultant”. The first sentence in that subsection stated: “It is the duty of a consultant retained by the College to provide an opinion that is fair, objective and non-partisan”. The following two paragraphs in that subsection of the letter emphasized the overriding objective of the process was “fairness” and that consultants are required to be “entirely neutral and objective”.

Exhibit 7 is the best evidence available to the Panel with respect to the manner in which Dr. Scurfield was engaged to opine on the issues identified by the Investigation Committee. Exhibit 7 supports the arguments of the Investigation Committee that Dr. Scurfield was engaged to provide an objective and factually based analysis of the issues which had arisen during the investigation.

Dr. Warraich’s criticisms of the Investigation Committee for engaging experts to provide opinions after charges had issued, presumably included the Investigation Committee’s engagement of Dr. Jawanda. However, as with the engagement of Dr. Scurfield, the Panel finds no fault with the timing of the engagement of Dr. Jawanda. The Investigation Committee has the discretion to determine whether to engage an expert and when to do so. The Panel has no basis for concluding that the Investigation Committee exercised any influence, which may have affected Dr. Jawanda’s objectivity when undertaking his analysis and providing his opinion. The Panel recognizes that after providing his initial written report, dated January 2, 2019, the

Investigation Committee asked Dr. Jawanda follow up questions, which prompted him to provide a second letter dated January 15, 2019. There is nothing in either the January 2, 2019 or January 15, 2019 letters which indicate that the Investigation Committee had attempted to influence Dr. Jawanda to provide an opinion supporting the Investigation Committee's theory of the case as it related to Count 3.

Dr. Warraich's second criticism of the Investigation Committee relating to the engagement of Dr. Jawanda was that the Committee provided him with inaccurate information on which to express his opinion. Specifically it was asserted that:

(i) Dr. Jawanda was told that Patient 2's ultimate diagnosis was appendicitis;

(ii) Dr. Jawanda was <u>not</u> given either the post operative or surgical pathology reports from the Grace Hospital.

Dr. Warraich argues that those two points are important because Dr. Jawanda testified that in providing his opinion he assumed that the information provided to him by the Investigation Committee was accurate, including the diagnosis of appendicitis. Dr. Warraich and his counsel submit that there is no conclusive evidence that Patient 2 ever had appendicitis despite the removal of her appendix. They argue that Dr. Jawanda's reports were therefore premised on inaccurate information. Furthermore Dr. Warraich's counsel submits that the Investigation Committee told Dr. Jawanda that Patient 2 had been diagnosed with appendicitis in order to elicit from him an opinion critical of Dr. Warraich.

The surgical pathology report from the Grace Hospital relating to the laparscopic appendectomy performed on Patient 2 on May 21, 2015, stated in part:

> ". . . clear evidence of primary mural appendicitis is not identified. However, periappendiceal serosa is associated with granulation tissue and active inflammation, findings compatible with an evolving periappendiceal abscess. . . ."

The operative report from the Grace Hospital relating to the same surgical procedure lists the “post-operative diagnosis” as “Chronic perforated appendicitis”. In the narrative description of the operative procedure, it states: “. . . with further dissection it was discovered that the appendix had likely perforated and was quite adherent to the cecal base and terminal ileum. . . .”.

The medical members of the Panel are of the view, based on their review of the relevant exhibits, that it was reasonable to state that Patient 2 had been subsequently diagnosed with appendicitis. Furthermore, Count 3 in the Amended Notice of Inquiry does not allege a failure on the part of Dr. Warraich to diagnose appendicitis. Count 3 alleges a failure to adequately examine and/or assess Patient 2, a failure to consider additional information and to revisit a presumptive diagnosis, and a failure to physically examine Patient 2.

The reliability of Dr. Jawanda’s opinion on those issues can be fairly assessed, regardless of what information he was given relating to Patient 2 being subsequently diagnosed with appendicitis.

The Panel therefore does not agree that the information given by the Investigation Committee to Dr. Jawanda was incorrect or that it negatively impacted the reliability of the opinion which he expressed relating to Charge 3.

2. Did Dr. Scurfield have sufficient independence, impartiality and lack of bias to provide expert evidence?

Counsel for Dr. Warraich and counsel for the Investigation Committee both referred the Panel to the Supreme Court of Canada’s decision in *White Burgess Langille Inman v. Abott and Haliburton Co. [2015] 2 SCR 182* as providing a definitive articulation of the duties of an expert when providing evidence to a court or tribunal. In that case, the Supreme Court stated:

> “Underlying the various formulations of the duty are three related concepts: impartiality, independence and absence of bias. The expert’s opinion must be impartial in the sense that

> it reflects an objective assessment of the questions at hand. It must be independent in the sense that it is the product of the expert's independent judgment, uninfluenced by who has retained him or her or the outcome of the litigation. It must be unbiased in the sense that it does not unfairly favour one party's position over another. The acid test is whether the expert's opinion would not change regardless of which party retained him or her: P. Michelle and R. Mandhane, "The Uncertain Duty of the Expert Witness" (2005), 42 *Alta L. Rev* 635 at pp. 638-39. Those concepts, of course, must be applied to the realities of adversary litigation. Experts are generally retained, instructed and paid by one of the adversaries. These facts alone do not undermine the expert's independence, impartiality and freedom from bias."

Counsel for Dr. Warraich argued that Dr. Scurfield's opinion relating to Dr. Warraich's diagnosis, treatment and management of Patient 1 cannot be considered as impartial, independent, and free of bias for many reasons, including that:

(i) She had conducted several audits of Dr. Warraich's practice prior to becoming involved in this case, including audits in November, 2015, May, 2016 and December, 2017. All of those audits were critical of Dr. Warraich's charting;

(ii) Her evidence that she did not recall those previous audits must be regarded with considerable skepticism given that one of the audits was in person and one of the audits had been performed relatively recently, in December, 2017;

(iii) She had undertaken audits at the request of the Investigation Committee for more than fifteen years and therefore cannot be considered independent of the Investigation Committee.

In contrast, counsel for the Investigation Committee argued that Dr. Scurfield's opinion was impartial, independent and free of bias. Counsel for the Investigation Committee asserted that there is an important distinction between the role of an auditor (which is to review a doctor's practice as part of an investigation into concerns about that doctor's fitness to practice) and the role of an expert (which is to

provide an opinion on specific matters which have been referred to the Inquiry Committee). Dr. Scurfield has conducted audits and acknowledged that her approach when doing audits has generally been guided by the principle “not documented, not done”. However, in this case, in relation to Count 2, she was acting as an expert and did not adopt that approach.

According to the Investigation Committee, the impartiality, independence and lack of bias of Dr. Scurfield’s opinion must be assessed on the basis of the instruction she was given by the Investigation Committee (in Exhibit 7), particularly the questions to which she was asked to respond, her answers to those questions, and the soundness of the analysis supporting her opinions.

Counsel for the Investigation Committee also submitted that given the numerous audits performed by Dr. Scurfield, her evidence that she did not remember her previous audits of Dr. Warraich is entirely believable.

It is significant that counsel for Dr. Warraich did not object to the admissibility of Dr. Scurfield’s report, or to her qualifications as an expert in family medicine, or to any aspect of her testimony at the hearing. Therefore, the arguments made on behalf of Dr. Warraich relating to a lack of impartiality and independence, and of potential bias on the part of Dr. Scurfield, are arguments relating to the weight which ought to be given to Dr. Scurfield’s evidence, not to its admissibility. Accordingly, if the Panel concludes that Dr. Scurfield lacked impartiality or independence, or that she was biased, her evidence will not necessarily be rejected in its entirety. However, such a conclusion will impact the Panel’s assessment of her evidence, and the reliance to be placed on her evidence, particularly in the context of a comparative assessment between her evidence, and the evidence of Dr. Reynolds, who provided opinion evidence on behalf of Dr. Warraich.

The Panel acknowledges that some of the criticisms of Dr. Scurfield’s evidence are legitimate. Her past audits of Dr. Warraich’s practice which were critical of his charting practices, raise questions about her impartiality. This is particularly so, given Dr. Scurfield’s conclusions relating to the audit she performed with respect to the matters

referred to in Count 1 of the Amended Notice of Inquiry. The frequency with which she has performed audits for the Investigation Committee over many years, also raises questions with respect to her independence. That is not to suggest that the Investigation Committee should not to utilize Dr. Scurfield's skills and experience as an auditor, but it will affect her independence as an expert and must be factored into a comparative assessment of her opinion in relation to that of another expert, expressing a differing opinion.

In this case, the Panel has concluded that these issues should not result in an outright rejection of Dr. Scurfield's opinions, because her opinions, and the analysis supporting those opinions, may be sound. Nonetheless, issues relating to her potential lack of impartiality and independence and her potential bias are factors which the Committee has taken into account in its overall assessment of her evidence in these proceedings.

3. Did the Investigation Committee utilize an improper standard when assessing the care being provided by Dr. Warraich to Patient 1, namely a standard of "not documented, not done"?

Dr. Warraich's counsel, in their written submissions, made two arguments in relation to this issue.

Firstly, the College has standards with respect to recordkeeping. However, the current Standards of Practice with respect to recordkeeping do not require that everything must be documented. There is no standard or policy which stipulates "not documented, not done" is the standard by which a physician is to be assessed. Moreover, courts have not imposed or set that standard in assessing physician conduct (see *Cameron (Litigation Guardian of) v. Louden, 2000 CarswellOnt 786*).

Secondly, Dr. Scurfield approached her review of Dr. Warraich's charts relating to Patient 1 in the manner of an audit with the direction "not documented, not done" as part of her assessment. Counsel for Dr. Warraich referred to the cross-

examination of Dr. Scurfield in support of the argument that Dr. Scurfield had adopted the standard of “not documented, not done” in arriving at her opinion with respect to the adequacy of Dr. Warraich’s management and treatment of Patient 1.

On the other hand, counsel for the Investigation Committee pointed out in their reply submissions, that in Dr. Scurfield’s cross-examination she was asked a series of questions relating to her role as an auditor [emphasis added]. In her cross-examination she did indicate that in relation to performing chart audits, she applied the standard of “not documented, not done” “for the most part”.

Counsel for the Investigation Committee correctly submitted that Dr. Scurfield did not acknowledge that she had adopted that standard in providing her opinion with respect to Dr. Warraich’s management and treatment of Patient 1.

The Panel recognizes that the standard of “not documented, not done” is not the standard by which Dr. Warraich’s management and treatment of Patient 1 is to be assessed. The Panel acknowledges that not every interaction between a physician and patient will be documented in a patient’s chart and not every thought or idea of a physician relating to diagnosis, testing or treatment, will always be documented.

Dr. Scurfield did not say, either in her report or in her testimony that she utilized a standard of “not documented, not done” in her assessment of Dr. Warraich’s management and treatment of Patient 1. Nonetheless, it was appropriate for counsel for Dr. Warraich to raise this issue, given Dr. Scurfield’s extensive experience as an auditor. By doing so, counsel for Dr. Warraich was effectively alerting the Panel to the possibility that the approach Dr. Scurfield usually adopts as an auditor may have influenced or informed her approach in providing her opinions with respect to Dr. Warraich’s management and treatment of Patient 1. Such a possibility has been considered by the Panel, and has been taken into account by the Panel in its consideration of Dr. Scurfield’s opinions.

4. What is the proper basis on which to assess whether or not a physician has committed professional misconduct or breached applicable standards of care?

Section 59.5 of *The Medical Act* states:

> "**Findings of Panel**
>
> 59.5 If, at the conclusion of a hearing, the panel finds that the member
>
> (a) is guilty of professional misconduct;
>
> (b) has contravened this Act, the regulations, the by-laws or the code of conduct of the college;
>
> (c) has been found guilty of an offence that is relevant to the member's suitability to practice;
>
> (d) has displayed a lack of knowledge of or a lack of skill or judgment in the practice of medicine;
>
> (e) has demonstrated an incapacity or unfitness to practice medicine;
>
> (f) is found to be suffering from an ailment that might, if the member continues to practice, constitute a danger to the public;
>
> it shall deal with the member in accordance with this Act."

The Panel has the jurisdiction to determine what conduct should or should not be subject to discipline.

Counsel for Dr. Warraich submits that the goal of public protection is clearly reflected in paragraphs 59.5(c), (e), and (f), and that the Panel ought to be guided by these same principles in findings under subparagraphs (b) and (d). Otherwise, any technical breach of the by-laws would be subject to discipline.

It is therefore Dr. Warraich's position that the Investigation Committee must establish on a balance of probabilities by evidence which is clear, convincing and cogent, for each of the allegations, that the care provided by Dr. Warraich:

- failed to meet the standard reasonably expected of the ordinary competent family medicine practitioner and/or hospitalist; and

- that such failure was so blatant or uncaring so as to justify the condemnation of the profession and thus equate to professional misconduct.

Counsel for the Investigation Committee strongly disagreed, and asserted that:

> "In essence, Dr. Warraich argues that to make a finding under any of the enumerated subsections at s.59.5 of the Act, the Panel should read into the very specific language of each and every enumerated finding that can give rise to an order under 59.6 an **additional** requirement involving "some quality of blatancy/some cavalier disregard for the patient and the patient's well being.
>
> . . .
>
> Dr. Warraich's suggested approach is fundamentally flawed and not consistent with the manner in which s.59.5 has been interpreted and applied."

In support of the Investigation Committee's position, counsel referred to and included in their Book of Authorities several cases in which inquiry panels had made findings of contraventions of s.59.5(b) and (d) based on a breach of a regulation or by-law or based on a lack of knowledge, without additional findings of blatancy or other findings equating to professional misconduct.

Based on the ordinary meaning of the words in s.59.5 of *The Medical Act*, and a review of the authorities submitted by the Investigation Committee, the Panel agrees with the Investigation Committee's submissions in paragraph 18 of their reply submissions, which stated:

> "To summarize:
>
> (a) subsection 59.5(b) is a finding available to the Panel if a contravention of the listed standards occurs on the facts of

> the matter. It would be incorrect to insert a prerequisite element that the contravention must be "blatant" or "cavalier". Whether the contravention can be described as blatant or cavalier is a consideration for the Panel when it determines if an order, or orders, under s.59.6(1) should be made at the second stage of the inquiry.
>
> (b) Respecting s.59.5(d) of the Act, the test related to the standard of care expected is described in the IC's Submission at paragraphs 21-26. The Panel must determine whether the deficiencies in the care provided by Dr. Warraich warrant a finding that he displayed a lack of skill, knowledge or judgment in the practice of medicine. . ."

Notwithstanding the foregoing, the Panel recognizes that a physician is not required to perform his or her professional services perfectly to meet an acceptable standard of care, and that not all errors or misjudgments by a physician will result in a finding against the physician pursuant to any of the subparagraphs in s.59.5 of *The Medical Act*.

The burden of proof in these proceedings is on the Investigation Committee and the standard of proof is on a balance of probabilities.

The Panel agrees with Dr. Warraich's submissions that:

> "A balance of probabilities means that the evidence is more likely than not to be true or accurate or prove the charge issued. How the panel reaches such a conclusion is based on its assessment of the evidence before it. The courts recognize (and emphasize) that the responsibility of the Panel is to carefully scrutinize the quality of evidence offered. Evidence to ground a conviction must always be sufficiently clear convincing and cogent to support the findings. Evidence that is equivocal is not enough to support a charge. This means that where there is evidence which is contradictory or which differs from one witness to another, the Panel must consider each piece of evidence in the totality to determine if the evidence meets the burden of proof on a balance of probabilities."

5. What is the proper approach to making the credibility assessments which will likely be necessary in this case?

This case presents at least three challenging credibility assessments to the Panel. They are:

(i) Whether Dr. Warraich's overall credibility is questionable given that his testimony at the hearing, particularly with respect to his interactions and communications with Patient 1 were considerably more detailed than his written reply dated June 8, 2018 and contained much more detail than outlined in the medical chart relating to Patient 1?

(ii) Should Dr. Warraich's evidence with respect to his communications with Patient 1 be accepted, given that Patient 1 was not called as a witness in the proceedings and has therefore not contradicted his evidence?

(iii) On what basis should the Panel resolve the stark differences between the evidence of Dr. Warraich and Patient 2 on the issue of whether Dr. Warraich ever physically examined Patient 2 during her hospital stay in May, 2015?

In making credibility assessments, the Panel has been made aware and has been mindful of two important judicial directions with respect to assessing credibility.

One is from the Supreme Court of Canada in *C.(R.) v. McDougall, 2008d S.C.C. 53:*

> ". . . where proof is on a balance of probabilities there is likewise no rule as to when inconsistencies in the evidence of a plaintiff will cause a trial judge to conclude that the plaintiff's evidence is not credible or reliable. The trial judge should not consider the plaintiff's evidence in isolation, but must look at the totality of the evidence to assess the impact of the

> inconsistencies in that evidence on questions of credibility and reliability pertaining to the core issue in the case."

The other is from the British Columbia Court of Appeal in *Faryna v. Chorny [1952] 2 D.L.R. 354*:

> "The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanor of the particular witness carried a conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions. . . ."

The Panel has been cognizant of those two judicial directions when undertaking the credibility assessments outlined below.

CONCLUSION AND DECISION

Count 2 in the Amended Notice of Inquiry

Count 2 contains three separate allegations against Dr. Warraich, namely that:

1. He failed to meet the standard of care in his management and treatment of Patient 1 by failing to adequately diagnose, manage and treat Patient 1's tuberculosis and congestive heart failure;

2. He failed to create and maintain adequate medical records in breach of By-Law 1 and By-Law 11 of the College, and/or;

3. He displayed a lack of knowledge, skill and judgment in the practice of medicine.

General Commentary

The Investigation Committee bears the onus of proving the above-noted allegations on the balance of probabilities, meaning that the Investigation Committee must introduce clear evidence establishing that it is more likely than not, that the above-noted allegations are true and correct.

The standard of care to which physicians are to be held is the standard reasonably expected of the ordinary, competent practitioner in the physician's field of practice, which in this case is the field of family medicine. A physician's conduct and decision making is not required to be perfect in order to comply with applicable standards. The applicable standard may be established by way of the evidence of experts, or by way of specific Standards, or other types of notices or bulletins published by the College.

It is noteworthy that Count 2 does not allege that Dr. Warraich engaged in professional misconduct. One frequently cited and venerable definition of professional misconduct is contained in *Davidson v. Royal College of Dental Surgeons of Ontario 1925 CarswellOnt 254 (C.A.)*, wherein the Ontario Court of Appeal stated:

> "If it is [shown] that a member of the college in the pursuit of [their] profession has done something with respect to which it would be reasonably regarded as improper by [their] professional colleagues of good repute and competency, then it is open to the board of directors of the college to decide that [they have] been guilty of improper conduct in a professional respect."

An updated articulation of the test for professional misconduct is outlined in *Strother v. Law Society of British Columbia, 2018 BCCA 481, 2018 CarswellBC 3465*:

> ". . .a hearing panel will consider whether the lawyer's conduct was a marked departure from the conduct expected of lawyers. Put another way, the lawyer's conduct must display culpability of a gross or aggravated nature, rather than a mere failure to exercise ordinary care."

Since Count 2 does not allege professional misconduct against Dr. Warraich, it is not necessary that the Investigation Committee prove culpability of a

gross or aggravated nature against Dr. Warraich in relation to his diagnosis, management and treatment of Patient 1's tuberculosis or congestive heart failure or in relation to the creation and maintenance of his medical records relating to Patient 1. As noted earlier in these Reasons, it is also not necessary for the Investigation Committee to prove that there was a "blatant" or "cavalier" element to a contravention of a particular professional standard.

Dr. Warraich's diagnosis, management and treatment of Patient 1's tuberculosis

In assessing Dr. Warraich's diagnosis, management and treatment of Patient 1's tuberculosis, it is necessary to consider and comment upon the Investigation Committee's submissions that significant portions of Dr. Warraich's testimony lacked credibility. In the Investigation Committee's written submissions dated February 24, 2020, counsel for the Investigation Committee stated at page 19, paragraph 39:

> "To summarize, the IC submits that Dr. Warraich is not a credible or reliable witness by any standard. The quality of his evidence as compared to the testimony of the witnesses called by the IC, the inconsistency and evasiveness with which he testified and his inability to accept responsibility for his actions all support this conclusion. As will be detailed in this submission, not only was Dr. Warraich's evidence inconsistent with other witnesses, his own account of his care and conduct was inconsistent over time. He frequently testified in a manner that was both self-serving and dramatically overstated. In addition, Dr. Warraich's evidence was not accurate with respect to many of the most important controversial facts underlying the allegations against him in the Notice of Inquiry. . ."

Among the many criticisms of Dr. Warraich's credibility made by the Investigation Committee, two general criticisms stand out as being particularly significant.

Firstly, the Investigation Committee emphasized the contrast between Dr. Warraich's relatively brief written reply dated June 8th, 2018 to the College's initial inquiries about his care and management of Patient 1, and his detailed testimony at the hearing, expanding on almost all of the notations in his medical record relating to Patient 1 from November 2017 to mid-May 2018. The Investigation Committee also stressed that

his testimony at the hearing was considerably more elaborate and contained more exculpatory information than was included in the Statement of Agreed Facts (a document into which his lawyers had input) or had been mentioned in Dr. Reynold's expert report. The Investigation Committee suggests that the truthfulness and accuracy of much of his testimony must be regarded very skeptically because the information on which his testimony was based had apparently not been shared at an earlier stage of the proceedings with his lawyers, or the expert who testified on his behalf, and had certainly not been shared with the College.

In the Investigation Committee's initial written submission, they specifically stated that:

> "45. To be clear, at no time prior to Dr. Warraich's testifying on January 16, 2020 did Dr. Warraich defend his care by advising of any other efforts on his part to rule out the TB after he became aware of the results of the x-ray, which he described in his oral testimony, either directly or through his legal counsel.
>
> 46. Based on Dr. Warraich's testimony on January 16 and 17, 2020, he now appears to be asserting that he did much more than what he previously described to even his own expert witness. In fact, he now described efforts he made that would suggest, from his point of view, that he went above and beyond for this patient in a manner which he appears to suggest exceeds the standard. . . ."

Secondly, the Investigation Committee disapproved of Dr. Warraich's decision to testify as the last witness in his own defence, suggesting that he had made that choice in order to have the benefit of hearing the testimony of most of the other witnesses in order to craft and adapt his evidence in a way which would be most beneficial to himself.

In addition to those two general criticisms, the Investigation Committee's written submissions contained many specific references to Dr. Warraich's testimony which the Investigation Committee submitted were questionable.

Two specific examples are illustrative.

On January 1, 2018, Patient 1 saw Dr. Warraich; this was one month after Dr. Warraich had become aware of the concerning x-ray result which identified the possibility of tuberculosis. In Dr. Warraich's letter to the College dated June 8, 2018, his only specific reference to the January 1, 2018 visit was: ". . . .On January 1, 2018, the patient returned for a follow up on her diabetes. I asked for a repeat chest x-ray at that time to follow up on the chest x-ray. . .".

Based on her review of the medical records and Dr. Warraich's letter of January 8, 2018, Dr. Scurfield stated in her report:

> "January 1, 2018 - In-person appointment which was focused on her diabetes management. There is one line "has symptoms like SOB, Cough, H\O pneumonia and known asthma was better when on levofloxacin. . .
>
> Her pulse is 103. BP 160\101. His exam states she has a clear chest on auscultation. This is surprising considering the chest x-rays both before and after this date. There does not appear to have been discussion about whether she had done the sputum testing or if there was some difficulty with her doing this. . ."

The Statement of Agreed Facts referenced the January 1, 2018 visit, but nothing was included in that Statement about Dr. Warraich discussing the AFB sputum testing or following up on ruling out TB.

However, in Dr. Warraich's direct examination at the hearing, he testified that he had a discussion on January 1, 2018 with Patient 1 about the sputum testing. His answers to his counsel's question about whether he had a discussion with the patient about the problems that she might have as a result of the initial x-ray, including TB were:

> "**Dr. Warraich:** Yes. They said they have done. I said, okay, so I'm waiting for result. As soon as result will come, I will talk to you. And she said she had no cough anymore. Off and on just she had a cough. So I said, okay, let us do another x-ray.

> So I also advised to this x-ray quickly, don't put for later date. So she was agreed to do x-ray."

In cross-examination, Dr. Warraich testified as follows:

> "**Question:** Okay. So you weren't concerned as time went on and you hadn't had this test back that. . .
>
> **Dr. Warraich:** I was waiting and then, you know, then I follow up. I did this x-ray.
>
> **Question:** Yes?
>
> **Dr. Warraich:** I gave the requisition, follow up what happened, because first chest x-ray shows so many things, okay?
>
> **Question:** Yes?
>
> **Dr. Warraich:** And then I give the following x-ray, and following x-ray is, you know, not clear. And then I was still waiting that this test is done. I was waiting for the test you know, because, you know.
>
> **Question:** All the while considering that she might have tuberculosis?
>
> **Dr. Warraich:** Yes, because, you know, that's why I did the test and I went - I did the test and I was waiting for the test result, you know. . ."

The foregoing evidence resulted in the Investigation Committee submitting that:

> ". . .Dr. Warraich's inconsistent and self-serving descriptions as to the conversations he had and that he was still actively thinking about the potential TB diagnosis do not ring true. In addition, his earlier portrayal of Patient 1 as habitually non-compliant is not consistent with his assertion that she was a nice lady and there was no reason to doubt her assertion that the test had been done. When no result was received he was content to simply wait. It is far more likely that his intention to rule out TB with the AFB sputum test had been lost to follow up by the time Patient 1 attended on January 1. . ."

A second specific example relates to Patient 1's attendances on February 4, 2018, with respect to a complaint of a cough and the results of the second x-ray.

In Dr. Scurfield's report, she commented as follows:

> "February 4, 2018 - he received her follow up chest x-ray from January 26 and requested that she be contacted to come for a follow up appointment. This request was made on January 29, 2018. She came on February 4, 2018. This long note is identical to the one on November 24, 2017 other than the Reason for visit and the first line of the "HOPt." otherwise it is identical including the diagnosis of Acute Chronic Bronchitis which is clearly not her diagnosis considering the significant abnormalities and deteriorating picture on her chest x-ray. It would be usual practice to review the chest x-ray from December 1 which should trigger questions about what happened with the sputum samples for AFB. . .
>
> . . .Once again there were not any questions about the sputum samples. This would have been another opportunity to speak to respirology."

The Statement of Agreed Facts included a similar summary of that visit and did not include anything about the AFB sputum testing or following up on ruling out TB.

In his direct examination, Dr. Warraich testified that, on February 4, he talked to Patient 1 about the second x-ray and the sputum test for diabetes:

> "**Dr. Warraich:** We are waiting, still waiting, because she said they have, she has done it, that one. But I said now we need to do CT scan just to make sure, because these two x-rays is confusing. One says something different, second ray after one month saying different. So in my opinion, if this was a TB diagnosis, so it could get worse if nothing, treatment had not been started, but now the radiologist comparing x-ray December 1 and January 26 and he is not mentioning anything except the nodules, which, you know, need to go for CT scan. . .
>
> **Dr. Warraich:** Yes, I was still waiting. I was still waiting because, honestly, I talked to them, I said, you know guys, you didn't do the sputum test both times. They said, we did. Still they said they did. You know, it is very sad story, but I

> cannot, you know, argue with them that it is not done. But if they know best, you know. I cannot comment on it.
>
> But, you know, that's like, it is a further, but, to me, I'm still waiting for that sputum. It is not being ruled out first, you know, issue, you know. . ."

There is no description of the patient's cough in the medical record made by Dr. Warraich for the February 4 visit. However, in cross-examination, he testified her cough was mild and mostly dry, and that it was not worsening.

As a result of the foregoing, the Investigation Committee submitted:

> ". . .that neither of the conversations described in the preceding two paragraphs occurred as described by Dr. Warraich. The exchange about Patient 1's cough on February 4 is yet another example of Dr. Warraich testifying as to a specific detail about the patient's symptoms on a specific visit over a year earlier and providing an answer that is favourable to his position without any documentation or other corroboration. Similarly the IC submits that Dr. Warraich neither reminded Patient 1 about the sputum testing nor did she tell him she had done it on that date."

Dr. Warraich's counsel put forward an entirely different assessment of his credibility. They argued that Dr. Warraich's detailed testimony during the hearing compared to his relatively brief letter dated June 8, 2018, can be explained by Dr. Warraich's understanding that the College's initial inquiry was narrow and focussed on his response to the December 1, 2017 DI report. Therefore, his response was limited and did not deal with all of his interactions with Patient 1 from late November 2017 to May 2018, or to the allegations which subsequently were made relating to congestive heart failure.

Counsel for Dr. Warraich also argued that, although his evidence at the hearing was considerably more detailed than his June 8, 2018 letter, his evidence was nonetheless consistent with the content of the integrated chart notes. Significantly, counsel also argued that there is no evidence before the Panel which contradicts Dr. Warraich's testimony and therefore Dr. Warraich's must be accepted because there is no contrary evidence available to the Panel.

In that context, Dr. Warraich's counsel asserted that because Patient 1 was not called to testify, there is a very significant evidentiary gap in the Investigation Committee's case. In the absence of evidence from Patient 1 denying the conversations which Dr. Warraich says he had with her, or providing an alternate version of those conversations, the Panel has no basis for disbelieving Dr. Warraich and no evidentiary foundation on which to make factual findings which contradict his evidence.

The evidentiary disputes in this case are both significant and substantial. There are some important counterpoints to Dr. Warraich's submissions.

It is not correct to say there is no evidence contrary to Dr. Warraich's testimony. The medical records available to the Panel, consisting of almost 60 pages, arguably constitute such evidence, both in terms of what those records actually contain (i.e. how they ought to be reasonably interpreted in the context of all of the evidence), and what they do not contain, i.e. the lack of information contained in the records.

A lack of information in the medical records is significant in two respects.

Firstly, it is not logical to allow Dr. Warraich to take advantage of use his own deficient charting practices (i.e. the absence of certain information from the medical records) to defend himself against allegations that he failed to diagnose and to properly manage and treat Patient 1's tuberculosis. Secondly, the case of *Skeels Estate v. Iwashkiw, 2006 ABQB 335*, provides useful guidance with respect to how an inquiry panel should assess charting deficiencies when assessing the care provided by a physician. In that case, the Alberta Court of Queen's Bench wrote:

> "110 This case raises concern about the quality of note taking and chart recording; and, where the outcome was so bad, the lack of notes is not reassuring. . .
>
> 111 In this particular case there is no substantive charting of the medical procedures undertaken from 18:30 until 20:00, when Dr. Morrison was called by hospital staff to resuscitate the child. . .
>
> 112 The lack of charting does not necessarily mean that procedures were not conducted, nor is the mere lack of

> charting prima facie evidence of negligence in the treatment. However, the lack of charting makes it more difficult for a court to determine matters of credibility where individuals who are trained to chart, did not do so. This failing, despite the opportunity to do so, makes it harder for a court to accept that the correct steps were followed and appropriate procedures were done as it would have been logical for them to be recorded had they been done. . .
>
> 126 The failure to chart when there is a legal or established hospital practice duty to do so is a breach of the standard of care. Equally important, it removes from the Court, another piece of evidence that may be used to explain or understand what happened. . .
>
> 127 I must also assess credibility when there is a clear, detailed and comprehensive note, which is then amplified in court by the witness who wrote the note. Where a chart entry is detailed and made contemporaneously with the procedure, evidence given at trial under oath that provides an additional element, not present in the chart, is difficult to accept . . .
>
> 139 On the witness stand Dr. Iwashkiw's description of the steps he took represented a model of specialized care. Nobody knows the procedures followed by the doctor better than he does, yet he elected not to chart those procedures, and took 11 months to collect his thoughts to complete his final discharge summaries. His failure to properly chart his observations, the steps taken, the length of the emergency, the details of his intubation efforts and who did what, all make it difficult to accept his assertion that he did the right things. . .

Similar factors are present in this case. Those difficulties are further compounded because, in the absence of information in the chart, Dr. Warraich did not testify, as might have been expected, on the basis of his usual practice. Instead, he was insistent that he had a clear specific recollection of his numerous encounters with Patient 1 between November 2017 and May 2018. Those recollections included the conclusions he reached after his various examinations of Patient 1 and the topics which he discussed with Patient 1 on each visit, in spite of most of those things not being contained in the records.

The Panel has therefore concluded that the medical records relating to Patient 1 constitute evidence which can be used to assess the veracity of Dr. Warraich's testimony and to support factual findings which contradict Dr. Warraich's evidence.

Furthermore, there is also another source of evidence contrary to that of Dr. Warraich, namely the expert opinions of Dr. Scurfield, both in her report dated January 10, 2019 and as expressed in her testimony.

Expert evidence relating to Dr. Warraich's diagnosis, management and treatment of Patient 1's tuberculosis

As noted earlier in these Reasons, there have been legitimate criticisms made relating to Dr. Scurfield's lack of impartiality and independence, which the Panel has recognized.

Dr. Warraich's counsel also emphasized the significance of an acknowledgement made by Dr. Scurfield in her cross-examination, namely that the Manitoba Tuberculosis Protocol does not require a family physician to consult with a respirologist upon becoming aware of the possibility of tuberculosis. According to Dr. Warraich's counsel, that acknowledgement was very important because:

(i) Dr. Scurfield's opined that Dr. Warraich ought to have consulted with a respirologist;

(ii) the Manitoba Tuberculosis Protocol can be regarded as a standard to which family physicians should refer for guidance and direction. However, Dr. Scutfield's opinion effectively requires that a physician do more than is required by the Protocol. Therefore, Dr. Warraich's counsel argued that Dr. Scurfield's opinion is not reflective of the standard currently prevailing in Manitoba with respect to the diagnosis and management of tuberculosis.

A few comments about the Manitoba Tuberculosis Protocol are warranted. The Protocol was not entered into evidence in the proceedings. Instead it was briefly referenced in the cross-examination of Dr. Scurfield. The Protocol was not proven to be a "Standard" of the medical profession in Manitoba to which competent family physicians

are required to comply. It was not issued by the College. It is a publication of the Government of Manitoba as part of the Communicable Disease Management Protocol, likely intended for physicians and others in the healthcare field, such as health administrators and public health nurses and other practitioners.

Therefore, although the Protocol is a very valuable reference, it is not the "Standard" of the medical profession which defines the responsibilities of a family physician in Manitoba with respect to the diagnosis, management, and treatment of tuberculosis. In the absence of a specific published "Standard", the standard to which family practitioners in Manitoba are required to comply with respect to those matters, may be established by expert evidence. The Investigation Committee sought to do so through the evidence of Dr. Scurfield.

Notwithstanding the legitimacy of some of the criticisms of Dr. Scurfield's opinions on the basis of a lack of impartiality and/or independence, the medical members of the Panel have concluded that Dr. Scurfield's description and explanation of the responsibilities of a reasonably competent family physician with respect to the diagnosis, management and treatment of tuberculosis, were reasonable and her description and explanation accurately reflected the standard which currently applies with respect to those in Manitoba.

Dr. Scurfield did not articulate an excessively high standard; she did not expect the ordinary family physician to have specialized knowledge of tuberculosis. She did however opine that family physicians should understand that the disease is highly infectious and potentially very serious. Given those factors, she also opined that family physicians must recognize the necessity of continually advising potentially affected patients of the seriousness and urgency of these matters. Furthermore, family physicians must also recognize the necessity of seeking out assistance and information from more knowledgeable sources, such as a respirologist. There are other sources from which a family physician can obtain useful information relating to tuberculosis, including Manitoba Health and the offices of the Chief Provincial Public Health Officer.

One other issue relating to the Manitoba Tuberculosis Protocol, which also arose during Dr. Scurfield's cross-examination, warrants comment. Counsel for Dr. Warraich pointed out, and Dr. Scurfield acknowledged, that a reporting obligation under the Protocol on the part of a family physician, does not arise until the diagnosis of the disease has been confirmed. No diagnosis was confirmed in this case until mid-March 2018, once a respirologist had become involved.

However, an argument based on that proposition is not an answer to Count 2, which includes an allegation that Dr. Warraich failed to diagnose and manage Patient 1's conditions. Dr. Warraich had been made aware of the possibility of tuberculosis on December 1, 2017, and a failure to diagnose and manage would include issues relating to not following up on the sputum test results and any shortcomings in Dr. Warraich's interactions with Patient 1 relating to the possibility of tuberculosis prior to the date of the diagnosis being confirmed.

The Panel therefore accepts Dr. Scurfield's evidence with respect to her definition of the professional standard in Manitoba applicable to family physicians in relation to the diagnosis, management and treatment of tuberculosis. Specifically, the Panel accepts Dr. Scurfield's opinions that:

> "Once the word tuberculosis is mentioned in the first chest x-ray a whole string of events should have taken place that did not. This is important not only to the management of the patient's health but also to protect the public . . . An urgent process to rule out tuberculosis should have been put into place considering the impact of her continuing on with potentially untreated tuberculosis. The sputum should have been done and followed up with. He should have consulted urgently with respiratory by phone to ensure that he was following protocol with respect to her immediate care as it does not appear he knew what to do in this case.
>
> He does not appear to have a process that keeps track of tests that were ordered, and no results have been returned . . . It should have been possible for him to realize that she did not have sputum results back and follow that up in a short period of time.

> As well he does not take the opportunity to follow up appropriately with respect to ongoing diagnoses at subsequent visits . . .”

The decision as to whether or not to accept Dr. Scurfield’s opinion that Dr. Warraich breached that standard, must consider Dr. Reynold’s contrary opinion.

There were several important features of Dr. Reynolds’ report dated May 28, 2019, and his testimony at the hearing. Those features included, but were not limited to:

(i) his opinion that Patient 1’s case was complicated, involving multiple conditions, including tuberculosis (a disease which is relatively rare in urban Manitoba), challenging and unusual x-ray and CT results, and a patient who was not particularly unwell upon initial presentation and who, at times, appeared to be improving. Given those factors, Dr. Reynolds’ opined that Dr. Warraich’s diagnosis, management and treatment of Patient 1’s tuberculosis were acceptable;

(ii) there were systemic issues present in this case, which Dr. Reynolds thought were more important than issues relating to the individual responsibility of Dr. Warraich; and

(iii) Dr. Reynolds acknowledged that Dr. Warraich’s record keeping with respect to Patient 1 was not acceptable.

There is much to commend in Dr. Reynolds’ analysis. Unlike Dr. Scurfield, there are no factors undermining his impartiality or independence. The Panel accepts that Dr. Reynolds was unbiased.

When coupled with the evidence of Ms Gill and Dr. Warraich, Dr. Reynolds’ conclusion that Dr. Warraich’s initial responses to the concerning DI Report of December 1, 2017 (including Dr. Warraich’s multiple efforts to contact Patient 1, opening the clinic on a Sunday, December 3, requisitioning a sputum sample and providing a sick note to allow Patient 1 to take time off work to obtain the sample) were reasonable.

Dr. Reynolds' conclusion on those matters is accepted by the Panel. The Panel recognizes that the above-noted efforts establish that, upon receipt of the DI Report of December 1, 2017, Dr. Warraich recognized the seriousness of the situation and reacted appropriately up to, and including, December 6, 2017.

Dr. Reynolds' conclusion that the balance of Dr. Warraich's management and treatment of Patient 1's tuberculosis from and after December 6, 2017 met the applicable standard, will be commented on more fully below.

With respect to Dr. Reynolds' position that systemic problems were present in this case, thereby lessening Dr. Warraich's individual responsibilities, the Panel believes that position presents a false dichotomy.

Undoubtedly, the diagnosis and treatment of a communicable disease like tuberculosis involves several components of the health care system. Any analysis relating to an unacceptable outcome of a particular case should involve an examination of potential systemic shortcomings. However, the possibility that systemic issues may have contributed to the delay in the diagnosis and treatment of Patient 1, does not provide Dr. Warraich with a defence to the allegations in Count 2 of the Amended Notice of Inquiry. Dr. Reynolds did not particularize or elaborate upon the systemic shortcomings to which he was referring. Furthermore, family physicians such as Dr. Warraich, are an integral part of the health care system's response to communicable diseases. Significantly, a major part of the College's mandate is the protection of the public. One of the ways in which the College fulfills its mandate to protect the public is to ensure that individual physicians comply with the standards of the profession.

The responsibility of the Panel is to determine whether Dr. Warraich breached those standards, as more particularized in Count 2, even if systemic problems may also have been present.

Some of the allegations against Dr. Warraich in Count 2, relate to the failure to create and maintain adequate medical records in breach of By-Law 1 and By-Law 11 of the College's By-Laws. Those allegations have undoubtedly been proven with respect

to both the tuberculosis and congestive heart failure issues. The deficiencies in the medical records relating to Patient 1 have been outlined in detail by Dr. Scurfield, acknowledged by Dr. Reynolds, and effectively admitted by Dr. Warraich. The Panel therefore finds Dr. Warraich guilty of breaching both By-Law 1 and By-Law 11 of the College's By-Laws.

The issue of whether or not Dr. Warraich failed to adequately diagnose, manage and treat Patient 1's tuberculosis is considerably more challenging. To reach its conclusion on that issue, the Panel was required to review the Statement of Agreed Facts, read and interpret the medical records relating to Patient 1, all within the context of the expert evidence of Dr. Reynolds and Dr. Scurfield, and the factual evidence of Ms Gil and Dr. Warraich.

The Panel has concluded that the allegation that Dr. Warraich failed to adequately diagnose, manage and treat Patient 1's tuberculosis has been proven on a balance of probabilities.

In reaching this conclusion, the Panel recognizes that Dr. Warraich's initial response to the DI Report of December 2, 2017, and his actions up to and including December 6, 2017, were acceptable. The Panel also recognizes that neither the report from the January 26, 2018 x-ray nor the results of the February 28, 2018 CT scan mentioned tuberculosis, but raised other issues of concern. The Panel also recognizes that Patient 1's various clinical presentations were variable and potentially confounding.

However, on the basis of the Panel's review of all of the evidence, the Panel has concluded that Dr. Warraich failed to adequately diagnose, manage and treat Patient 1's tuberculosis from and after December 6, 2017. The basis for the Panel's conclusion consists of three constituent elements, which are outlined below:

1. The Statement of Agreed Facts, into which Dr. Warraich's lawyers had input, contained several examples of a lack of follow-up on the sputum samples. The Statement of Agreed Facts also referred to Dr. Warraich paying attention to other conditions such as diabetes, asthma, and

hypertension, while not adequately addressing the serious risk that Patient 1 was suffering from tuberculosis.

2. Many of Dr. Scurfield's opinions, based on her thorough review and analysis of the medical records relating to Patient 1, are logical and persuasive. The Panel specifically accepts her opinions that:

- "An urgent process to rule out tuberculosis should have been put into place considering the impact of Patient 1 continuing on with potentially untreated tuberculosis. The results of the sputum test should have been diligently pursued. Dr. Warraich should have consulted urgently with a respirologist or other knowledgeable person or organization to ensure he was following accepted procedure with respect to her immediate care."

- Dr. Warraich did not appear to use (and the Panel notes was unable when pressed in cross-examination to describe) any process to keep track of tests which were ordered with no results returned. It is the responsibility of the physician to ensure that he or she has a system to follow up on tests that have been ordered. Dr. Warraich should have realized in a timely way that he had not received the results of the sputum test.

- Dr. Warraich did not take the opportunity to follow-up appropriately with respect to ongoing diagnoses at subsequent visits.

- "Dr. Warraich was not gathering the necessary data nor synthesizing the data he did gather to consistently make plausible working diagnoses and plans for testing and treatment. For example, stating someone has controlled diabetes when their bloodwork does not support this, or saying they have acute chronic bronchitis when it is clear from an x-ray that is not correct, illustrates a disconnection

between the data being collected and the formulation of a reasonable diagnosis."

3. Much of Dr. Warraich's evidence given at the hearing has been rejected by the Panel as not being credible or reliable. This is particularly so in relation to matters on which Dr. Warraich provided much more detailed information than he provided in either his written reply dated June 8, 2018, or was included in the Statement of Agreed Facts.

   Examples of portions of Dr. Warraich's evidence which the Panel has concluded were not credible or reliable have been provided earlier in these Reasons with respect to interactions with Patient 1, occurring on January 1, 2018 and February 4, 2018.

   In addition, the Panel was dissatisfied with Dr. Warraich's evidence relating to:

   (i) His attempts to bring forward information helpful to himself, which he apparently had not earlier provided to either his own lawyers (when they were considering and reviewing the Statement of Agreed Facts), or to Dr. Reynolds (when he was formulating his opinions in support of Dr. Warraich's position in these proceedings); and

   (ii) Dr. Warraich's self-serving insistence that he could remember specific details of his examinations of Patient 1, his thought processes relating to his diagnosis and treatment of Patient 1's multiple conditions and his conversations with her, when those matters were not referred to in his medical records. The Panel does not accept that his memory going back to the 2017-2018 time period can be that precise given the number of patient interactions he would have had in the intervening period.

Based on the foregoing three factors, namely the Statement of Agreed Facts, Dr. Scurfield's opinion, and the Panel's assessment that Dr. Warraich's own

evidence is neither credible nor reliable, the Panel has concluded that notwithstanding the absence of evidence from Patient 1, there are compelling grounds to make factual findings which are adverse to Dr. Warraich.

In the result, the Panel finds that Dr. Warraich failed to meet the standard of care in his management and treatment of Patient 1, in that he failed to adequately diagnose, manage and treat Patient 1's tuberculosis.

With respect to the further allegation in Count 2 that he displayed a lack of knowledge, skill and/or judgment of the practice of medicine in relation to Patient 1's tuberculosis, the Panel has concluded that the allegation has not been proven on a balance of probabilities.

Tuberculosis is a relatively rare disease in urban Manitoba. There were complexities in this case as described elsewhere in these Reasons. It would therefore be unfair and unreasonable to conclude that the deficiencies in Dr. Warraich's management and treatment of Patient 1 were so deficient that they reflect a lack of knowledge, skill or judgment in the practice of medicine.

Dr. Warraich's diagnosis, management and treatment of Patient 1's congestive heart failure

The Investigation Committee's case against Dr. Warraich in relation to congestive heart failure is based, in part, on his awareness from January 1, 2018 onwards of signs and symptoms which were consistent with the ultimate diagnosis of congestive heart failure, and the allegations that those symptoms were not adequately assessed, followed-up on, or investigated.

In Dr. Scurfield's report, she refers to Dr. Warraich's notations in Patient 1's medical records relating to leg edema, elevated resting pulse rate and elevated blood pressure on January 1, 2018 and January 9, 2018, and swelling in both legs and leg edema on March 27, 2018. Dr. Scurfield explained that such symptoms give rise to several serious possibilities, including a pulmonary embolism and/or heart failure.

As a result, Dr. Scurfield was critical of Dr. Warraich for not asking more questions and including much more detailed information about those symptoms in the medical record. Similarly, she was very critical of Dr. Warraich for not pursuing and adequately following up on those issues during the January to March 2018 time period.

Dr. Reynolds, in his report and in his testimony, pointed out that neither of the x-rays nor the CT scan suggested congestive heart failure.

The Investigation Committee's position relating to the allegations with respect to congestive heart failure were summarized in paragraphs 154 and 155 of their initial written submission:

> "154. The IC submits that the concerns about Dr. Warraich's failure to adequately diagnose, manage and treat Patient 1's congestive heart failure must not only be considered in relation to the diagnostic imaging as suggested by Dr. Warraich and Dr. Reynolds, but rather by considering his assessments and plan from about January 1, 2018 when he first documented "leg edema+" onward. The deficiencies in his care and management escalated as Patient 1 continued to present with persistent dyspnea and increasing leg edema such that she eventually could not ambulate when she was seen on March 27. He did not adequately address the etiology. Another physician assessed her only several weeks after Dr. Warraich and recognized congestive heart failure, later shown to be secondary to cardiomyopathy.
>
> 155. The IC further submits that Dr. Warraich did not adequately assess Patient 1 on the numerous occasions up to and including shortly before she was diagnosed with congestive heart failure by another physician; and that he did not meet the standard of care and demonstrated a lack of care, skill and judgment in his approach to Patient 1's care and management of the signs and symptoms that led to her diagnosis of congestive heart failure."

Dr. Warraich's counsel responded by relying on Dr. Reynolds' statements that leg edema, on its own, is not a strong indicator of heart failure and also emphasized that the two x-rays and the CT scan were not suggestive of congestive heart failure. In addition, Patient 1's clinical presentation was variable and the ultimate diagnosis of congestive heart failure was made several weeks after specialists had become involved

in her treatment, indicating that the diagnosis was not self-evident and that further investigations and/or analysis were required before the diagnosis could be made.

Dr. Warraich and his counsel also suggested that the cause of the heart failure may have been related to the medication she was receiving to treat her tuberculosis. However, that proposition was not supported by any expert opinion and, therefore, has not been accepted or relied upon by the Panel in its consideration of Dr. Warraich's diagnosis and management of Patient 1's heart issues.

The numerous deficiencies and inadequacies in Dr. Warraich's records relating to Patient 1 with respect to leg edema and the paucity of information in the records relating to follow up on the possibility of serious underlying heart issues, clearly establish that Dr. Warraich failed to create and maintain adequate medical records and breached the recordkeeping requirements of By-Law 1 and By-Law 11 of the College in relation to the congestive heart failure issues. As noted earlier, the Panel finds Dr. Warraich guilty of breaching By-Law 1 and By-Law 11 of the College's By-Laws.

However, the allegations in Count 2, that he failed to meet an acceptable standard of care in the management and treatment of Patient 1's congestive heart failure, and that he displayed a lack of knowledge, skill or judgment in the practice of medicine in relation to the congestive heart failure issues, have not been proven.

Although Dr. Warraich did not meet a "gold standard" with respect to the diagnosis, management and treatment of Patient 1's congestive heart issues, the patient's presentation was complex. Although the x-ray and CT results were concerning for various reasons, they were not specifically suggestive of heart failure. Dr. Warraich ultimately made appropriate referrals to specialists and those referrals contributed to positive results in relation to Patient 1's treatment.

Therefore, the charges in Count 2 alleging that Dr. Warraich failed to meet an acceptable standard of care in the management and treatment of Patient 1's congestive heart failure and that he displayed a lack of knowledge, skill or judgment in the practice of medicine, are dismissed.

Count 3 in the Amended Notice of Inquiry

Count 3 contains three specific factual allegations against Dr. Warraich in his capacity as a hospitalist, namely that he:

(i) failed to examine or assess Patient 2 when she was first admitted to the Seven Oaks General Hospital (the "Hospital") in May 2015;

(ii) failed to adequately monitor and assess Patient 2 while she was under his care in the Hospital and failed to consider additional information and to revisit a presumptive diagnosis; and

(iii) documented a complete physical examination of Patient 2 as part of her admission history, when he did not physically examine Patient 2 on admission, or at all.

On the basis of those factual allegations, the Investigation Committee submits that Dr. Warraich displayed a lack of knowledge, skill and/or judgment in the practice of medicine, that he created false and/or misleading medical records in breach of By-Law 1 of the College and that he committed acts of professional misconduct.

To determine whether or not the allegations in Count 3 have been proven, the Panel considered whether:

(i) Dr. Warraich conducted a proper assessment, including a physical examination of Patient 2 when she was admitted to the Hospital under his care on May 7, 2015; and

(ii) Dr. Warraich adequately monitored and assessed Patient 2 while she was in the Hospital between May 7 and May 15, 2015, including monitoring her clinical course, and conducting appropriate physical examinations.

The only expert evidence available to assist the Panel in its deliberations with respect to the Count 3, was the evidence of Dr. Jawanda, who was called on behalf of the Investigation Committee.

Dr. Jawanda's report dated January 2, 2019 contained criticisms of Dr. Warraich's documentation. Specifically, Dr. Jawanda's report stated:

> "(i) *Patient Assessment*. Dr. Warraich's documentation is limited in detail during each day of Patient 2's admission after his Admission History and Physical on May 8, 2015. There is no clear documentation of subjective complaints or physical examinations performed from May 9 to 15, 2015 during each day of the hospital stay. The medical record does not support that appropriate physical assessments were performed. Further, there is no documentation for May 14.
>
> . . .
>
> (v) *Documentation*. Dr. Warraich's documentation allows me to understand the treatment plan as a whole during the admission, however does not appropriately address specific clinical assessments in terms of subjective complaints and objective findings during daily rounds. I can appreciate the complicating and confounding features of Patient 2's admission including her previous multi-drug resistant positive urine culture and duration of symptoms, with subsequent pneumonia in hospital. However clear documentation of patient improvement/decline, physical examination findings, or differential diagnoses would be appropriate and helpful in this setting.
>
> . . .However, his documentation in the medical record is deficient and does not meet standard of care. Clear documentation of daily rounds including subjective and objective findings including presence of a physical examination, or presence of a differential diagnosis may have assisted him in arriving at the diagnosis sooner. Further, there is no clear documentation of clinical and patient assessments during the hospital admission. Lack of clinical/patient assessments and reassessments during a hospital admission would not meet standard of care. . ."

With respect to the issue of monitoring, reassessing and revisiting a presumptive diagnosis, Dr. Jawanda commented:

> "(iv) *Plan*. As mentioned above, with the information Dr. Warraich had at the time and taking into consideration a retrospective diagnosis of appendicitis, I can support his treatment plan on May 9 and May 10 according to his documentation. I also support his eventual treatment plan carried out with an ultrasound on May 14, with an order for CT abdomen/pelvis on May 15, however expediting the imaging on May 11 or sooner would have him arrive at a diagnosis sooner. His use of IV antibiotics, oral antibiotics for hospital acquired pneumonia, and choice analgesia were appropriate . . ."

Elsewhere in his report, Dr. Jawanda commented on the complexities of the case which made a diagnosis difficult and expressed the opinion that "his care was appropriate in terms of his initial assessment and plan, his choice of antibiotics/analgesia and imaging choices. . .", all of which met standard of care.

Dr. Jawanda's report and his testimony were fair and balanced. Dr. Jawanda's only significant specific criticism of Dr. Warraich's monitoring and reassessing of Patient 2 during her hospital stay, was a delay of several days in having a renal ultrasound and CT of Patient 2's abdomen performed. Such a criticism, muted as it was by Dr. Jawanda's recognition of the complexities of the case, is not sufficient to support a finding of professional misconduct in relation to failing to adequately monitor and assess Patient 2 while in the hospital and failing to revisit a presumptive diagnosis.

With respect to the issue of whether or not Dr. Warraich physically examined Patient 2, either on admission on May 7, 2015, or at any time thereafter, the parties are in agreement that <u>if</u> Dr. Warraich did not physically examine Patient 2 upon admission or thereafter, he did not meet the required standard with respect to his care of Patient 2. It also follows that if Dr. Warraich did not physically examine Patient 2, he would be guilty of failing to adequately monitor and/or assess Patient 2 (notwithstanding Dr. Jawanda's other conclusions), because physical examinations of Patient 2 while she was in the Hospital would be an essential component of monitoring and reassessing her, and would be necessary as part of revisiting a presumptive diagnosis.

Coupled with the inclusion of false information in the medical record, such actions would constitute professional misconduct because they would be reasonably regarded as improper by competent family physicians. They would also be regarded as conduct of an aggravated nature, not merely a failure to exercise ordinary care.

This issue will be determined on the basis of a comparative credibility assessment between Dr. Warraich and Patient 2. Dr. Warraich insists he examined Patient 2 on admission and on every day of her hospital stay except May 10. In contrast, Patient 2 is adamant that Dr. Warraich never physically examined her, either on admission, or at any other time during her hospital stay.

In terms of a comparative assessment of Dr. Warraich and Patient 2, the following considerations are relevant:

- Patient 2 initially filed a complaint with the College, raising several concerns about Dr. Warraich's interactions with her while she was in the Hospital in May 2015. Only one of those concerns resulted in a charge against Dr. Warraich. Counsel for Dr. Warraich say the other concerns were dismissed because they were "objectively wrong" and indicated a desire on the part of Patient 2 "to have Dr. Warraich punished".

- Patient 2 was not particularly diligent in pursuing her complaints, and had to be prompted by the College to provide further information in support of her complaints. There was an approximate two year delay in her doing so.

- Her recollection of all of the details of her admission to the Hospital were vague. For example, she could not remember if she had been physically examined by an emergency physician during the admission process.

- Conversely, she presented her evidence in a forthright and open manner. She provided a plausible explanation for her very specific recollection that Dr. Warraich had not physically examined her. She stated he did not physically examine upon admission, and following her admission, she was in isolation. Therefore, anyone entering her room would need to "gown and

glove" and she distinctly remembers Dr. Warraich did not do so and stayed at the entrance door of her room, asking her questions from that distance.

- Dr. Warraich was adamant that he did physically examine Patient 2 when he first saw her on May 8, 2015. He points to his admission note in the medical record which states, among other things "ear, nose and throat examine not remarkable, . . .CVS examination - heart sounds are audible . . .GIT exam - oral cavity dry. Abdomen is tender on right more than left but she had tenderness and pain on bilateral angle. Bowel sounds are audible. . ."

- Dr. Warraich also provided detailed evidence with respect to all of his attendances on Patient 2 between May 8 and May 15, outlining his thought processes and his ongoing assessments. He maintained that he conducted physical examinations of her on every day she was in the Hospital except May 10 and that his assessment of her and his treatment decisions were the logical result of his ongoing assessments, including his physical examinations of Patient 2.

The Panel has carefully considered the conflicting evidence on the issue of whether or not Dr. Warraich physically examined Patient 2 including, but not limited to, all of the above-noted factors.

Within the context of all of the evidence relating to Count 3, the Panel has concluded that Patient 2's testimony is more credible than Dr. Warraich's and her recollection of events more reliable that those of Dr. Warraich.

The reasons for the Panel's conclusions are outlined below:

1. Dr. Warraich's evidence at the hearing was more detailed than the information contained in his written reply to the College dated August 24, 2015. More concerning was that his evidence was more detailed than the information recorded in the medical chart. His adamant insistence that he could specifically recall physically examining Patient 2 when he first saw her

in the Hospital on May 8, 2015 and several times thereafter, even when his own notes, with one possible exception, did not refer to such examinations is unusual and warrants considerable skepticism on the part of the Panel. He was testifying approximately 4½ years after the events in question and would have had countless interactions with patients in the intervening period.

2. It is more likely that Patient 2's recollections are accurate. The events of May 2015 would have been very unusual and disturbing for her. It is reasonable that her recollection of her stay at the Hospital would be vivid and memorable to her. Her recollection that Dr. Warraich did not "gown and glove" while she was in isolation, and therefore did not enter her room to physically examine her, is consistent with the preponderance of probabilities which likely prevailed at that time.

3. The Panel's own review of the medical records relating to Patient 2 did not reveal any conclusive evidence that physical examinations were conducted by Dr. Warraich. In fact, those records indicate that it is more probable than not that such examinations were not conducted. Patient 2 was definitely physically examined in the Emergency Department at the time of her admission on May 7, 2015. Dr. Warraich's recorded information with respect to May 8, 2015, when he first saw Patient 2, are consistent with, and could have been taken from the Emergency Department record. The vital signs recorded in Dr. Warraich's admission report are identical to those recorded when the patient attended at the Emergency Department on May 7, 2015. On May 11, there is a note stating "chest congested", but that is preceded by a nurse's note which refers to Patient 2 stating "I feel congested, I feel that I cannot take a deep breath". Dr. Warraich's May 12 note simply reflects what the x-ray showed. In summary, his notes in the medical records do not demonstrate that physical examinations were conducted. If such examination had been conducted, it would be expected that the records would contain more information relating to the results of such examinations.

In reviewing the medical records in relation to Dr. Warraich's credibility, the Panel has also been mindful of the presiding judge's remarks in *Skeel Estate v. Iwashkiw 2006 ABQB 335* referred to elsewhere in these Reasons.

In the result, the Panel has determined that the evidence establishes that Dr. Warraich failed to physically examine Patient 2 when she was first admitted to the Hospital under his care as alleged in Count 3(a)(i) of the Amended Notice of Inquiry, and that he did not physically examine Patient 2 at any time thereafter during her stay at the Hospital. His failure to conduct such physical examinations meant that he failed to adequately monitor and/or assess Patient 2 and failed to revisit the presumptive diagnosis which was made when Patient 2 was seen in the Emergency Department as alleged in Count 3(a)(ii) of the Amended Notice of Inquiry. In addition, the Panel has determined that Dr. Warraich documented a complete physical examination of Patient 2 as part of her admission history when, in fact, he had not physically examined Patient 2 on admission, or at all, as alleged in Count 3(b) of the Amended Notice of Inquiry. Dr. Warraich therefore breached the record keeping requirements of By-Law 1 of the College and included false information in the relevant medical records. Dr. Warraich thereby committed acts of professional misconduct.

The failure on the part of Dr. Warraich to physically examine Patient 2 when she was first admitted to the Hospital, and his failure to physically examine her thereafter while she remained in the Hospital, coupled with Dr. Warraich's false documentation of a complete physical examination of Patient 2 as part of her admission history, support a finding that Dr. Warraich displayed a lack of knowledge, skill and judgment in the practice of medicine. Conducting an adequate physical examination of a hospital patient who is not recovering as expected, is a fundamental part of the practice of medicine. Not doing so displays a lack of knowledge, skill and/or judgment in the practice of medicine.

In view of the foregoing, the Panel finds Dr. Warraich guilty of displaying a lack of knowledge, skill and/or judgment in the practice of medicine, creating a false and/or misleading medical record in breach of the recordkeeping requirements of

By-Law 1 of the College, and of committing acts of professional misconduct as more particularly alleged in Count 3 of the Amended Notice of Inquiry.

Counts 1, 4, 5 and 6 in the Amended Notice of Inquiry

Dr. Warraich entered guilty pleas in relation to all of the above-noted counts. None of the facts and matters referred to in Counts 1, 4, 5 and 6 of the Amended Notice of Inquiry or in the Statement of Agreed Facts in relation to those Counts, were taken into consideration or relied upon by the Panel in reaching its conclusions with respect to Counts 2 and 3.

The facts in the Statement of Agreed Facts, which are not contested by Dr. Warraich, are clearly adequate to prove that he is indeed guilty of all of the matters alleged in those Counts.

The Panel recognizes that some of the facts relied upon by the Investigation Committee and set forth in the Statement of Agreed Facts with respect to Counts 1, 4, 5 and 6 are disputed by Dr. Warraich. However even on the basis of the facts which are not disputed the material allegations outlined in those counts have been proven and the facts put forward by Dr. Warraich to explain and provide context for his action do not detract from his guilt, or from the seriousness of the breaches which he committed.

With respect to Count 1 Dr. Warraich's guilty plea constitutes an acknowledgement that since in or about 2013, despite attempts to remediate his deficiencies, he has failed to demonstrate that he is providing adequate care to his patients. He has failed to create and maintain adequate medical records and their inadequacy is apparent because they do not allow for a comprehensive assessment of the nature and extent of the care he is providing to his patients. Dr. Warraich's guilty plea to Count 1 is also an acknowledgment that the deficiencies particularized in Count 1 establish that he has failed to meet the standard of the profession and has breached the record keeping requirements in By-Law 1 and By-Law 11 and that he has displayed and continues to display a lack of care, skill and judgment in the practice of medicine. The

nature and extent of his deficiencies and breaches are particularized in Count 1 of the Amended Notice of Inquiry and need not be repeated herein.

Count 4 relates to Dr. Warraich's inappropriate billing practices between September, 2013 and September, 2016 when he was providing services at the Middlechurch Home of Winnipeg and at the Riverview Health Centre.

Dr. Warraich acknowledges that he arranged for claims for services, purportedly provided by him to residents in those facilities, to be submitted to Manitoba Health as visits to those patients, when in fact his general practice was not to see or examine the patients for whom he billed a visit. He has admitted that by doing so he repeatedly committed acts of professional misconduct.

The nature and extent of his breaches and deficiencies are outlined in detail in Count 4 of the Amended Notice of Inquiry and need not be repeated herein.

With respect to Count 5, Dr. Warraich has pled guilty and has admitted to having created entries in the medical records of certain residents, who were under his professional care in Middlechurch, that were misleading as to the nature and extent of his involvement in the visits in question. He has acknowledged that he routinely documented information in patient charts suggesting that he had conducted an assessment or examination or provided care to a patient when he had not done so. The allegations in Count 5(b) have been admitted namely that he falsely represented that he had seen and assessed 13 listed patients on certain dates when in fact he had not personally attended to or interacted with those patients.

The nature and extent of his breaches and deficiencies are adequately particularized in Count 5 of the Amended Notice of Inquiry and need not be repeated herein.

Dr. Warraich has pled guilty to Count 6 acknowledging that with respect to the matters referred to in Counts 1, 4 and 5 of the Amended Notice of Inquiry he displayed a lack of knowledge of or a lack of skill and judgment in the practice of medicine. As noted elsewhere in these Reasons, the Panel has also decided that Dr. Warraich has displayed

a lack of knowledge of or a lack of skill and judgment in the practice in medicine in relation to the matters referred to in Count 3.

DECISION

The decision of the Inquiry Panel is as follows:

1. Pursuant to s. 56(3) of *The Medical Act*, there shall be no disclosure of the names or other identifying information of Patients 1 or 2 and there shall be no disclosure of the names or other identifying information of any other patients who may be referred to in the proceedings or in any exhibits in the proceedings.

2. Dr. Warraich is guilty of failing to demonstrate that he is providing adequate care to his patients and/or of failing to create and maintain adequate medical records, such that his records do not allow for a comprehensive assessment of the nature and extent of the care he is providing to his patients. He has thereby failed to meet the standard of the profession and breached the record keeping requirements of By-Law 1 and By-Law 11 of the College and displayed a lack of knowledge, skill and/or judgment in the practice of medicine.

3. Dr. Warraich is guilty of failing to meet the standard of care in his management and treatment of Patient 1 between in or about November, 2017 and March, 2018 in that he failed to adequately diagnose, manage and treat Patient 1's tuberculosis and he failed to create and maintain adequate medical records and thereby breached the record keeping requirements of By-Law 1 and By-Law 11 of the College.

4. Dr. Warraich is guilty of displaying a lack of knowledge, skill and/or judgment in the practice of medicine and/or creating false and/or misleading medical records thereby breaching the record keeping requirements of By-Law 1 of the College and of committing acts of professional misconduct, between on or about May 7 and May 15, 2015 when he was the most responsible physician for the care and management of Patient 2 in his capacity as a hospitalist as particularized in Count 3 of the Amended Notice of Inquiry dated December 7, 2018.

5. Dr. Warraich is guilty of engaging in unethical and inappropriate billing practices between in or about September 2013 and September 2016. During that period, he arranged for claims for services purportedly provided by him to residents in personal care homes to be routinely submitted to Manitoba Health as visits to those patients, when he had not, in fact, seen or examined the patients for whom he billed a visit, thereby committing acts of professional misconduct.

6. Dr. Warraich is guilty of breaching the recordkeeping requirements of the College's By-Laws and of committing acts of professional misconduct in that, between in or about September 2013 and September 2016, in relation to his attendance at one of the personal care homes to which he attended weekly, he created medical records which were misleading by routinely documenting information in charts which suggested he had conducted assessments, examinations and/or provided care to various patients when, in fact, he had not.

7. By reason of the findings of guilt in relation to the matters referred to in paragraphs 1, 3, 4 and 5 above, Dr. Warraich is guilty of displaying a lack of knowledge of or a lack of skill and judgment in the practice of medicine.

8. A further hearing before this Panel will be convened as soon as reasonably practical for the purpose of receiving the parties' submissions with respect to the order or orders which should be issued by the Panel pursuant to s. 59.6(1) of *The Medical Act*.

DATED this 1st day of October, 2020.

Dr. Carry Martens-Barnes, Chairperson

Dr. Valerie St. John

Russ Toews, Public Representative

IN THE MATTER OF:	*An Inquiry under The Medical Act C.C.S.M. c.M90*
AND IN THE MATTER OF:	*Dr. Naseer Ahmed Warraich, a member of the College of Physicians and Surgeons of Manitoba*
AND IN THE MATTER OF:	*An Amended Notice of Inquiry dated December 7, 2018.*

INQUIRY PANEL:

Dr. Carry Martens-Barnes, Chairperson

Dr. Valerie St. John

Russ Toews, Public Representative

RESOLUTION AND ORDER OF AN INQUIRY PANEL
OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

Counsel for The Investigation Committee
of The College of Physicians and Surgeons of Manitoba:

Lynne Arnason

Jeremy de Jong

Counsel for the Member Dr. Naseer Ahmed Warraich:

Helga Van Iderstine

Martin Minuk

Kelsey Schade

Counsel for the Inquiry Panel:

Blair Graham

RESOLUTION AND ORDER OF THE INQUIRY PANEL

WHEREAS Dr. Naseer Ahmed Warraich ("Dr. Warraich"), a member of the College of Physicians and Surgeons of Manitoba (the "College") was charged with displaying a lack of knowledge of, or a lack of skill and judgment in the practice of medicine, and of being guilty of professional misconduct, and with contravening By-Law 1 and By-Law 11 of the By-Laws of the College, as more particularly outlined in six counts of a Notice of Inquiry dated December 7, 2018;

AND WHEREAS on May 15, 2019, Dr. Warraich made a motion to be heard by a Panel of the Inquiry Committee (the "Panel") of the College for an order that the allegations set forth in Counts 2 and 3 of the Notice on Inquiry be severed from the remaining counts in the Notice of Inquiry;

AND WHEREAS on May 16, 2019, the Investigation Committee of the College made a motion to be heard by the Panel for an order amending Count 1 in the Notice of Inquiry;

AND WHEREAS both motions were heard by the Panel on June 3, 2019;

AND WHEREAS an order granting the amendment to Count 1 in the Notice of Inquiry was issued by the Panel on June 3, 2019 by consent;

AND WHEREAS Dr. Warraich's motion to sever Counts 2 and 3 from the remaining counts in the Amended Notice of Inquiry was dismissed by the Panel with written reasons for the decision being issued on June 11, 2019;

AND WHEREAS on June 3, 2019 certain other preliminary matters were determined, and certain documents were marked as exhibits in the proceedings, including the Amended Notice of Inquiry, and an order was granted pursuant to s. 56(3) of *The Medical Act* protecting the identity of patients who may be called as witnesses in the proceedings or who may be referred to in the proceedings;

AND WHEREAS on June 3, 2019, Dr. Warraich, through his counsel, entered a plea of guilty to Counts 1, 4, and 5 in the Amended Notice of Inquiry and also to Count 6, but on the understanding that his plea of guilty to Count 6 (displaying a lack of knowledge of or a lack of skill and judgment in the practice of medicine) was in specific relation to the allegation in Counts 1, 4, and 5 of the Amended Notice of Inquiry;

AND WHEREAS the Panel reconvened on January 14, 2020 in the presence of Dr. Warraich and his counsel and in the presence of counsel for the Investigation Committee, for the purpose of conducting an inquiry pursuant to Part X of *The Medical Act*;

AND WHEREAS on January 14, 2020, Dr. Warraich, through his counsel, confirmed his plea of guilty to Counts 1, 4, 5, and 6, and entered a plea of not guilty to Counts 2 and 3 in the Amended Notice of Inquiry;

AND WHEREAS the inquiry pursuant to Part X of *The Medical Act* proceeded before the Panel on January 14, 15, 16, and 17, 2020, in the presence of Dr. Warraich and his counsel and in the presence of counsel for the Investigation Committee and counsel for the Panel;

AND WHEREAS the Panel heard *viva voce* evidence from various witnesses and entered various exhibits into evidence including an extensive Statement of Agreed Facts and a Book of Documents;

AND WHEREAS thereafter the Panel received detailed written submissions from the counsel for the Investigation Committee and counsel for Dr. Warraich, and a rebuttal submission from counsel for the Investigation Committee, which written submissions were received in February, March, and April, 2020;

AND WHEREAS the Panel has considered the evidence introduced at the inquiry and has considered the oral submissions of the parties and has read and considered the written submissions of the parties;

NOW THEREFORE BE IT AND IT IS HEREBY RESOLVED AND ORDERED THAT:

1. Pursuant to s. 56(3) of *The Medical Act*, there shall be no disclosure of the names or other identifying information of Patients 1 or 2 and there shall be no disclosure of the names or other identifying information of any other patients who may be referred to in the proceedings or in any exhibits in the proceedings.

2. Dr. Warraich is guilty of failing to demonstrate that he is providing adequate care to his patients and/or of failing to create and maintain adequate medical records, such that his records do not allow for a comprehensive assessment of the nature and extent of the care he is providing to his patients. He has thereby failed to meet the standard of the profession and breached the record keeping requirements of By-Law 1 and By-Law 11 of the College and displayed a lack of knowledge, skill and/or judgment in the practice of medicine.

3. Dr. Warraich is guilty of failing to meet the standard of care in his management and treatment of Patient 1 between in or about November, 2017 and March, 2018 in that he failed to adequately diagnose, manage and treat Patient 1's tuberculosis and he failed to create and maintain adequate medical records and thereby breached the record keeping requirements of By-Law 1 and By-Law 11 of the College.

4. Dr. Warraich is guilty of displaying a lack of knowledge, skill and/or judgment in the practice of medicine and/or creating false and/or misleading medical records thereby breaching the record keeping requirements of By-Law 1 of the College and of committing acts of professional misconduct, between on or about May 7 and May 15, 2015 when he was the most responsible physician for the care and management of Patient 2 in his capacity as a hospitalist as particularized in Count 3 of the Amended Notice of Inquiry dated December 7, 2018.

5. Dr. Warraich is guilty of engaging in unethical and inappropriate billing practices between in or about September 2013 and September 2016. During that period, he arranged for claims for services purportedly provided by him to residents in personal

care homes to be routinely submitted to Manitoba Health as visits to those patients, when he had not, in fact, seen or examined the patients for whom he billed a visit, thereby committing acts of professional misconduct.

6. Dr. Warraich is guilty of breaching the record keeping requirements of the College's By-Laws and of committing acts of professional misconduct in that, between in or about September 2013 and September 2016, in relation to his attendance at one of the personal care homes to which he attended weekly, he created medical records which were misleading by routinely documenting information in charts which suggested he had conducted assessments, examinations and/or provided care to various patients when, in fact, he had not.

7. By reason of the findings of guilt in relation to the matters referred to in paragraphs 1, 3, 4 and 5 above, Dr. Warraich is guilty of displaying a lack of knowledge of or a lack of skill and judgment in the practice of medicine.

8. A further hearing before this Panel will be convened as soon as reasonably practical for the purpose of receiving the parties' submissions with respect to the order or orders which should be issued by the Panel pursuant to s. 59.6(1) of *The Medical Act*.

DATED this 1st day of October, 2020.

Dr. Carry Martens-Barnes, Chairperson

Dr. Valerie St. John

Russ Toews, Public Representative